June 4, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: ACP Recommendations for Maintaining Certain Telehealth Policies and Waivers after the Public Health Emergency

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am writing to share ACP's recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding certain telehealth policies and regulatory waivers that should remain in place for an extended period of time after the national public health emergency is lifted. The College is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Many of the patients most at risk from the COVID-19 are or will be treated by internal medicine specialists, especially older patients and those with pre-existing conditions like heart disease, asthma, and diabetes.

The College sincerely appreciates CMS' swift actions throughout the public health emergency (PHE) to provide regulatory flexibilities that help healthcare clinicians participating in both Medicare and Medicaid respond to and contain the spread of COVID-19, while also caring for the needs of their broader patient population during this time of crisis. ACP is particularly appreciative of CMS' policy changes to significantly expand patient access to and physician use of telehealth services. In order to help reduce the spread of COVID-19, while providing as much ongoing and routine care to their patient populations as is feasible, physician practices across the country have worked to quickly shift much of their patient care services to virtual visits and telephone services. It is clear that the policy changes provided by CMS to allow for increased access to and use of telehealth functionality and virtual care have played a pivotal role in mitigating the effects of the COVID-19 pandemic while providing a source of much needed revenue for physician practices across the country.

Many of these flexibilities and policy changes are due to expire at the conclusion of the PHE, wherein patients and physician practices would be expected to revert back to primarily face-to-face services without any type of risk-based assessment for gradually reopening medical practices and health systems to care for non-COVID and non-acute patients.[1] This quick reversal in policy does not take into account

[1] Doherty R, Erickson S, Smith C, Qaseem A. "Partial Resumption of Economic, Health Care and Other Activities While Mitigating COVID-19 Risk and Expandinge System Capacity." American College of Physicians, May 6, 2020:

patients' comfort level in returning to physician offices to seek necessary care, as well as changes in office workflow and scheduling practices to mitigate spread of the virus within practices resulting in substantially lower volume of in-person visits for as long as the pandemic is with us. Therefore, the quick reversal in policy is not an effective way to recover from the PHE, nor prepare for possible future outbreaks. The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. In order to address the many barriers to patient access and physician adoption and use of telehealth prior to the COVID-19 pandemic, and properly assess how to foster and strengthen longitudinal, patient-centered care delivery, ACP believes there are a number of interim policies that should remain in effect for a period of time after the PHE is lifted. **Specifically, the following policies and waivers should remain in effect through at least the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend even further, or consider making permanent, based on the experiences and learnings of both patients and physicians utilizing these revised policies:**

- Pay Parity for Audio-Only and Telehealth Services
- Geographical Site Restriction Waivers
- Telehealth Cost-Sharing Waivers
- Flexibilities in Direct Supervision by Physicians at Teaching Hospitals
- Revised Policies for Remote Patient Monitoring Services
- Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action
- Facility Fee Payment for Provider-based Departments

The following discussion provides more detailed comments on the importance of maintaining these telehealth policies and flexibilities after the conclusion of the PHE.

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports the agency's actions to provide additional flexibilities for patients and their doctors by providing payment for telephone E/M services — and more recently, the decision to provide payment parity between telehealth E/M codes 99201-99215 and telephone E/M codes 99441-99443 by cross-walking telephone E/M codes to E/M codes 99212-99214 and adding these codes to the Medicare telehealth list. These changes in payment policy address some of the biggest issues facing physicians as they struggle to make up for lost revenue and provide appropriate care to patients. ACP values the opportunity to communicate with CMS about these issues, and we are very appreciative of the agency's receptiveness to our concerns by adopting these recommended changes.

