ALLIANCE for CONNECTED CARE

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Comments on CY 2024 Physician Fee Schedule Proposed Rule (CMS-1784-P)

Dear Administrator Brooks-LaSure,

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide feedback on the Centers for Medicare & Medicaid Services' ("CMS") Medicare Physician Fee Schedule (PFS) proposed rule, which updates the schedule for Calendar Year 2024 (CY 24) and includes several important reforms with respect to telehealth. We look forward to working with you to continue efforts to ensure permanent access to services provided via telehealth post-pandemic.

The Alliance is dedicated to creating a statutory and regulatory environment in which patients can receive and providers can deliver safe, high-quality care using connected care technology. Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of more than 50 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

As reflected in the comments below, the Alliance appreciates the proposal to continue virtual direct supervision through December 31, 2024 and the consideration for how telehealth services can be furnished in all residency training locations beyond December 31, 2024. The Alliance generally appreciates the proposal to pay claims billed with place of service (POS) 10 (Telehealth Provided in Patient's Home) be paid at the non-facility PFS rate. The Alliance is committed to leveraging telehealth and remote patient monitoring to improve quality of care while also lowering costs and improving the clinician experience.

The Alliance would like to emphasize the following overarching priorities in advance of our more detailed response:

- The Alliance appreciates and supports the proposal from CMS to pay claims billed with POS 10 (Telehealth Provided in Patient's Home) at the non-facility PFS rate. We applaud CMS for this choice, which recognizes that Medicare services provided via telehealth are simply a different modality for patients to receive the same care. *However, rather than defining this payment rate around POS 10, we recommend that CMS consider instead offering the non-facility payment rate to any non-facility telehealth service.*
- The Alliance strongly supports the continued availability of direct supervision through telehealth for both the treatment of patients and the training of residents. We urge CMS to make expanded

direct supervision through telehealth permanent. The option for virtual direct supervision is needed to strengthen our health system's capability to meet longstanding health care challenges through increased access and a more flexible workforce.

- We appreciate CMS efforts to expand access to remote monitoring for Medicare patients served by Rural Health Clinics (RHCs) and Federally Qualified Health Care Centers (FQHCs), but believe that the use of code G0511 as proposed will fail to expand access or improve health equity due to restrictions on how the code can be billed and the reimbursement rate which is far lower than equivalent services when offered by other providers.
- We are optimistic for the revised review process for the Medicare Telehealth Services List but have some concerns with how this process is described – specifically around the thresholds for a code to be considered on a provisional status. We applaud CMS for attempting to provide more transparency in its process, and look forward to working with you to strengthen the process through which we evaluate which services are appropriate for delivery through telehealth.

Telehealth has become integrated into the care for America's seniors, allowing individuals to remain in their home when appropriate. We believe it is important for Seniors to have the option to remain in their home or another location for medical treatment and services like end-of-life care. With telehealth as an expected platform to access health care services, it is imperative telehealth continues as an option for America's seniors.

Please find below high-level comments in response to proposals in the CY2024 PFS. We look forward to meeting with you to discuss these items in more detail, as needed.

Requests to Add Services to the Medicare Telehealth Services List for CY 2024

We were disappointed that CMS found that none of the requests were eligible for Category 1 or Category 2 criteria for permanent addition to the Medicare Telehealth Services List. In the proposal, CMS notes concerns around these requested services including the need for a service to be inherently face-to-face to be considered for telehealth modality, the need for further action by Congress, and hospital and emergency department (ED) services via telehealth outside of the COVID-19 setting.

CMS notes that, in absence of further action by Congress, there are limitations from current authority on what CMS can do. CMS notes that it does not have the authority to expand the list of eligible Medicare telehealth practitioners, however the Alliance believes that CMS can do more with existing statutory authority, as explained later in our comments.

