



September 9, 2021

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

Re: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements; CMS-1751-P

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to provide comments on the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS) proposed rule.

ACHP represents the nation's top-performing non-profit health plans improving affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that provide high-quality coverage and care to more than 24 million Americans across 36 states and D.C. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data driven systems improvement.

ACHP appreciates the Administration extending telehealth within the Medicare program and encourage additional efforts that support a long-term goal of value-based care and reimbursement for telehealth. We offer the following comments on provisions included in the proposed rule and the Request for Information (RFI) on Health Equity:

Telehealth

ACHP supports Congressional expansion of the Medicare telehealth benefit for mental health services furnished in the home and without geographic restrictions.

ACHP has long supported and promoted telehealth as a vehicle for providing affordable and efficient access to care, especially in areas challenged with widespread access to timely and available care. ACHP understands that the Administration is codifying the telehealth expansions authorized by the Consolidated Appropriations Act of 2021. However, we

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underscore that the in-person requirements before and after telehealth services in order to be eligible for reimbursement are absolutely unnecessary restrictions.

ACHP does not support the requirement for in-person patient encounter before payment of telehealth services for any mental health disorder. However, we recognize that CMS must codify the provisions of the Consolidated Appropriations Act of 2021. While ACHP will continue to advocate to Congress to reverse this legislative requirement, we encourage CMS to implement this provision with as little burden to patients as possible. Under section 1834(m)(7) of the Social Security Act, as added by the SUPPORT Act, there is no requirement that the patient have an in-person visit before payment for telehealth services treating substance use disorders, co-occurring mental health disorder, or to services furnished in an originating site that meets the geographic requirements. Therefore, clarifying the distinction between the two provisions is warranted.

ACHP also supports steps to decrease barriers to access by allowing the in-person prerequisite visit to be furnished by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth service. In the instance where an in-person visit is required every 6 months after the initial telehealth visit, ACHP encourages CMS to provide flexibility regarding the practitioner providing the service in instances where the original practitioner is not available, or they are within the same specialty, sub-specialty or physician group.

Telehealth significantly expanded patient access to health care as an efficient and effective tool through which patients overcome transportation challenges or a lack of qualified professionals in the areas in which they reside. In addition, over the past ten years, every state and the District of Columbia has removed in-person requirements as a prerequisite to treatment through telehealth recognizing the harmful effects of in-person requirements on patients. There is no compelling clinical rationale for a requirement for an in-person encounter for the diagnosis, evaluation or treatment of a mental health disorder before payment is made for telehealth services. Imposing such a requirement will result in inequitable access to care; patients who cannot travel will be denied needed care. Some patients may also be discouraged from seeking care for their mental health disorders by such a requirement. Patients will also be confused why certain mental health services require an initial in-person encounter while others do not. The outcome of such a policy will be negative patient outcomes and poorer quality of care for patients. Such a requirement will also exacerbate problems with health care equity.

The policy poses additional burdens for providers and practitioners who will have to determine on a patient-by-patient basis whether an in-person encounter is required for payment for telehealth services to diagnose, evaluate or treat a mental health disorder. The requirement for an initial or subsequent in-person encounter(s) for mental health disorders is not clinically necessary. While the agency could encourage such encounters where it does not result in access issues or negative impacts on patient outcomes, CMS should act where appropriate to mitigate the barriers to access.

ACHP supports the proposal to permit audio-only communications technology when used for telehealth services for the diagnosis, evaluation or treatment of mental health disorders furnished to established patients when the originating site is the patient's home. CMS proposed to permit telehealth services that consist of the use of audio-only communications technology for the diagnosis, evaluation or treatment of mental health disorders furnished to established patients in the patient's home. This will facilitate access to mental health services for those beneficiaries who lack access to two-way audio/video technology as well as to those patients who are either unable to, or do not want to use, that technology. However, consistent with our position stated above, we do not support policies that include in-person requirements, recognizing CMS's does not have the authority to regulate outside the scope of the legislation.

Medicare Diabetes Prevention Program

ACHP supports the proposed changes to the Medicare Diabetes Prevention Program. In our [Healthcare 2030: ACHP's Roadmap to Reform](#), ACHP members have pledged to measure and address specific drivers of chronic conditions such as diabetes in communities across the country. As chronic conditions are responsible for 75 percent of total health care costs and the majority of deaths in the United States, we support interventions designed to reduce costs and improve quality of life. We are asking for consideration to offer a digital option in the Medicare Diabetes Prevention Program, a proven means to increase participation.

Response to Health Equity RFI

ACHP and our member organizations are committed to improving health equity by removing obstacles in our nation's health care system. We recognize the impact that the COVID-19 pandemic has had in drawing out and exacerbating inequities in health care. We strongly agree that closing the health equity gap is an essential part of transitioning as a nation towards a value-based health care system and support public policies that advance more equitable access, treatment and health outcomes for everyone. As such, we support CMS' efforts to build on its Disparity Methods to consider additional stratification, data collection and potential future quality metrics with a goal of quantifying, examining and addressing health equity.

ACHP encourages CMS to take additional time and host forums before proceeding on additional data reporting requirements, imputations of demographic information onto quality measures and creation of new composite health equity scores for hospitals or other Medicare providers or payers. We look forward to working with the Administration and participating in those forums to identify best practices and improvements for data collection and utilization for health equity.

We also recommend CMS consider additional analysis of the impact of imputing demographic data and creating new metrics before proceeding with full, nation-wide requirements. For example, a pilot project could examine the implications of new reporting of health disparities based on social risk factors and race and ethnicity. The pilot could

determine if and how to ensure such information is comprehensive and actionable for providers, patients and payers living within a limited geographic area before proposing new national data reporting requirements or changes to quality metrics.

ACHP appreciates your consideration of our comments and look forward to being partners with the Administration to increase health equity throughout the healthcare system and ensure telehealth continues to grow in the Medicare program. Please contact Michael Bagel, Director of Public Policy at mbagel@achp.org or 202-897-6121 with any questions or to discuss further.

Sincerely,

A handwritten signature in cursive script that reads "Ceci Connolly". The signature is written in black ink and is positioned below the word "Sincerely,".

Ceci Connolly
President and CEO