



Maryland  
Hospital Association

September 13, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1751-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Dear Ms. Brooks-LaSure:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed 2022 Physician Fee Schedule (PFS) to align with revisions in accordance with the Consolidated Appropriations Act, 2021.

MHA supports CMS's proposal to make permanent access to some telehealth services that were expanded during the COVID-19 public health emergency (PHE). These measures help hospitals continue to deliver safe, effective services, while ensuring Medicare beneficiaries can access quality care when and where they need it. Telehealth also remains an increasingly vital tool for our hospitals and health care professionals to reach the goals of Maryland's Total Cost of Care Model contract.

Our members use these flexibilities to innovate, shifting care delivery in a way that will outlast the PHE if there is an appropriate statutory and regulatory framework. MHA recognizes CMS's regulatory authority is restricted by federal law. We support federal legislation that would give the agency authority to boost access to clinically appropriate care, regardless of the modality through which it is delivered.

MHA's comments on the PFS focus on several key issues. We aim to preserve remote access to the Medicare Diabetes Prevention Program, access to telemental health services, extension of Category 3, remote monitoring services alignment, and supervision allowances.

MHA advises that future work include a thorough and complete accounting of the costs of virtual visits and how such expenses relate to the need to maintain capacity for in-person services. Armed with this information, CMS should ensure health care practitioners receive adequate payment for the substantial upfront and ongoing costs to establish and maintain virtual infrastructure, including secure platforms, licenses, IT support, scheduling, patient education, and clinician training. Adequate reimbursement will make telehealth sustainable and promote opportunities for practitioners to improve health care equity.

## **Medicare Diabetes Prevention Program – Key to Maryland’s Model**

The Maryland Total Cost of Care Model, one of CMMI’s top performing programs, aims to improve quality and cost in both hospital and non-hospital settings. Population health improvement and chronic disease management are central aims. The state agreed to focus on population health goals to reduce diabetes, obesity, and overdose-related deaths. Since 2018, the Medicare Diabetes Prevention Program (MDPP) has offered behavior change interventions to Medicare beneficiaries at risk of developing type 2 diabetes. Unfortunately, to date, Medicare beneficiaries have been unable to access this program when offered remotely because CMS has not allowed digital practitioners to be reimbursed in the MDPP expanded model.

MDPP is a vital resource to meet population health goals agreed to by CMMI and the state of Maryland. ***MHA urges the agency to align payment policy with the decisions of the Centers for Disease Control and Prevention (CDC) and ensure CDC-recognized virtual Diabetes Prevention Program clinicians can participate in MDPP after the PHE.***

## **Telehealth Expansion for Mental Health Services**

### *In-Person Requirement for Certain Telemental Health*

MHA appreciates CMS’s proposal to eliminate originating site requirements for mental health services delivered via telehealth. However, CMS proposed several provisions to implement statutory requirements for an in-person exam before beginning mental health services delivered via telehealth at the patient’s home. MHA understands this requirement stems from statutory requirements in the Consolidated Appropriations Act, which we hope Congress will reconsider.

Maryland hospitals report more patients accessing mental health care via telehealth. Mental health care via telehealth netted a 70-90% decline in appointment “no-show” rates. Patient preference and professional discretion for in-person visits are crucial to successful telehealth implementation. MHA will continue to urge Congress not to override clinical judgment to determine when an in-person visit is required.

Current law requires an in-person visit within six months of an initial telehealth visit. CMS proposed to keep that condition and to require an in-person visit in the six months before subsequent telehealth visits. This effectively creates a new, arbitrary mandate for the patient to have an in-person mental health visit every six months to continue receiving care. The statute gives CMS ample flexibility to expand that time or eliminate it altogether by allowing visits to occur “at such times as the Secretary determines appropriate.” ***MHA requests CMS remove these requirements for additional in-person to ensure Marylanders maintain access to care.***

### *Telehealth Visits with Alternate Practitioner at Same Practice*

CMS requested comments to address the scenario when an individual is unable to schedule a telehealth appointment with their designated specialist at a practice, but another health care professional at that same practice is available. Hospitals do not want patients to lose access to care. Hospitals leverage a team approach to care and limiting patients to a specific doctor can hinder collaborative care. ***MHA suggests CMS allow physicians in the same practice to offer***