<u>Emergency Department Services</u>

CMS notes it does not believe that several hospital care and emergency department (ED) codes (CPT Codes 99221-99226; 99238-99239; 99281-99283) meet the criteria for inclusion on the Medicare Telehealth Services List on a Category 2 basis, outside of the immediate risk associated with the COVID-19 disease exposure. The Alliance disagrees with this reasoning and believes the provision of emergency services through telehealth are an important supplement to in-person care. Telehealth can be an important tool to support and direct patients to the most appropriate form of treatment, and in many cases does serve the same triage functions as an emergency room. If a health care provider is staffing a telehealth

capability with individuals who would otherwise be performing emergency department services, they should be able to bill for the appropriate care. We also note that Health care-associated infections are a leading cause of morbidity and mortality. Hospital-acquired conditions (HACs) cost an estimated additional $1.06 million and 757 additional days in the hospital per year. HACs occur outside of just the COVID-19 pandemic. The use of telemedicine can help reduce HACs by allowing the patient to receive care from home, further reducing the spread of disease.

Additionally, the Alliance urges CMS to align the requirements of HCPCS G0425-G0427 with the requirements for in-person ED codes (99282-99285) and inpatient codes (99221-99223/99231-99233). Currently HCPCS G0425-G0427 requires a varying level of collection of patient history:

- *Practitioners taking ~~a problem focused history, conducting a problem focused examination~~, and engaging in medical decision making that is straightforward, would bill HCPCS code G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth).*
- *Practitioners taking ~~a detailed history, conducting a detailed examination~~, and engaging in medical decision making that is of moderate complexity, would bill HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth).*
- *Practitioners taking ~~a comprehensive history, conducting a comprehensive examination~~, and engaging in medical decision making that is of high complexity, would bill HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth).*

However, we believe the complexity of medical decision making should already align to what was done in-person. We recommend replacing the varying level of patient history requirement with "medically appropriate history and/or exam" for all three HCPCS codes. To provide a clinical example, if a patient had a stroke in the in-person setting and received IV TPA (which would need to be closely monitored for toxic side effects), it would be appropriate to code a 99223 based on high complexity medical decision making. On the other hand, a telestroke service should not be coded as a G0427 because it would not be clinically necessary to perform an 8-organ system examination, obtain a 10 system ROS, or possibly obtain family history for this patient.

Social Determinants of Health Assessment

The Alliance supports the addition of HCPCS Code GXXX5 (*Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes)* to receive a permanent status on the Medicare Telehealth Services List. CMS notes that the use of two-way interactive audio-video technology, as a substitute to in-person interaction, means an analogous level of care, in that using either modality would not affect the accuracy or validity of the results gathered via a standardized screening tool. Several studies have demonstrated the benefits of utilizing telehealth in capturing social

determinants of health (SDOH).[12] A 2022 survey found that 63 percent of respondents strongly agreed that concerns related to their SDOH were addressed when receiving care via telehealth. While we agree that the preferred method of telehealth patients is two-way, audio-video communications, we are concerned that CMS is limiting access for those who face barriers to a two-way audio-video platform. We caution CMS on limiting this service to only two-way interactive audio-video technology. Audio-only codes have demonstrated benefits – particularly for brief communication technology-based evaluation and management services for patients who do not have access to broadband. According to the Federal Communications Commission (FCC), approximately 19 million Americans still lack access to broadband. In rural areas, nearly one-fourth of the population —14.5 million people—lack access to this service.

On a related issue, while CMS has issued guidance indicating that health risk assessment for the purposes of risk adjustment may be offered through telehealth in 2023, it has not yet created clarity on these services in 2024 and beyond. We respectfully request that CMS update its permanent guidance on risk adjustment through telehealth.

E-Consults

The Alliance requests CMS to consider adjusting CPT 99452 code for e-Consults. CPT code 99452 (*Interprofessional Telephone/Internet/Electronic Health Record Consultations*) to allow treating providers to request the opinion and/or treatment advice of another provider with specific specialty expertise to assist in diagnosis or management of the patient's problem without seeing the patient. However, the time requirement of a minimum of 16 minutes is difficult for providers to meet. Several studies showed average time spent on e-consult requests was less than 10 min on average.[34] The Alliance requests CMS to lower the time frame to a reasonable amount based on the average time used for e-Consults or to consider including another code that captures additional follow-up time. It is widely known that e-consults provide clinical value and can reduce referrals to specialists – reducing costs to the Medicare program. Due to these considerations, CMS should take additional steps to make these services easy to use and attractive for primary care and other practitioners.

