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***Sent via e-mail: Seema.Verma@cms.hhs.gov***

May 14, 2020

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

Dear Administrator Verma:

On behalf of the Association of American Medical Colleges, thank you for the significant actions you and the agency have taken during the COVID-19 pandemic to support hospitals and physicians by providing regulatory relief and flexibility throughout the health care system. These changes have increased the ability of the nation's teaching hospitals and faculty physicians to expand vital care to patients. Our members remain at the front lines of the crisis, employing health care providers across the nation, developing and deploying SARS-CoV-2 tests, providing cutting edge care to the sickest COVID-19 patients, increasing access to care by deploying telehealth, expanding their facilities to provide services to COVID-19 patients, continuing research to understand the biology of the virus and the spread of the disease, and working to develop new treatments and vaccines, while continuing to train residents.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

To help address the crisis caused by COVID-19, CMS created new coverage and payment policies that have facilitated the widespread use of telehealth and other communication-based technologies and provided other important relief through additional waivers and regulatory changes. By allowing audio-only as well as video telehealth visits, the Agency has leveled the field for many patients who do not have the means to have smart phones or tablets or who are not comfortable with the technology. Hospitals, physicians, and other providers have responded by rapidly implementing telehealth in their practices in order to provide continued access to medical care for their patients. Physicians have been able to monitor non-critically ill COVID-19 positive

patients, follow up on other individuals with chronic disease who can be cared for without risking a visit to the hospital or clinic, and provide care for many Medicare beneficiaries without imposing the burden of travel. In addition to treating ambulatory patients through telehealth, and remotely triaging COVID-19 patients, academic medical centers have deployed sophisticated telehealth technologies to monitor the sickest intensive care unit (ICU) patients. Amid this crisis, teaching hospitals and teaching physicians currently battling a surge in infections and managing the needs of their communities are sharing their knowledge on deploying telehealth and other advances on publicly available websites.

The development of telehealth capabilities has required investing significant resources in the technology, training, and infrastructure. These are not one-time costs but will be continuous costs to ensure the quality and security of these systems. The result is that in a matter of weeks a transformation occurred in the way in which health care is delivered, opening the door to a future that will increase access, maintain quality, and work to the advantage of patients and providers. This year, the U.S. telehealth market is expected to experience an 80 percent year-over-year growth due to the COVID-19 pandemic, according to a report by Arizton[1] marketing research. Nearly 30 percent of all visits at ambulatory practices are now being provided by telehealth according to a report from the Commonwealth fund.[2] We have heard from some faculty practices that they are providing approximately 50 percent of their ambulatory visits through telehealth during the COVID-19 pandemic, a dramatic increase from the use of telehealth prior to the crisis.

The flexibilities provided by CMS for telehealth coverage and payment have enabled teaching hospitals, teaching physicians, and other health care providers, and their patients to experience the benefits of telehealth. Beyond aiding with the COVID-19 response, telehealth offers the long-term promise of expanding quality healthcare in the future, particularly to individuals with limited access to services, individuals with disabilities, and elderly patients who have difficulty traveling. Telehealth can reduce the time it takes to seek medical expertise for diagnoses and treatments and can allow for monitoring of chronically ill patients.

We recognize that the current flexibilities are limited to the Public Health Emergency (PHE); however, given the massive changes that have occurred as well as the improvements to patient access and patient satisfaction, these changes cannot be rolled back with the push of a button, nor should they be. It is imperative that the progress that has been made since March continue when the PHE ends. Therefore, we urge Congress and CMS to make changes to legislation and regulations that will make permanent the current changes and will ensure that reimbursement remains at a level that will support the infrastructure needed to provide telehealth services. At a minimum, we urge you to maintain these telehealth waivers and flexibilities for at least one year following the end of the PHE, to allow sufficient time for legislation to be enacted and notice and comment rulemaking to occur. Specifically, we recommend the following:

- **Patient Location:** Telehealth services should be covered for patients in any geographic location and at any site, including the patient's home.

