



February 14, 2022

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
House of Representatives
Washington, DC 20515

Dear Majority Leader Schumer, Minority Leader McConnell, Speaker Pelosi, Minority Leader McCarthy:

On behalf of the American College of Physicians (ACP), I am writing to share our recommendations for legislation to expand telehealth flexibilities in health care beyond the COVID-19 pandemic. We are grateful that the Centers for Medicare and Medicaid Services (CMS) and Congress have enacted reforms to expand the use of telehealth during the Public Health Emergency (PHE) but we remain concerned that many of these flexibilities are due to expire at the conclusion of the PHE, or soon after. We urge you to extend these flexibilities, some on a permanent basis, and pass reforms, as outlined below, to ensure that our physicians have the tools and resources they need to expand access to care for their patients through telehealth.

The American College of Physicians is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 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. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

ACP supports the expanded role of telehealth as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care from physicians and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. Telehealth can be most efficient and beneficial between a patient and physician with an established, ongoing relationship and can

serve as a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area.

Studies have already shown the benefits of the use of telehealth, which has risen sharply since the pandemic. According to the Department of Health and Human Service's December 2021 [report](#) on telehealth use, the number of Medicare fee-for-service beneficiary telehealth visits increased 63-fold in 2020, from approximately 840,000 in 2019 to nearly 52.7 million in 2020. A recent [study](#) by the Centers for Disease Control and Prevention (CDC) concerning the use of telehealth in health centers, suggested that "telehealth can facilitate access to care, reduce risk for transmission of SARS-CoV-2, conserve scarce medical supplies, and reduce strain on health care capacity and facilities while supporting continuity of care." An article published by the [Commonwealth Fund](#), notes that "tele- mental health has a robust evidence base and numerous studies have demonstrated its effectiveness across a range of modalities (e.g. telephone, videoconference) and mental health concerns (depression, substance use disorders)."

Expand the Extension of Telehealth Services Through the 1135 Waiver Authority

In 2020, CMS used its discretion under the 1135 waiver authority to expand access to telehealth services since patients were reluctant to travel to health care facilities due to the spread of COVID-19. This waiver allowed Medicare to pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence. ACP supported this measure, but we remain concerned that some of the telehealth services expanded under the 1135 waiver, as discussed further later in this letter, are due to expire at the end of the PHE. These telehealth services, which are used by internists to provide evaluation and management services to treat patients' chronic conditions, have been a valuable resource to expand access and coordinate patient care and should remain in place for at least two years after the PHE to ensure that our physicians are able to continue to use this modality to enhance patient care.

We are pleased that Senators Cortez Masto and Young have introduced bipartisan legislation, **S. 3593, the Telehealth Extension and Evaluation Act**, that would expand the telehealth expansions under the 1135 waiver for an additional two years after the end of the PHE. We also appreciate that Representatives Doggett and Nunes have introduced **H.R. 6202, the Telehealth Extension Act of 2021**, that includes a provision to expand 1135 waivers for telehealth services, including Medicare coverage of audio-only telehealth services between physicians and patients, for an additional two years after the PHE declaration expires.

Expand Telehealth Services Under Category 3 of the Medicare Physician Fee Schedule

We are also pleased that the 2021 Medicare Physician Fee Schedule Final Rule provided coverage through the end of the PHE for more than 100 services via the creation of a temporary Category 3 status. In the 2022 Medicare Physician Fee Schedule Final Rule, CMS finalized its proposal to retain all services added to the Medicare telehealth services list on a temporary, Category 3 basis until the end of CY 2023. **ACP supports CMS' retention of all services added to the Medicare telehealth services list on a temporary, Category 3 basis. While the College supports this extension, we strongly recommend that Congress enact legislation to ensure Category 3 be made permanent as to provide for a more consistent and efficient on-ramp for**

new telehealth services to be added. ACP also appreciates the Agency adding coverage for outpatient cardiac rehabilitation to the Category 3 Medicare telehealth services list. The College strongly encourages CMS add coverage for audio-only evaluation and management telehealth services to the Category 3 list and retain these services until at least the end of CY23.

Pay Parity for Audio-Only Telehealth Services

The College wholeheartedly supports many actions taken by CMS to provide additional flexibilities for patients and their doctors by providing payment for audio-only services. During the PHE, Medicare has covered some audio-only services for tele-mental health as well as evaluation and management services provided to patients and will reimburse for both telehealth services and audio-only services as if they were provided in person. Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue while still providing appropriate care to patients.