The College recommends that CMS maintain pay parity between telephone E/M claims and in-person E/M visits and between all telehealth and in-person visits after the PHE is lifted. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these visits. First**,** emerging evidence suggests that patient visits to ambulatory practices have declined

https://www.acponline.org/acp_policy/policies/acp_guidance_on_resuming_economic_and_social_activities_2020.pdf

significantly and despite a rebound, visits remain 30% lower than they were pre-pandemic.[2] Given the uncertainly around the timeline for a COVID-19 vaccine or treatment, many expect that the virus will continue to spread well into 2021. Therefore, as the need to contain the virus and maintain appropriate social distancing protocols continues into next year, it is unlikely that in-person visits to practices will return to pre-pandemic levels as patients remain uncomfortable with making these in-person visits and physicians schedule fewer patients to be seen in the office.

Second, patients have become accustomed to and appreciate telehealth/telephone visits and many appreciate the flexibility these visits provide. The transition from in-person visits to the greater use of telehealth and telephone visits during this PHE has provided patients a safe option of receiving equivalent or nearly equivalent care to what they otherwise would receive in an in-person setting in an effort to control the spread of COVID-19. Third, physicians will also have to adjust their workflows and practices to allow for appropriate social distancing protocols and prevent patient infection. This again will mean that practices will not in many cases be able to maintain economic viability without maintaining payment for these remote services.

Finally, internists are skillfully adapting to gathering necessary information via telehealth or the telephone that they would have gathered during an in-person visit. The use of telehealth has allowed physicians to visit patients virtually in their homes, allowing in some cases for certain unexpected improvements in care, as the clinician may better be able to identify the impact of social determinants on a patient's health. It is imperative that physicians and payers have an opportunity to evaluate the impact of these changes and adapt before moving forward. Moreover, it is essential that policies align in such manner that allows physician practices to gradually resume healthcare activities that have been modified, delayed, or stopped altogether. As the College laid out in recent policy guidance, ACP strongly encourages CMS to chart a way forward that allows healthcare services to be resumed in a phased and prioritized way, based on the best available evidence, in a manner that mitigates risk (slows and reduces the spread of COVID-19, and associated deaths and other harm to patients) and rapidly expands health system capacity to diagnose, test, treat, conduct contact tracing (with privacy protections), and conduct other essential public health functions.

ACP has long believed that healthcare innovation is important for the sake of patients and their health. Hence, given the breadth of systematic changes and the need for physicians and payers alike to fully evaluate and understand their impact, we again urge the agency to allow these changes to remain in place at least through the end of 2021 to allow all stakeholders to determine what innovation will look like for the future of healthcare. We look forward to working with CMS to address these discrepancies.

To build on these positive changes, ACP continues to recommend that CMS establish clear guidelines around billing for telephone E/M claims. The agency did note that the office/outpatient E/M level of selection for telehealth E/M services can be based on medical decision-making (MDM) or time, with time defined as all of the time associated with the E/M visit on the day of the encounter. **We encourage CMS to allow clinicians to use the same aforementioned guidelines when billing telephone E/M claims. It is important that clinicians have similar rules and guidelines to minimize administrative complexity and maximize their time focused on delivering patient care.**

---

[2] Mehrotra, A., Chernew, M., Linetsky, D., Hatch, H., & Cutler, D. (2020, May 19). What Impact Has COVID-19 Had on Outpatient Visits? Retrieved June 03, 2020, from https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits

Finally, we strongly encourage CMS to remove the requirement that telephone E/M visits not originate from a related in-person E/M visit within the past 7 days or lead to an E/M visit/procedure within the next 24 hours. It is critically important that CMS work to remove barriers that may prevent patients from accessing the care they need at the time they need it. It is possible that patients may need follow-up visits to prevent the exacerbation of a condition or to monitor symptom presentation to determine the need for a COVID-19 test. For example, if a patient had an in-person visit in the last 7 days where the physician determined that a follow-up visit was necessary but could be done remotely, this language would not allow a remote visit to be billable. Additionally, this language does not allow an in-person follow-up visit to be billed following a remote visit if that remote visit occurred within the previous 24 hours. We encourage CMS to ensure that the language in this code descriptor does not inadvertently subject high-risk groups to COVID-19 infection due to the inability of practices to use in-person and telephone visits in concert with each other.