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[1] https://finance.yahoo.com/news/telehealth-market-us-reach-revenues-150000310.html
[2] https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits

- **Payment:** Providers should receive the amount of Medicare Physician Fee Schedule payment as if the services had been provided in-person.
- **Hospital Payment**: Hospitals should be allowed to bill a facility fee when the patient is an established patient of an outpatient department and receives the service at their home via telehealth.
- **Expansion of Telehealth Services:** CMS should expand the list of covered telehealth services to include services that were added during the pandemic.
- **Relationship with Patient:** Allow telehealth services to be provided to new and established patients.
- **State Licensure/Practitioner Locations:** Remove Medicare and Medicaid requirements that physicians and non-physician practitioners be licensed in the state where they are providing telehealth services to allow payment across state lines.
- **Residents:** For evaluation and management (E/M) services, allow residents to provide telehealth services if supervision requirements are met.
- **Telephone evaluation and management (E/M) codes (99441-99443):** Maintain the increased payment rates for these codes to equal Medicare's established in-person codes (99212-99214) to ensure that patients without advanced video-sharing capabilities are able to access care.

**<u>Other Regulatory Changes That Should Become Permanent</u>**

CMS has made the following other changes that we recommend be made permanent.

- When a teaching hospital rotates residents to a non-teaching hospital, the teaching hospital should be able to include the time at the non-teaching hospital for both direct graduate medical education reimbursement and the indirect medical education adjustment provided that the teaching hospital continues to pay the resident's salary and fringe during the time spent at the non-teaching hospital. The rotations to the non-teaching hospital should not trigger the per resident amount (PRA) or the FTE resident cap for the non-teaching hospital.
- When counting beds for the indirect medical education adjustment any time that a Public Health Emergency is declared hospitals should be held harmless for bed increases that are due to that emergency
- Allow teaching physicians to provide supervision through interactive telecommunications technology for the key portion of an evaluation and management service.
- Expand the services that are covered under the Primary Care Exception.
- Allow payment under the Physician Fee Schedule for fully licensed residents who are moonlighting in the inpatient site of the hospital where they are training.

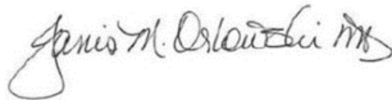
**Interprofessional Consults During the Pandemic: Request for Flexibility**

As stated, we appreciate the recent steps taken to expand telehealth and the use of communication-based technology during the COVID-19 pandemic. We would like to draw your attention to one additional change to policies regarding interprofessional consults that would

enable better access to quality care for patients during the pandemic. During the COVID-19 pandemic, there has been an increase in physician interprofessional consultations occurring in the inpatient hospital setting, which could be billed to Medicare using the CPT Codes for Interprofessional Telephone/Internet/Electronic Health Record Consultations: 99446, 99447, 99448, 99449, 99451 and 99452. These services allow physicians to obtain interprofessional consults without exposing patients and health care providers to the risks associated with COVID-19. Due to the complexity of COVID-19 patients and the rapid change in their condition, these consults may need to occur with greater frequency and may be needed for continued evaluation of a medical condition. We request CMS waive the frequency limits for these services, and also allow them for the same medical condition during the PHE to allow necessary interprofessional exchange of advice and minimize exposure risks of COVID-19 to all patients. During the COVID-19 pandemic, we ask that CMS apply flexibility to enable greater use of interprofessional consultations, and other forms of remote care delivery.

We appreciate your leadership and the steps that you have taken to expand telehealth services and allow other flexibilities during the pandemic. These actions have been vital to our collective effort to respond to the COVID-19 crisis. We strongly urge CMS to continue to take actions to extend access to high quality care in the future by making some of these changes permanent. We would welcome the opportunity to meet with you if possible to discuss further. Thank you for your consideration. If you have any questions, please contact Gayle Lee at galee@aamc.org or Kate Ogden at kogden@aamc.org.

Sincerely,



Janis Orlowski, M.D., M.A.C.P
Chief, Health Care Officer, AAMC

cc: Marion Couch
Alina Czekai