Revisions to the Process to Add Services to the Medicare Telehealth Services List for CY 2024

We applaud CMS for its effort to revise and improve the process to consider changes to the Medicare Telehealth Services List. As the Alliance commented in our response to the CY 2023 Physician Fee Schedule, the current process by which CMS reviews and approves codes is time-consuming and a costly endeavor for organizations to submit codes to consideration. The cost-benefit analysis of undertaking this effort for health care organizations is difficult without CMS demonstrating that it regularly approves new codes. The Alliance is generally supportive of the revised process as it transparently outlines the process for CMS's review and includes notifications to the submitted on the status of the code submission as mentioned in the proposed Step One.

[1] https://news.unchealthcare.org/2022/03/study-finds-providing-telehealth-technology-access-may-expand-reach-and-benefits/
[2] https://journals.lww.com/clinicalobgyn/Abstract/2021/06000/Using_Telehealth_Approaches_to_Address_Social.13.aspx
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6747903/
[4] https://medinform.jmir.org/2016/1/e6

It was shown during the COVID-19 Public Health Emergency that Medicare telehealth services were used simply as a different modality for a patient's existing providers to improve access and maintain continuity of care. According to a COVID-19 Healthcare Coalition survey, nearly 80 percent of the more than 2,000 patients surveyed indicated that they received telehealth services from their own provider, demonstrating that more often than not patients can and will get care from their existing providers. The Alliance appreciates CMS for recognizing that telehealth as a substitute for an in-person encounter in the proposed Step Two and Three.

The Alliance appreciates the proposed steps four and five. Last year, the Alliance comments argued that there should not be a need for CMS to separately evaluate whether providing a service through telehealth adds clinical value if CMS already knows that the service itself provides clinical value, and it can meet all clinical requirements when offered through telehealth. There should not be a need for CMS to specifically evaluate whether providing a service through telehealth adds clinical value, if CMS already knows that the service itself provides clinical value. Telehealth is simply a modality for providing the same care – it is not a different service or type of care. Re-proving that a service which has already been deemed by CMS to have clinical value a second time is a redundancy and is holding telehealth to a higher standard than other care.

The Alliance cautions CMS from prematurely removing services from the Medicare Telehealth Services List because the service elements are deemed unfit under the criterion. As the care system and technology continues to transform, there will be new possibilities for telehealth as a modality for services that must be tested – our system is continuing to evolve to support new more flexible modalities of care.

Support for the Proposed Assignment of "Permanent" or "Provisional" Status

The Alliance also appreciates CMS outlining a plan for a code to have "provisional" status on the Medicare Telehealth Services List, but we have concerns about how CMS has described the threshold of eligibility to be considered on a provisional basis.

The Alliance strongly urges CMS to reconsider the provision to not assign a code a provisional status when it is improbable that a code would ever achieve permanent status. Provisional status should be an opportunity to evaluate data round a specific code. A requirement that codes are likely to be made permanent undermines the opportunity created for testing provisional telehealth codes. As more data is released, there will be changes in the care model system and more services may demonstrate the ability to be offered in a virtual manner. As the care system and our technology continues to transform, there will be new possibilities for telehealth as a modality for services that must be tested.