Geographical Site Restriction Waivers

ACP supports CMS' policy changes to pay for services furnished to Medicare beneficiaries in any healthcare facility and in their home — allowing services to be provided in patients' homes and outside rural areas. ACP has long-standing policy in support of lifting these geographic site restrictions that limit reimbursement of telehealth services by CMS to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas.[3] While limited access to care is prevalent in rural communities, it is not an issue specific to rural communities alone. Underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social determinants of health such as lack of transportation or paid sick leave, or sufficient work schedule flexibility to seek in-person care during the day, among many others. The experience with COVID-19 suggests many patients are at higher overall risk of mortality and morbidity due to these types of social determinants and racial and ethnic characteristics, particularly for African-Americans.[4] Such patients are more likely to reside in these underserved communities that fall within the metropolitan statistical areas that are normally not included in Medicare telehealth reimbursement outside of the waivers offered through the PHE.[5] Research has shown the extensive role that social determinants play in health and health equity,[6] and the pandemic has highlighted how providing expanded access to telehealth services within underserved communities, rural and urban, is an important aspect for infection control as well as addressing social determinants that exist outside of the pandemic. Moreover, the funding provided through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to the Federal Communications Commission (FCC), and other efforts through the FCC to expand access to telehealth services, offer the opportunity to provide the technologies and broadband needed for these underserved patient populations to utilize these services. **It is essential to maintain expanded access to and use of telehealth services for these communities, as well as rural**

[3] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

[4] Webb Hooper M, Nápoles AM, Pérez-Stable EJ. "COVID-19 and Racial/Ethnic Disparities." *JAMA.* Published online May 11, 2020. doi:10.1001/jama.2020.8598

[5] Robert Wood Johnson Foundation. "Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America." Princeton: Robert Wood Johnson Foundation; February 2008. Accessed at www.rwjf.org/content/dam/farm/reports/reports/2008/rwjf22441 on 11 May 2017.

[6] Daniel H, Bornstein S, Kane G. "Addressing Social Determinants to Improve Patient Care and Promote Health Equity." American College of Physicians, April 17, 2018: https://www.acpjournals.org/doi/10.7326/M17-2441

communities, and ACP recommends CMS permanently extend the policy to waive geographical and originating-site restrictions after the conclusion of the PHE.

Telehealth Cost-Sharing Waivers

ACP welcomes the flexibility provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. At the same time, we call on CMS to ensure that they make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding these physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining treatment. This critical action has led to increased uptake of telehealth visits by patients. **At the conclusion of the COVID-19 PHE, ACP recommends that CMS continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these visits.** This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they are. The College looks forward to working with CMS to address opportunities to maintain these flexibilities.

Flexibilities in Direct Supervision by Physicians at Teaching Hospitals

In the first interim final rule (IFR) published by CMS to combat the COVID-19 PHE, the agency noted that in instances where direct supervision is required by physicians and at teaching hospitals, CMS will allow supervision to be provided using real-time interactive audio and video technology. The College welcomes this decision by the agency to allow attending physicians and residents/fellows the ability to communicate over interactive systems asynchronously by waiving the in-person supervision requirement. This important step promotes efficient patient care and allows physicians and supervisees to work together unencumbered by social distancing restrictions. **We encourage CMS to maintain these modifications for a period of time after the PHE ends and until supervising physicians feel comfortable they are able to control the spread of infection rates. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these supervision flexibilities. The College remains ready and willing to work with CMS on these changes to ensure that they work in harmony with the additional historic actions taken to date.**

Revised Policies for Remote Patient Monitoring Services

CMS finalized policy that now allows remote patient monitoring (RPM) to be used for both new and established patients. The agency also notes that consent to receive RPM services can be obtained once annually, including at the time services are furnished for the duration of the PHE for the COVID-19 pandemic. CMS will also allow RPM codes to be used for both acute and chronic conditions. Currently, CMS provides payment for seven CPT codes in the RPM code family:

- **99091** *(Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time)*;
- **99453** *(Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment)*;

- **99454** *(Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days)*;
- **99457** *(Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes)*;
- **99458** *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes*;
- **99473** *(Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration); and*
- **99474** *(Separate self-measurements of two readings one minute apart, twice daily over a 30- day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient).*

The College applauds the agency's decision to expand access to RPM codes by allowing physicians to bill them for both new and established patients during the PHE. We also welcome the burden reduction attained by allowing patients to consent to these services once annually. Additionally, the decision by the agency to allow these codes to be used for both acute and chronic conditions further expands access to these services at this important time when patients and their care teams need additional resources to meet the current challenges. These changes will help to relieve physician burden and allow physicians more time to treat the more complex patient issues that require more than remote monitoring. **We encourage CMS to maintain these modifications at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these services.**

Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action

ACP supports a streamlined approach to obtaining several medical licenses that would facilitate telehealth services across state lines while allowing states to retain individual licensing and regulatory authority.[7] **We appreciate CMS' temporary waiver allowing physicians to provide telehealth services across state lines, as long as physicians meet specific licensure requirements and conditions. ACP recommends these changes remain in place at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these flexibilities.** These waivers offer an opportunity to assess the benefits and risks to patient care in addressing the pandemic as well as the ability to maintain longitudinal care for patients who move across state lines. While these waivers do not supersede any state or local licensure requirements, they provide the opportunity to promote state-level action that may further promote more streamlined licensure requirements across the country.

[7] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

Facility Fee Payment for Provider-based Departments

Typically, if a provider-based department (PBD) located on the campus hospital (and therefore was paid the hospital Outpatient Prospective Payment System (OPPS) rate) relocates to be off-campus, it would have to bill the reduced rate. However, it was recognized that this would be extremely difficult to sustain the PBD at the lower rates if it relocates due to COVID-19. Therefore, in order to provide greater flexibility to hospitals so that they can rapidly deploy temporary expansion sites and thus improve patient access to care, CMS has temporarily adopted an expanded version of the extraordinary circumstances relocation policy during the COVID-19 PHE. This means that during this time on-campus PBDs can relocate off-campus and still bill at the OPPS rate — but to do so, their affiliated hospital must align their PBD relocations with the state's emergency preparedness or pandemic plan to ensure continuity with state efforts. The College does not support provider-based billing for care delivered in an outpatient, hospital-system owned practice when that care is not dependent on the hospital facility and its associated technologies.[8] Rather, in line with the College's high value care initiative, ACP supports delivery of care in the most efficient setting, while maintaining quality of care. As we have stated previously, the expansion of telephone and telehealth services have allowed patients to connect with their care teams while protecting their health and that of others. If patients are receiving care from a PBD from their home, they are using the hospital's technology based platforms and other associated technologies to support the care provided. Therefore, ACP supports CMS' temporary policy to allow hospitals to bill a facility fee when the patient is an established patient of a provider-based outpatient department and receives care via telehealth services at their home. These policies allow for the ability to contain infection rates while still providing necessary care to established patients through established PBDs. **Risk-based assessments are needed before these types of facilities are expected to shift back to regular face-to-face visits; therefore, ACP recommends this policy remain in place for an extended period of time after the designation of the PHE, possibly through the end of 2021, or until such a time when effective vaccines and treatments are widely available.**

The College greatly appreciates CMS' efforts to rapidly expand access to and use of telehealth services during this unprecedented time. Thank you for the opportunity to provide our input and recommendations around the important policy changes and flexibilities that are necessary to maintain and improve upon patient-centered care delivery after the conclusion of the PHE. Should you have any questions or need additional information, please contact Brian Outland, Director of Regulatory Affairs, at boutland@acponline.org.

Sincerely,

Jacqueline Fincher, MD, MACP
President
American College of Physicians

[8] "American College of Physicians Policy on Provider-Based Billing." American College of Physicians, April 2013: https://www.acponline.org/acp_policy/policies/provider_based_billing_2013.pdf