Gift and CMS Team

Thanks for meeting with our multispecialty group of ten organizations on Jan 29. I apologize for the long email but we are writing to follow up with additional information regarding the questions and comments that were raised by CMS. Maintaining payment parity for telemedicine visits and in-person visits is a top priority for all our organizations to ensure that physician practices can continue providing vital care via telemedicine in 2025 and beyond.

Telemedicine Practices

The unanimous consensus of the societies is that audio-visual (AV) and audio-only telemedicine provide fundamental patient services when in-person access is a challenge. Telemedicine visits dramatically expand access to care and, in our view, have improved care for Medicare beneficiaries. Unfortunately, not everyone with a serious medical condition has reliable transportation or the ability to take time off work to attend in-person visits 100% of the time. For these patients, telehealth services are a lifeline. Additionally, many Medicare beneficiaries lack access to reliable broadband internet and do not have a smart phone, making audio-only the only accessible telehealth modality.

The typical practice that furnishes telemedicine is a hybrid practice that also performs in-person visits. While telemedicine-only practices exist, they are atypical. According to a recent AMA white paper[1] only 10% of physician practices utilize video visits for more than 20% of their visits and only 4.8% of practices utilize video visits for more than 40% of their visits. We believe this supports our contention that telemedicine-only practices are atypical and should not factor into CMS rate setting for telemedicine visits, especially in regard to practice expense.

Literature on Telemedicine Services

Below are summaries and links to several articles and papers we have reviewed on the utilization of telemedicine. The articles highlight that while the volume of telemedicine has been decreasing since the onset of the public health emergency (PHE), telemedicine availability has persisted and greatly increased access to care. Several articles have shown increased use of audio-only visits among marginalized groups including African-Americans, non-English speakers, older patients, those with public insurance as opposed to private insurance and patients living in rural communities and communities with low broadband access. We know that these social determinants of health contribute to complexity and risk and while the underlying causes like limited broadband access need to be addressed, telemedicine can serve as a stopgap to support the health of these communities as progress is made. Any change in payment parity, for physician work or practice expense reimbursement, risks decreasing access for these populations that are in the greatest need and could further widen existing disparities in access and outcomes. Our societies are committed to promoting public health and working with CMS to ensure widespread access to care.

Payment Parity

For all office-based specialties that provide predominantly cognitive services, the typical telemedicine visit involves seeing a patient located in their home and entails equivalent work and practice expense as

[1] "Policy Research Perspectives, Telehealth in 2022: Availability Remains Strong but Accounts for a Small Share of Patient Visits for Most Physicians

an in-person visit. CMS outlined the argument for parity in CY 2024 final rule[2] in their rationale for supporting payment parity for behavioral telehealth services (emphasis added):

> Now that behavioral health telehealth services may be furnished in a patient's home, which now may serve as an originating site, **we believe these behavioral health services are most accurately valued the way they would have been valued without the use of telecommunications technology, namely in an office setting.** There was an increase in utilization of these mental health services during the PHE that has persisted throughout and after expiration of the PHE for COVID–19. It appears that practice patterns for many mental health practitioners have evolved, and they are now seeing patients in office settings, as well as via telehealth. **As a result, these practitioners continue to maintain their office presence even as a significant proportion of their practice's utilization may be comprised of telehealth visits. As such, we stated that we believe their practice expense (PE) costs are more accurately reflected by the non-facility rate.**
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> Therefore, we proposed that, beginning in CY 2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the non-facility PFS rate. When considering certain practice situations (such as in behavioral health settings, **where practitioners have been seeing greater numbers of patients via telehealth), practitioners will typically need to maintain both an in-person practice setting and a robust telehealth setting. We expect that these practitioners will be functionally maintaining all of their PEs, while furnishing services via telehealth.** When valuing services, we believe that there are few differences in PE when behavioral health services are furnished to a patient at home via telehealth as opposed to services furnished in-person (that is, behavioral health settings require few supplies relative to other healthcare services). Claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the PFS facility rate beginning on January 1, 2024, as we believe those services will be furnished in originating sites that were typical prior to the PHE for COVID–19, and we continue to believe that, as discussed in the CY 2017 PFS final rule (81 FR 80199 through 80201), the facility rate more accurately reflects the PE of these telehealth services; this applies to non-home originating sites such as physician's offices and hospitals

Physician Work

We believe the CMS rationale above applies to the typical modern medical practice, not just behavioral health. We know that the hybrid model, in which practices see some patients in-person and some patients via telemedicine, is the typical practice. We have also heard overwhelmingly from our members that the work of seeing patients via telemedicine is equivalent to the work of seeing patients in-person; medical decision making is the same irrespective of modality and the time it takes to review records, take a history, formulate a plan, communicate next steps and write a note is the same whether that work is done for an in-person visit or a telemedicine visit.

Practice Expense

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[2] Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies,Vol. 88,F.R., 78875, (Finalized Nov 16, 2023) https://www.federalregister.gov/d/2023-24184

Our members who comprise many medical specialties including behavioral health, agree that hybrid practices are typical and that those practices must maintain offices and purchase supplies and equipment. While the clinical staff time, supplies and equipment may not be identical, they are equivalent. More importantly, as CMS agreed was true for behavioral and mental health professionals, most practices must continue to maintain office based-practices and will thus incur the practice expense costs of maintaining these hybrid models. For that reason, parity is needed to ensure that access to telemedicine is sustained.