Overall, we appreciate the proposal from CMS to modernize the Category 1-3 taxonomy that CMS currently uses, as telehealth utilization continues to remain above pre-pandemic levels and we continue to expect more telehealth services to emerge for consideration.[5] According to a 2023 Assistant Secretary for Planning and Evaluation (ASPE) report, beneficiaries who were insured by Medicare were 1.23 times

[5] Koonin LM, Hoots B, Tsang CA, et al. Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. MMWR Morb Mortal Wkly Rep 2020;69:1595–1599. DOI: http://dx.doi.org/10.15585/mmwr.mm6943a3

more likely to use telehealth compared to those who were insured by a private payer using data from April 2021 through August 2022. These findings were consistent with findings from previous analyses.[6][7]

In addition to examining the utilization and clinical benefits when evaluating telehealth services, future CMS evaluations should consider increases in patient access and efficiencies afforded, such as the removal of transportation, work, childcare, and other everyday barriers to in-person care. Furthermore, broader clinical benefits, such as the number of missed appointments and general adherence to a care plan, should be considered.

Feedback on Telehealth Provisions of the CAA, 2023

The Alliance appreciates CMS implementation of CAA, 2023, which would extend certain telehealth flexibilities through December 31, 2024. According to CMS data, there are over eight million Medicare beneficiaries that access a health care services via telehealth. The Alliance urges CMS to continue to continue to provide timely communication to its stakeholders with clarify around regulatory guidance. Without clear guidance, regulatory uncertainty may deter stakeholders from investments to innovative care, like telehealth.

While the Alliance also appreciates the extension of certain telehealth services through December 31, 2024, we believe that telehealth services should be made permanent. We understand that without additional action by Congress, CMS is unable to make permanent the telehealth services. However, we believe CMS can still address a few items of note under current authority.

Place of Service for Medicare Telehealth Services

The Alliance applauds CMS for its decision to pay POS 10 claims at the non-facility rate. As noted, through years of comments, the Alliance believes telehealth serves as another modality to same care services and should not be paid differently by the Medicare program.

While the Alliance supports the non-facility rate payment, the Alliance and its members urge CMS to alter its definition of what services are eligible for the non-facility rate. Rather than limiting this payment to the patient's home through POS 10, CMS should instead simply apply the non-facility rate for any telehealth service not offered from a facility. Another option would be to update the definition of POS 10 to represent any patient location except a health care facility or other medical setting. While we appreciate CMS's attempts to be clear that "home" is a broad definition, we still consider it to be limiting for the potential of telehealth services. Patient should be able to access telehealth from any location, including the home. Approximately 19 million Americans still lack access to fixed broadband service at threshold speeds. In rural areas it is nearly 14.5 million Americans. Many of these populations use telehealth from partnership programs, including libraries, parking lots, and hotels.[8][9] It is our understanding that CMS has undertaken this approach to avoid paying the non-facility rate for facility-

[6] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf
[7] https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf
[8] https://www.libraryjournal.com/story/Public-Libraries-Tackle-Telehealth-Challenges
[9] https://www.ama-assn.org/practice-management/digital/telehealth-progress-relies-making-temporary-policies-permanent

based telehealth care. If that is indeed the primary concern from CMS, we request they simply make that the criteria, rather than limiting telehealth to the patient's home.

We note that the Telehealth Impact Study, an initiative of the COVID-19 Healthcare Coalition, surveyed patients about their telehealth usage and found that 90.9 percent of seniors ages 65 or older indicated that they had seen their own provider or another provider in their provider's practice through telehealth. The telehealth care was used to strengthen the patient-provider relationship and ensure continuity of care throughout the pandemic – and it would have the same effect after. Nearly all Medicare fee-for-service (FFS) telehealth was with patients who also utilized in-person care, and nearly all Medicare FFS telehealth was provided by providers who also offered in-person care. That means that telehealth is being offered as a service to Medicare beneficiaries, but it is not in any way reducing practice expenses for those providers.

Direct Supervision via Telehealth

The Alliance applauds CMS for its proposal to continue to include supervision through real-time audio and visual interactive telecommunications through December 31, 2024. Virtual direct supervision through telehealth can support innovative home-based care models, can expand workforce capacity, and will of course have utility in any future outbreak or public health emergency situation. Virtual supervision is crucial to the transformation of our health care system – from one in which patients sit in offices and wait, to one that meets patients and their needs when and where they are. We strongly urge CMS to make permanent its guidance allowing direct supervision through real-time audio and virtual interactive telecommunications rather than hold an arbitrary deadline of December 31, 2024 (a deadline which has no statutory basis).

