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July 15, 2020

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Seema Verma
Administrator
Ctrs for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

The Society of General Internal Medicine (SGIM), a society of 3,500 general internists, thanks you for your leadership during the COVID-19 pandemic and your continued efforts to ensure that all Americans have access to high quality health care services during the public health emergency (PHE). The flexibilities implemented by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have transformed care delivery and ensured that our patients have not been unnecessarily exposed to COVID-19. We write today with recommendations on which of these policies could support the delivery of high-quality care, as well as the economic recovery, once the PHE concludes.

Our members practice in both inpatient and outpatient settings, serve as the primary internal medicine faculty of every medical school and major teaching hospital in the United States, and are actively involved in all aspects of health services research. SGIM is committed to identifying and addressing system-based disparities of health care delivery. All of our efforts are directed toward equitable and affordable access to the highest quality of care possible.

The waivers implemented by HHS and CMS have allowed physicians and enterprises the opportunity to expand health care access and maintained continuity of care for patients with chronic conditions such as diabetes and hypertension. HHS recently indicated that the Secretary will extend the PHE for another 90 days beyond the current expiration date of July 25, 2020. SGIM is deeply appreciative of this as COVID-19 continues to be a threat to our patients, many of whom have multiple chronic conditions.

SGIM members quickly converted the majority of their patient visits to virtual visits and continued to deliver the same high-level care as they had delivered in-person prior to the COVID-19 outbreak. Maintaining the flexibilities that have ensured patients retain access to COVID and non-COVID related care is necessary in order to contain the COVID-19 pandemic and ensure economic recovery. This will be an ongoing process. **The Society strongly recommends that all of the telehealth waivers currently in place remain at least through June 30, 2022 to ensure that patients continue to receive necessary care without unnecessary exposure to COVID-19.**

As the administration begins to contemplate post-pandemic telehealth policy, SGIM offers the following recommendations discussed in detail below:

- Maintain Coverage and Enhanced Payment for Audio-only Evaluation and Management Services



- Revise Payment for Telehealth Services to Accurately Reflect the Resources Required
- Relax the Telehealth Originating Site and Geographic Eligibility Requirements
- Retain the Flexibilities in Direct Supervision by Physicians
- Retain the Revised Policies for Remote Patient Monitoring

BACKGROUND

COVID-19 created a number of economic and logistical challenges for general internal medicine

The COVID-19 pandemic has been a sobering experience. Many SGIM members have served as front line physicians and provided hospital level care. Others have been active in primary care, both managing the non-hospitalized COVID-19 patients and all those with chronic conditions. COVID-19 has threatened the sustainability of our practices as its infectivity and associated morbidity and mortality is unlike any other condition we have confronted. The decisions the administration, health care institutions, and physicians make now must be coordinated and strategic with a goal of maintaining the health of Americans while guarding against the next pandemic.

Once the pandemic is controlled, consumer confidence must rebound to spur economic recovery, which may take months or perhaps years. The recovery of the health care sector will require policy and practice flexibility and creativity as well as the support at the level of the individual physician whose credibility with their individual patients remains high. Developing a trusting patient-doctor relationship is at the core of primary care, and will be critical to supporting the economy at this time. SGIM is fully committed to addressing the immediate needs to contain COVID-19 and the longer term needs to support the economy. This will take time, and therefore, we urge HHS and CMS to extend the current waivers and flexibilities until June 30, 2022.

Like the administration, SGIM is committed to support the development of a safe and effective vaccine as quickly as possible. However, vaccines or targeted therapeutics will not eradicate COVID-19 alone. As general internists, we have experienced the limitations associated with effective vaccines highlighted by our recent experience with Shringrix. First approved in 2006, yet we still encounter shortages. Even when accessible, physicians must address the fear of side effects with patients individually. General internists, other primary care physicians, and the entire medical community will need time to address these issues as well as any supply issues while providing the same level of patient care as prior to the pandemic.

COVID-19 has engendered new fears in our patients - related to normal patient visits and the generalized fear of public contact of any sort. Counseling patients has become more complicated and nuanced to address these concerns. Recent events have also highlighted longstanding issues of systemic bias that must be addressed. Any apprehension that any individual feels about approaching the health care system, be it based on economic, social, or ethic factors, presents an impediment to care and ultimately undermines individual patients' health as well as efforts to eradicate COVID-19.



COVID-19 has highlighted the precarious financial footings for all primary care practices. Aforementioned, SGIM members quickly converted the majority of their patient visits to virtual visits in response to the COVID-19 outbreak. Our members do not expect in-person visits to return to pre-pandemic levels this calendar year, and the loss of revenue will hit general internal medicine practices particularly hard. A recent *Health Affairs* study estimated the impact of COVID-19 on primary care practices who primarily bill evaluation and management (E/M) visits and found that these practices are estimated to lose \$67,774 in gross revenue per full time physician and a net loss to primary care of \$15 billion due to the effect of COVID-19 on fee-for-service (FFS) payments in 2020.¹ The effect of these reductions on primary care practices will be particularly profound as they generally operate on very narrow margins. Our country needs a strong primary care system during and after the COVID-19 PHE as a strong primary care system has demonstrated reduced health care costs and better health outcomes.

