April 4, 2023

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201
Email: xavier.becerra@hhs.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201
Email: Chiquita.Brooks-LaSure@cms.hhs.gov

*Sent electronically*

RE: End of the Public Health Emergency

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Academy of Sleep Medicine (AASM) appreciates the consecutive extensions and thoughtful preparation for ending the COVID-19 public health emergency (PHE). While the AASM recognizes that the US Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) must reassess and adjust policies due to the end of the PHE, we also hope that the agencies will consider feedback from providers, to ensure a smooth transition without interruption to being able to provide high quality care to patients, once the PHE ends.

The AASM appreciates the opportunity to comment on the provisions set for the end of the PHE, as they will directly impact the care provided by AASM members to patients with sleep disorders and will also significantly affect the way these services are provided. The AASM is dedicated to advancing sleep care and enhancing sleep health to improve lives, and the comments included in this response reflect the needs of more than 9,000 individual AASM members and 2,500 AASM-accredited sleep facilities, providing sleep medicine services to the Medicare population.

*Telehealth*

The AASM is appreciative of the Agency's efforts to increase adoption of telehealth throughout the PHE. The implementation of telehealth during the PHE has helped sleep medicine providers expand and improve access to high-quality care. Despite CMS concerns about potentially fraudulent billing practices during the PHE, a review by the Office of Inspector General (OIG) identified a mere 1,714 providers out of 742,000 whose billing for telehealth services in the first year of the PHE posed a high risk for fraud, waste, or abuse (DHHS, 2022).[i] Therefore, the AASM continues to strongly urge CMS to make several temporary telehealth flexibilities permanent, including continuing to allow the following:

- Telehealth visits, where in-person visits have been previously required, under the condition that medical necessity requirements are met and documented
- Removal of originating site and geographic location requirements for federally administered programs
- An expanded list of qualifying healthcare providers that can provide distant site telehealth
- Removal of geographic restrictions and the inclusion of a beneficiary's home as a permissible originating site for the diagnosis, evaluation, and treatment of mental health disorders, coupled with a delay in the requirement for an in-person visit
- Permitting the provision of audio-only telecommunications telehealth services
- Provision of telehealth, including remote monitoring services, to both new and established patients, in instances where a physical exam is not required

While the extension of the expiration date for these flexibilities has universally been extended to December 31, 2024, we urge CMS to take the extended time to review data to affirm the low percentage of fraud, waste, and/or abuse, and to identify scenarios where telehealth would not be appropriate long-term.

*Direct Supervision Requirements*

During the PHE, CMS temporarily changed the regulatory definition of "direct supervision," which requires the supervising physician or practitioner to be "immediately available" to furnish assistance and direction during the service, to include "virtual presence" of the supervising clinician using real-time audio and video technology. This flexibility is currently set to return to pre-pandemic rules at the end of the 2023 calendar year. The AASM continues to support making the PHE flexibilities for direct supervision requirements permanent, given the successes demonstrated throughout the PHE. The flexibilities have increased communication amongst clinicians and their residents, allowing them to provide guidance in many different scenarios, using audio/visual telecommunications and also leveraged earlier career physicians, during this challenging time of nationwide medical staff shortages and physician burnout. Struggles with shortages and burnout are ongoing, and making these flexibilities permanent will greatly assist current medical personnel as they shoulder the brunt of these issues. We continue to maintain that in high-risk patients and specific scenarios (e.g., surgical procedures), in-person supervision is required. The AASM is concerned that returning to the original rules will limit the amount of supervision that can be provided, as not all scenarios require in-person observation.

*Oxygen Recertification*

CMS currently requires that home oxygen and other related items undergo recertification of medical necessity 12 months after the initial certification. While this recertification is not explicitly addressed in the Agency's plans for the end of the PHE, the AASM requests that CMS consider

temporarily modifying this requirement, to allow providers additional time to catch up on completing the recertifications that were not completed during the PHE. This would help reduce the burden of completing a backlog of recertifications, as providers may have a significant number of patients to recertify once the PHE comes to an end. Specifically, the AASM requests that CMS implement a transition period for home oxygen patients, particularly those with sleep apneas, hypoventilation syndromes, and thoracic restrictive disorders.

*Audits of Medicare Part B Telehealth Services*

The OIG has announced that it will conduct a series of audits of Medicare Part B telehealth services, in two phases to 1) assess whether services meet Medicare requirements and 2) review distant and originating site locations, virtual check-in services, electronic visits, remote patient monitoring, use of telehealth technology, and annual wellness visits to determine whether Medicare requirements are met.[ii] The AASM urges the Agency to consider the potential excessive cost and administrative burden to clinicians and practices to complete these audits, particularly when data from the first year of the PHE clearly shows a low incidence of fraud, abuse, and misuse. Medicare audits may also be disruptive to patient care, as audits will require time and attention from clinicians to provide documentation and to participate in audit follow-up activities, including provision of supplemental data and appeals, as needed.

Thank you for your consideration of these comments. The AASM appreciates the Agencies' efforts to prioritize maintaining the provision of efficient, high-quality care as the public health emergency comes to an end. We encourage the Agency to consider the feedback summarized in this letter. Please feel free to contact Diedra Gray, AASM Director of Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

Jennifer Martin, PhD

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[i] US Department of Health and Human Services. (2022, September). Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks. Office of the Inspector General. https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf

[ii] US Department of Health and Human Services. (2023). Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency. Office of the Inspector General. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000556.asp