One particularly notable use case is the direct supervision of a medical professional offering telehealth or other virtual care. It simply does not make sense to require that the supervising clinician to be in the physical room, when the patient is being treated remotely. It should be fully adequate for the supervising clinician to have virtual access to the patient-practitioner interaction, as this is the same level of access that the patient has to the care being offered.

Additionally, as the elderly population in the United States grows, there is an increasing need for home-based care services, which may include both medical and nonmedical caregiving. Given the drastic workforce shortages that exist, the opportunity for a Medicare-billing practitioner to supervise care being offered by a non-billing practitioner in the home is a monumentally large opportunity to transform the delivery of health care in the United States to better meet patient needs when and where they are.

Supervision of Residents in Teaching Settings

The Alliance applauds CMS and its proposal to allow the teaching physician to have a virtual presence in all teaching settings, for clinical services furnished virtually (for example, a 3-way telehealth visit, with all parties in separate locations). The Alliance and its members believe virtual supervision of residents by teaching physicians provides an opportunity for residents to assist them with meeting the rapidly-growing demand for telehealth and prepare them for diverse job opportunities. In a pilot program, a majority of

residents noted the value of having a telehealth rotation in the curriculum, citing that "it prepared for telehealth in the specialty program."

The Accreditation Council for Graduate Medical Education (ACGME) recognizes the benefits for allowing virtual supervision of residents and recommends this as a best practice in its Common Program Requirement. Many residents starting their first year of postgraduate training are unlikely to have been exposed to telehealth training. Familiarizing the next generation of health care providers with the knowledge of telemedicine serves as a valuable skill to serve populations that do not have more direct access to quality medical care. Without allowing virtual supervision of residents after December 31, 2024, residents and attending physicians may not acquire valuable skills in their ability to consult and treat patients remotely.[10]

Additionally, medical teaching hospitals have seen a growing number of requests from its providers to leverage the efficiencies of virtual modalities to supervise residents who may be physically co-located with a patient at facility while the attending is off-site. For example, at some of these hospitals, a resident might be on site and speak with and examine a patient in person, while the teaching physician offering supervision over video. When the attending physicians bill for this interaction, they will do so using the appropriate telehealth billing information (as they are seeing the patient over telehealth) and they should be allowed to include the information they obtained from the resident provider in their medical decision making. The Alliance encourages CMS to consider this innovative supervisory model.

Remote Monitoring Services

CMS is proposing to clarify that the 16-day data collection minimums apply to existing RPM and RTM code families for CY 2024. The Alliance for Connected Care continues to be concerned about this proposal, as it prevents clinicians from offering these services for part of a month. Additionally, providers will not know whether 16 days of data are achieved until the end of the month, but will need to continue ongoing treatment management services from the beginning of the month and throughout the month. This puts providers at a significant risk of not being paid at all.

CMS is also clarifying that RPM and RTM may not be billed together and reasserting that multiple practitioners may not bill RPM for the same patient. The Alliance and its members have broad concerns about the restrictions on RPM billing for one practitioner. There are medical instances during which two practitioners may need to collect different information from a patient in order to manage multiple chronic conditions and multiple devices may be needed. There are also instances where a complex, high-need patient may need multiple monitoring devices to capture different chronic conditions/risks. The better management of these conditions is both good for these patients and will decrease overall spending in the Medicare program. There are over 38 million Medicare beneficiaries who suffer from two or more chronic conditions. Practitioners should not be penalized when working on team-based care to provide the best care to patients.

To this end, the Alliance urges CMS to reimburse 99454 for monitoring associated with each device utilized in the delivery of RPM services. It is often clinically reasonable and necessary to collect data from two or

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9756963/

more separate medical devices to manage certain conditions and/or combinations of conditions. Existing reimbursement practically limits complex patients to monitoring via a single device, decreasing access to effective care and diminishing the potential for cost-savings to Medicare.