RECOMMENDATIONS

- **Maintain Coverage and Enhanced Payment for Audio-only Evaluation and Management Services**

SGIM appreciates CMS for providing flexibility and support for innovation in patient care by adding the telephone E/M codes (CPT codes 99441-99443) to the telehealth list without geographic restriction and valuing these services at the same rate as CPT codes 99212-99214 respectively. These audio-only visits have played a critical role in preserving the access to care for patients with chronic conditions who take multiple medications, preventing health complications before they become acute. Our members have encountered numerous situations where they could not establish a simultaneous audio and visual connection with a patient and the coverage of these codes allowed patients to receive necessary care. CMS' decision to cover and reimburse for these services has also helped general internists offset some of the revenue lost by reduction in face-to-face visits.

Requiring both audio and visual capabilities is simply impractical for many patients, and impossible for some. Studies have consistently demonstrated disparities in internet and broadband access as well as willingness to use audio-visual technology. The inequities span many different populations, including elderly, low-income, low-education, Black, Hispanic and rural populations.²³⁴⁵. One study reported that just 10.1 percent of 75-79 year-olds were willing

¹ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00794/>

² <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/>

³ Gell, NM, Rosenberg DE, Demiris G, LaCroix AZ, Patel KV. Patterns of technology use among older adults with and without disabilities. *Gerontologist*. 2015;55(3):412-421. doi:10.1093/geront/gnt166

⁴ Crouch E, Gordon NP. Prevalence and Factors Influencing Use of Internet and Electronic Health Resources by Middle-Aged and Older Adults in a US Health Plan Population: Cross-Sectional Survey Study. *JMIR Aging*. 2019;2(1):e11451. Published 2019 Mar 26. doi:10.2196/11451

⁵ https://www.fcc.gov/reports-research/maps/connect2health/#l=39.97712,-95.009766&z=4&t=insights&inb=in_bb_access&inh=in_pcp_access&dmf=none&inc=none&slb=90,100&slh=0.0.0008&zlt=county/



to conduct an audio-visual visit⁶. Though there may be limitations to audio-only visits, we believe that the medical decision-making and visit complexity do not differ significantly between audio-only visits and those with simultaneous audio and visual connections. Continuing to cover both audio-only and audio-visual encounters will provide flexibility to deliver the best possible care for all patients in all circumstances, which is especially important given the uncertainty in the post-COVID era.

The Society strongly recommends that CMS maintain coverage for audio-only care once the PHE concludes in order to optimize access and flexibility for Medicare beneficiaries.

CMS placed the telephone E/M codes (99441-99443) on the telehealth list in 2008, but never paid for these services until this public health emergency. Our members report there are limitations to the time-based coding structure of this code family that do not reflect the realities of delivering audio-only evaluation and management care to new and established patients. The collection of data, the assessment and integration of these data into the medical decision making, and the development of a diagnostic and/or treatment plan is not substantially different when delivered face-to-face, using simultaneous audio-visual connection, or with audio-only technology. Practice expense is what differentiates these modalities.

SGIM has long advocated for an evidence-based payment policy in order to ensure that care delivered by general internists and other cognitively-focused providers is accurately reimbursed. The decisions CMS makes now regarding the value of audio-only care will influence future patient access to general internists and other physicians who primarily provide E/M care.

SGIM urges CMS to review CPT codes 99441-99443 to ensure they reflect the physician work and practice expense required to deliver audio-only care using a data driven approach to defining and valuing these services.

Payments for virtual visits should be based on the time, medical decision making, and technical support that practices need to provide to support high quality virtual care. We encourage CMS to use real world evidence on virtual care from the COVID-19 PHE to address the knowledge gaps that have skewed Medicare payments toward proceduralists and interventionalists.

- **Revise Payment for Telehealth Services to Accurately Reflect the Resources Required**

Prior to the PHE, CMS reimbursed physicians at the facility rate for telehealth services, which is approximately 30 percent less than the in-person reimbursement rate. We have learned that the care delivered face-to-face and via telehealth is roughly equivalent. SGIM recognizes that all virtual visits do not incur the same costs for space, supplies, and staff as in-person visits do. However, practices must make significant investments in telehealth equipment and software as

⁶ Gordon NP, Hornbrook MC. Differences in Access to and Preferences for Using Patient Portals and Other eHealth Technologies Based on Race, Ethnicity, and Age: A Database and Survey Study of Seniors in a Large Health Plan. *J Med Internet Res*. 2016;18(3):e50. Published 2016 Mar 4. doi:10.2196/jmir.5105



well as continue to rely on support staff to deliver virtual care. CMS may conclude certain refinements are necessary to reflect the cost of telehealth visits, but SGIM does not believe simply paying at the services' facility rate accurately reflects their value. CMS should not penalize practices financially for expanding access to telehealth, which will ultimately reduce delays in care and the costs of managing chronic conditions. Again, the Society recommends that any policy decisions about the value of a telehealth service be based on real world evidence and would welcome the opportunity to work with CMS to accurately reflect the practice expense of virtual care.