Clinical Staff
The majority of telemedicine visits are prescheduled and the clinical staff time is the same as for an in-person visit. In the pre-service period, clinical staff must assess the need for imaging, lab or test results and ensure that information has been obtained; that applies to telemedicine as much as to in-person. On the day of the visit, clinical staff must greet the patient, ensure appropriate medical records are available, enter patient reported vital signs, prepare the patient for the visit by ensuring their audio and/or visual connectivity, review and document history and medications, communicate instructions, share education and coordinate home care; again, this applies to both telemedicine and in-person. Clinical work in the post-period occurs after the visit is complete and by definition would be the same for in-person and telemedicine visits because in both circumstances the post-period work occurs after the visit has concluded.

Supplies
While it is true that there is no E/M pack or sanitizing wipes used in a telemedicine visit, the full cost of telemedicine visit equipment and rising cost of cybersecurity, software, and additional licenses are not recognized in the current PE data.

Equipment
Typically, physicians perform telemedicine visits in one of two places: (1) the physician office, or (2) an exam room outfitted for telemedicine visits. Because the exam table and any other equipment cannot be used on another patient while the physician is doing a telemedicine visit in these spaces, it can conceptually be allocated to the patient who is receiving the telemedicine visit.

Malpractice

The malpractice risk is the same for telemedicine visits as it is for in-person visits.

Conclusion
We would like to thank CMS for their work to promote equity and access and for their recent support of expanding telehealth coverage and flexibilities in the CY2024 final rule. We appreciate CMS making the time to meet with us and allowing us to share our experience delivering care via telehealth. We hope that in 2025 CMS will continue its policy of parity based on the evidence and clinical experience we have presented. This is essential to ensuring that patients across the country can continue accessing telemedicine services, especially those whose social determinants of health would otherwise limit their care. Please don't hesitate to follow up with any additional questions you may have.

Sincerely,

American Geriatrics Society
American Academy of Neurology

American College of Gastroenterology
American Gastroenterological Association
American Nurses Association
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Regional Anesthesia- Pain Medicine

Health Care Access on the **Line** - **Audio**-Only **Visits** and **Digitally Inclusive Care**.
Hughes HK, Hasselfeld BW, Greene JA.
N Engl J Med. 2022 11 17;387(20):1823-1826.
Health Care Access on the Line — Audio-Only Visits and Digitally Inclusive Care | NEJM

Chen J, Li KY, Andino J, Hill CE, Ng S, Steppe E, Ellimoottil C. Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic. J Gen Intern Med. 2022 Apr;37(5):1138-1144. doi: 10.1007/s11606-021-07172-y. Epub 2021 Nov 17. PMID: 34791589; PMCID: PMC8597874.
Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic - PubMed (nih.gov)

https://connectwithcare.org/jama-network-open-comparison-of-quality-performance-measures-for-patients-receiving-in-person-vs-telemedicine-primary-care-in-a-large-integrated-health-system/ **JAMA Network Open: Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System** A study found that virtual care methods can expand health care capabilities, performing on par or better than in-person care on most quality measures evaluated. Patients with telemedicine exposure in primary care had comparably better performance in 11 of 16 quality measures with statistically significant differences. The study examined whether quality of care among patients exposed to telemedicine differs from patients with only in-person office-based care. Researchers concluded that telehealth could augment care for various conditions, especially chronic diseases. The study also supplies information that could assist providers in determining an ideal ratio of in-person and telehealth visits.

https://pubmed.ncbi.nlm.nih.gov/36085158/. The impact of expanded telehealth availability on primary care utilization. The expanded availability of telehealth due to the COVID-19 pandemic presents a concern that telehealth may result in an unnecessary increase in utilization. We analyzed 4,114,651 primary care encounters (939,134 unique patients) from three healthcare systems between 2019 and 2021 and found little change in utilization as telehealth became widely available. Results suggest telehealth availability is not resulting in additional primary care visits and federal policies should support telehealth use.

https://connectwithcare.org/association-between-telemedicine-use-in-nonmetropolitan-counties-and-quality-of-care-received-by-medicare-beneficiaries-with-serious-mental-illness/ **JAMA Network Open: Association Between Telemedicine Use in Nonmetropolitan Counties and Quality of Care Received by Medicare Beneficiaries With Serious Mental Illness**. A study to assess whether greater telemedicine use in a nonmetropolitan county is associated with quality measures, including use of specialty mental health care and medication adherence, found that greater use of telemental health visits in a county

was associated with modest increases in contact with outpatient specialty mental health care professionals and greater likelihood of follow-up after hospitalization. The study suggests that telemental health can improve quality of care for Medicare beneficiaries with serious mental illness.

https://connectwithcare.org/majority-of-physicians-say-telehealth-enables-more-comprehensive-quality-care/ **American Medical Association: Majority of physicians say telehealth enables more comprehensive quality care**. A survey conducted by the American Medical Association found that the vast majority of physician respondents say they're currently using telehealth. The results suggest enduring interest in virtual care among physicians. Among physician respondents, 85 percent indicated they currently use telehealth, with the majority of decreased use attributed to a mix of virtual and in-person visits. There findings are similar to a survey conducted by the **Alliance for Connected Care** in March. An accompanying blog post on this survey from the American Medical Association can be found here.

1. A Comparison of Patients' and Neurologists' Assessments of their Teleneurology Encounter: A Cross-Sectional Analysis https://pubmed.ncbi.nlm.nih.gov/37624656/

2. Neurologists' Evaluations of Experience and Effectiveness of Teleneurology Encounters https://pubmed.ncbi.nlm.nih.gov/35834603/

3. Rapid implementation of virtual neurology in response to the COVID-19 pandemic https://pubmed.ncbi.nlm.nih.gov/32358217/