The Alliance appreciates CMS recognition that RPM is working to strengthen the care management capabilities of primary care clinicians. As mentioned in Section B(2), CMS recognizes RPM CPT codes 99457 and 99458 as primary care services for the purposes for beneficiary assignment in the Shared Savings Program. RPM enables providers to gain a comprehensive understanding of the patients' conditions while at home, facilitating more coordinated and engaged care efforts. This is particularly useful for patients that may have transportation or other barriers to frequent primary care access.

Telephone Evaluation and Management

The Alliance applauds CMS for continuing to assign active payment status to CPT codes 99441 -99443 (provider codes) and 98966 through 98968 (non-provider codes) for CY 2024 to align with telehealth-related flexibilities that were extended via the CAA, 2023, specifically section 4113(e), which permits the provision of telehealth services through audio-only telecommunications through the end of 2024. While we believe that audio-video communication is the preferred modality for most telehealth, we strongly support continued flexibility for audio-only telehealth – when clinically appropriate and when meeting the need or request of the patient. We believe that failure to allow audio-only services will result in significant care gaps that disproportionately affect the Medicare population.

Nutrition Management Training Through Telehealth

The Alliance supports codifying billing rules for DSMT services furnished as Medicare telehealth services. Despite robust evidence demonstrating the effectiveness of DSMT, less than 5 percent of Medicare beneficiaries with a new diagnosis of diabetes receive DSMT. There is strong evidence that increased participation in DSMT reduces health care spending by preventing emergency and urgent care visits and inpatient hospitalizations. A study found that DSMT delivered via telehealth offers effective, efficient, and affordable ways to reach and support the underserved minorities and other people with diabetes and related comorbidities. The Alliance believes that codifying billing rules for DSMT services via telehealth expands access to diabetes care and education specialists, particular in areas with shortages to accessing these services. Additionally, DSMT services are beginning to be commonly furnished as a Medicare telehealth service, as one member noted 50 percent of its DSMT program is provided via telehealth.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The Alliance supports efforts to allow RHCs and FQHCs to be able to individually bill for RPM and RTM services, but has some concerns with the implementation of these provisions in the proposed rule. While only 15 percent of Americans live in rural areas, they represent two-thirds of primary care health professional shortage areas. RHCs in particular play a critical role in serving rural communities, with approximately 20 percent of care provided to rural residents were provided by these centers.

The Alliance disagrees that HCPCS code G0511 is the most appropriate code to capture these services provided. We believe payment for these services should more closely resemble the payment offered to

other types of health care providers – creating consistent payment structures for virtual services across provider types, reducing complexity for these and other providers.

The primary challenge with the use of G0511 is that these care management services may be billed only once per month, but now capture a wide range of care management services like CCM, behavioral health integration, principal care management, chronic pain management, among others. We believe forcing a practitioner to choose only one care management service to offer in a month is an inappropriate restriction on the practice of medicine. Additionally, this rapidly becomes a health equity issue – as more wealthy beneficiaries in areas not served by RHCs or FQHCs would have access to providers who can bill multiple care management services in a month, and those who rely on RHCs or FQHCs would not. Given this, we recommend the creation of a new code for RPM services – one that more closely mirrors the payment structures that exist for other Medicare providers.

Finally, the Alliance is concerned that the current payment calculation CMS is using to determine reimbursement for components of the G0511 services do not reflect the true cost of providing RPM services. It appears CMS averaged the costs of services in order to estimate a payment amount, but this calculation did not seem to consider the fact that most patients using RPM are served by multiple RPM services concurrently – which are cumulatively much higher than $73. The Alliance strongly urges CMS to consider revising its payment calculation methods to accurately capture the true cost of RPM services and bring this number more in line with Medicare payment for RPM in other settings.