ACP is discouraged to learn that CMS will not continue coverage of audio-only telehealth evaluation and management (E/M) services beyond the PHE, despite [mounting evidence](#) about the effectiveness of expanding coverage for these services. While ACP has supported the Agency's actions to provide coverage and payment parity for such telephone services, the College is very concerned about the impact of reversing these changes at the conclusion of the PHE.

We urge Congress to enact legislation to ensure that payment for audio-only telehealth evaluation and management services between physicians and patients will continue for two years after the end of the PHE along with expanded flexibility for **an option for CMS or Congress to extend it even further or consider making it permanent, based on the experience and learnings of patients and physicians who utilize these visits.**

Geographical Site Restriction Waivers

ACP strongly supported CMS' policy changes to pay for services furnished to Medicare beneficiaries in any health care 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. 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 insufficient work schedule flexibility to seek in-person care during the day, among many others.

We are pleased that in the final 2022 Medicare Physician Fee Schedule Rule CMS is broadening the scope of services for which the geographic restrictions do not apply and for which the patient's home is a permissible geographic originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE. **ACP supports any efforts to expand access to mental and behavioral health services, including allowing beneficiaries to access services from home, or if the technology is not available at home, from a rural health clinic or hospital.**

We appreciate that the Telehealth Extension Act, H.R. 6202, would **permanently lift geographic and site-based restrictions** for additional telehealth services covered under Medicare regardless of a beneficiary's zip code, and in the comfort and convenience of their own home or at designated health facilities offering telehealth. **We urge adoption of this provision that will increase access to telehealth services beyond mental and behavioral health services in any legislation that Congress chooses to advance on telehealth.**

Telehealth Cost-Sharing Waivers

ACP appreciated the flexibility previously provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telehealth visits for the duration of the PHE. This critical action has led to increased uptake of telehealth visits by patients. At the same time, we call on CMS, or preferably Congress, to 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 physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining telehealth services, including those related to mental and behavioral health treatment.

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. health care system and care delivery models, even after the PHE is lifted. **At the conclusion of the COVID-19 PHE, ACP recommends that Congress urge, or if necessary, require CMS to 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 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 reside.

Improve Health Equity in Telehealth

We remain concerned about the increasing inequities associated with telehealth, as there are disparities in access to this technology. A February 2022 HHS [publication](#) reported that telehealth utilization during the period of April to October 2021 varied by race, region, education, income, and insurance. For those in rural and underserved communities, the nearest clinic may be hours away. Unfortunately, rural communities also suffer from more limited access to broadband internet, which restricted the ability of many in rural communities to access telemedicine pre-pandemic. Additionally, [research](#) shows that Black and Hispanic

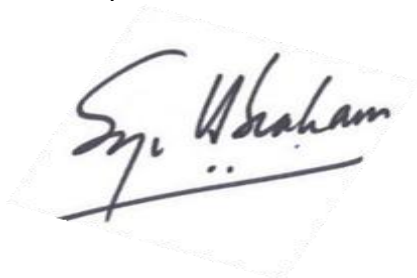
Americans own laptops at lower rates than White Americans, further dividing pre-pandemic access to telemedicine. Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. We [urge](#) Congress to provide support for further broadband deployment to reduce geographic and sociodemographic disparities and access to care.

We also support a provision in H.R. 5376, the Build Back Better Act (BBBA) that would provide \$280 million to establish a pilot program that will provide grants to public private partnerships for projects that increase access to affordable broadband service in urban communities, including communities of color and low- and middle- income consumers, through long-term solutions. Lacking access to reliable and affordable Internet or mobile service limits not only a person's ability to utilize technology for health-related purposes but also their ability to access other important services, such as emergency assistance or employment opportunities.

Conclusion

We urge Congress to act on these bipartisan recommendations to advance access to telehealth and reduce inequities in its adoption. We look forward to working with you to advance these objectives as Congress considers legislation to improve the use of telehealth in the weeks and months ahead. Should you have any questions regarding this letter, please do not hesitate to contact Brian Buckley, Senior Associate for Legislative Affairs at bbuckley@acponline.org.

Sincerely,

A handwritten signature in black ink that reads "George M. Abraham". The signature is written in a cursive style and is positioned above a horizontal line. The entire signature is enclosed within a faint, light-colored rectangular border.

George M. Abraham, MD, MPH, MACP, FIDSA
President