***telehealth services to the patient if the principal physician is unavailable or if the patient would like to change physicians in the practice.***

#### *Interactive Systems-Audio-Only*

MHA strongly supports CMS's proposal to allow use of audio-only technologies because a caregiver's attention to a patient and ability to care for the patient does not change with the technology. Audio-only technologies are essential to help patients, especially those with limited or no internet connectivity, to continue to access health care. ***MHA applauds CMS's expansion of access to audio-only services and agrees it is appropriate to consider the patient's preference and technology limitations when considering applicability of audio-only care.***

Moreover, COVID-19 underscored the disproportionate effects the digital divide has on already underserved and disadvantaged communities. Black and Latinx and rural communities, who have long-standing disparities in access to care, more often rely on audio-only health services. Areas with lower median household incomes and older residents, including many with impaired eyesight or motor skills, relied on audio-only health services due to lack of internet and audio-visual capable devices. Similarly, MHA members experienced this firsthand:

- At one hospital, 94% of families using audio-only health services had Medicaid
- Another hospital observed that over 80% of patients using audio-only health services had Medicaid, with the greatest concentration in patients aged 50-59 years; at one facility, use of audio-only services by Medicaid patients reached 91%
- At a third hospital, 29% of Medicaid patients used audio-only services, compared to 11% of commercially insured patients.

MHA recently led efforts to change Maryland law to include audio-only for all state payers. ***MHA advises CMS to consider which other services outside of mental health could be appropriately delivered via audio-only technology, especially if the patient does not have access to full audio-visual technologies.***

#### **Category 3 Extension**

MHA appreciates CMS's extension of the Category 3 telehealth service list until Dec. 31, 2023. Category 3 could be a useful framework to maintain access to services beyond 2023 and the end of the COVID-19 pandemic. We hope CMS will make Category 3 a permanent process through which new telehealth services can be temporarily added while CMS collects evidence to support making additional services permanent.

With this understanding, ***MHA urges CMS to reconsider eliminating services from the current approved list until further recommendations and data can be reviewed in 2023.***

#### **Remote Therapeutic Monitoring (RTM) and Remote Patient Monitoring (RPM)**

MHA appreciates CMS's swift action to adopt, cover, and reimburse remote monitoring service codes in the proposed rule. We agree with CMS's recognition that currently proposed coding for RTM services may face challenges. For example, only a specific set of provider types can bill the

codes, and clinical staff time cannot be billed to physician/nonphysician practitioner services under general supervision.

***Given the similarities between different remote monitoring services, MHA requests CMS consider aligning policies for coverage and payment.*** MHA suggests CMS expand the existing covered codes. These policies should include provisions related to acute and chronic patients, obtaining consent at the time of service, general supervision, cost-sharing waivers for COVID-19 patients, and allowing access to new and established patients.

Further, ***MHA encourages CMS to make permanent the current temporary policy allowing for access to remote patient monitoring services for new patients.***

### **Direct Supervision via Telehealth**

MHA agrees with CMS's amendment of the current definition of "direct supervision" (both under 42 CFR 410.27 (a)(1)(iv)(D) for hospital outpatient services and under 42 CFR 410.32(b)(3)(ii) for physician office services). Our members and their patients benefited from direct supervision via telehealth during the pandemic, and hospitals should continue to have this option in the future. Health care professionals generally should have the autonomy to determine when direct supervision via telehealth is clinically appropriate and in line with the relevant standard of care. We encourage CMS to avoid adding requirements that do not otherwise exist for in-person services.

MHA strongly encourages CMS to consider the above recommendations when finalizing proposed rules to support meaningful coverage of clinically appropriate telehealth services. Maryland Medicaid will seek guidance from CMS to cover the expansion of critical services for some of our most vulnerable populations. Thus, the sooner CMS acts on covering this vital service modality, the sooner our hospitals can boost access to care for Maryland's most vulnerable people.

Thank you for the opportunity to share feedback on this proposed rule. If you have questions or would like to discuss our recommendations further, please contact Jennifer Witten, Vice President, Government Affairs at [jwitten@mhaonline.org](mailto:jwitten@mhaonline.org).

Sincerely,



Bob Atlas  
President & CEO  
Maryland Hospital Association