Mental Health

The Alliance applauds CMS for recognizing marriage and family therapists (MFT) and mental health counselors (MHC) as telehealth practitioners. The Alliance believes expanding types of providers permitted to provide telehealth services can reduce barriers to accessing telehealth. According to a 2021 study, approximately 66 percent of all behavioral health care is delivered virtually. Additionally, telehealth helped engage patients in mental health treatments such as addition, by improving access and convenience. The Alliance urges CMS to continue to review the data on other types of providers to be considered as a telehealth practitioner.

The Alliance is pleased that CMS continues to recognize the patient's home as a permissible originating site for mental health care services. Allowing telehealth visits to originate in the beneficiary's home, regardless of where the beneficiary lives, will expand providers' ability to deliver timely follow up care. Telehealth services in the beneficiary's home will increase communication between patient and provider, allowing for earlier identification and intervention of complications, and can enhance care coordination and efficiency. We look forward to Congress making this access permanent.

Request on the Provision of Telehealth Services from a Remote Location

The Alliance for Connected Care once again urges CMS to address provider enrollment and billing concerns related to the provision of telehealth services from a provider's home or non-clinical location. As you know, CMS currently allows practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment or billing paperwork.

There are a multitude of reasons for this request. The current location-based enrollment structure is outdated and does not support providers new operational and privacy concerns faced in a digital age. Furthermore, we encourage thoughtful consideration of the implications of telehealth on providers – not just patients. All the conveniences that telehealth provides for patients, are also afforded to providers.

Care can be delivered dynamically and in many settings. A provider may not be just at their office, they can be at home, or at an off-site clinic, etc., and there are operational issues with how to list all of those various addresses. In addition, all providers (whether 0%, 51%, or 100% virtual care) are associated with a medical practice that has a primary address. The associated address for that clinic represent the "operational structure." Therefore, the infrastructure has little to do with where the provider is located physically during the virtual visits. We note that when crafting regulations for the delivery of telehealth to patient in their home, CMS has adopted a broad definition of "home" to reflect significant variation in patient situations – we believe these updated views must also translate to the provider of a telehealth service.

In addition to operational concerns, providers have personal privacy and safety concerns with submitting their personal home addresses. Given that CMS declined to address this issue under this rulemaking, we urge examination of these concerns and adoption of appropriate changes as described herein.

In response to these concerns, we offer a specific proposal that we believe offers a path forward while respecting CMS concerns about potential bad actors:

1. We request that CMS make permanent the pandemic-era location flexibility to allow clinicians to bill telehealth services from a location at which at the clinician is capable of offering in-person care to patients, even when offering services from a different location such as the home.

2. For those providers without a physical practice location, we request that CMS develop an alternate method of reporting geographic location. One suggestion would be to allow a business address to be reported for purposes of enrollment, and a geographic indicator such as a zip code be reported for appropriate payment adjustment by geographic cost and wage index. An alternate option would be for CMS to identify a population of provider organizations at higher risk of "gaming" the system and leverage CMS claims data to monitor for unexpected geographic distribution of services related to enrolled location of those providers.

3. If the above changes cannot be implemented by 2024, we request that CMS align current flexibilities around provider location with the statutory allowance for telehealth until December 31, 2024 and engage stakeholders in a meaningful discussion around permanent policies that would address our concerns described above.

We respectfully request that CMS promptly issue guidance related to these concerns, well in advance of the cessation of current guidance which will expire at the end of 2023.

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The Alliance greatly appreciates CMS's leadership in working to ensure that seniors are able to realize the benefits of telehealth and remote patient monitoring. We appreciate the opportunity to provide feedback on the Medicare Physician Fee Schedule (PFS) proposed rule for calendar year (CY) 2024, and look forward

to continuing to work with CMS to increase access to high quality connected care for Medicare beneficiaries. If you have any additional questions, please do not hesitate to contact Chris Adamec at cadamec@connectwithcare.org.

Sincerely,

Krista Drobac

Krista Drobac
Executive Director
Alliance for Connected Care