SGIM recommends that CMS reimburse telehealth services at a rate commensurate with the time, medical decision making, and technical support needed to provide high quality care.

- **Relax the Telehealth Originating Site and Geographic Eligibility Requirements**

The originating site and geographic eligibility requirements limit the delivery of telehealth services to areas outside of metropolitan statistical areas and health professional shortage areas. During the COVID-19 public health emergency, individuals are able to seek routine care without unnecessary exposure to COVID-19 and without placing physicians at risk if the patient was suspected to be COVID positive because of this policy change. SGIM recommends maintaining this policy for a number of reasons. First, patients at higher risk of the seasonal flu and other infections will be able to reduce their potential exposure by continuing to see their providers via telehealth. A permanent policy change also has the potential to address many of the social determinants of health that limit patient access to health care. COVID-19 has exposed the racial and ethnic disparities in our health care system and facilitating greater access to primary care will help to address these disparities. Some patients have transportation barriers and telehealth reduces burden on patients that have to travel significant distances to see a provider and those who may have to choose between going to work or receiving necessary medical care. By allowing people to access care where they are, they will be less likely to ignore certain conditions until they become acute.

SGIM also supports relaxing the requirement that physicians update their Medicare Provider Enrollment, Chain and Ownership System (PECOS) with their home or other address to allow them to deliver care from locations outside of their offices. This will reduce administrative burden on physicians and their practice administrators while potentially expanding patient access to care, as providers may be able to expand the hours in which they can see patients.

SGIM recommends these requirements be permanently relaxed since we now recognize patients can receive care in their homes and other locations outside of originating sites as a result of our experience treating patients during the public health emergency.

- **Retain the Flexibilities in Direct Supervision by Physicians**



Many SGIM members are responsible for training the next generation of general internists and serve as teachers for residents and fellows at teaching hospitals throughout the United States. Waiving the in-person supervision requirement and allowing physicians to supervise residents using asynchronous audio and visual communication has protected providers and patients from COVID-19 while ensuring patients have access to necessary care. There has been some confusion about the need for audio and visual communication, whether it is between the resident and the patient or between the resident and the supervisor. For all the reasons listed above for direct patient care, the requirement for audio and visual in either situation imposes unneeded burden and impairs access to care.

SGIM recommends that CMS consider maintaining this flexibility once the PHE concludes. In rural and underserved areas, permanently maintaining this policy has the potential to expand access to care and has the promise of helping to address the health disparities that are common in these communities. This policy ensures that patients will continue to have access to health care services during future pandemics and PHEs.

SGIM urges CMS to maintain the expanded list of services residents can deliver under the primary care exception, including the new and established E/M services, annual wellness visits, translational care management services, virtual check-ins, e-visits, telephone E/M services, and the interprofessional consultation service. The minimal technology for supervision should be audio only.

- **Retain the Revised Policies for Remote Patient Monitoring**

CMS revised the requirements for billing remote patient monitoring (RPM) services (CPT codes 99091, 99453, 99454, 99457, 99458, 99473, 99474) during the COVID-19 PHE. Providers can now bill these services for new and established patients with both acute and chronic conditions. Additionally, patients are only required to consent once annually.

SGIM urges CMS to retain these policy changes once the PHE concludes as they allow for early interventions and patients to be monitored at home rather than in hospitals, improving patient outcomes and reducing the cost of care.

Should CMS have concerns about retaining these policies, SGIM would welcome the opportunity to work with the agency to revise the policy to preserve patient access.

Again, thank you for all the policy changes that have ensured patient access to appropriate care during the PHE. Should you have any questions, please do not hesitate to contact Erika Miller at emiller@dc-crd.com.



Sincerely,

A handwritten signature in black ink that reads 'Jean S. Kutner'. The signature is written in a cursive style and is contained within a thin black rectangular border.

Jean S. Kutner, MD, MSPH
President, SGIM

Co-signatories:

Jennifer Bracey, MD – Chair, SGIM Health Policy Clinical Practice Subcommittee
Anders Chen, MD – Co-Chair, SGIM Health Policy Clinical Practice Subcommittee
Mark Earnest, MD – Chair, SGIM Health Policy Committee
John Goodson, MD – Chair, Cognitive Care Alliance