AMERICAN OSTEOPATHIC ASSOCIATION

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February 16, 2024

Gift Tee
Director, Division of Practitioner Services, Hospital & Ambulatory Policy Group
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Follow-up to Meeting Regarding Telehealth Payment on January 29, 2024

Dear Gift and CMS team:

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students we represent, greatly appreciated your team making the time to meet with the AOA and 9 other specialty societies on January 29 to discuss telehealth payment. We greatly appreciate CMS' efforts to support telehealth service delivery in the CY2024 Medicare Physician Fee Schedule (MPFS) rule. We strongly urge the agency to maintain its policy of payment parity for telehealth and in-person services, particularly between in-person office/outpatient evaluation and management (E/M) services and telehealth E/M services for 2025 and beyond. **Ensuring appropriate payment will enable physician practices to leverage telemedicine in providing longitudinal care and to sustain these vital services into the future.**

Osteopathic physicians are trained in a patient-centered, whole-person approach to care, and tools that support building longitudinal relationships with our patients are vital. Many DOs practice in rural and underserved settings, and regularly witness the impact delays in access have on adherence to treatment plans and how policies can support vulnerable patients' access to care.

The dramatic nature of healthcare access challenges across the U.S. is reflected by the fact that 74 million Americans reside in a primary care health professional shortage area, and workforce shortages for other specialties, such as psychiatry are even more profound.[1] While telehealth should not be a substitute for in-person care, physicians are able to deliver clinically equivalent care via telemedicine for many conditions.[2, 3] Telehealth plays a critical role when patients need to travel long distances to see a provider, live in rural and underserved settings, face transportation challenges, experience mobility issues, are unable to take off work, or face a range of social determinants that limit their ability to receive in-person care.

We would also like to highlight that appropriate payment for both audio-visual and audio-only services is essential. Many Medicare beneficiaries lack access to reliable broadband internet and do not have a smart phone, making audio-

[1] Health Resources & Services Administration. "Health Workforce Shortage Areas". January 18, 2024. Available here.
[2] Baughman DJ, Jabbarpour Y, Westfall JM, et al. Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System. *JAMA Netw Open.* 2022;5(9):e2233267
[3] Thawani SP, Minen MT, Grossman SN, Friedman S, Bhatt JM, Foo FA, Torres DM, Weinberg HJ, Kim NH, Levitan V, Cardiel MI, Zakin E, Conway JM, Kurzweil AM, Hasanaj L, Stainman RS, Seixas A, Galetta SL, Balcer LJ, Busis NA. A Comparison of Patients' and Neurologists' Assessments of their Teleneurology Encounter: A Cross-Sectional Analysis. Telemed J E Health. 2023 Aug 25. doi: 10.1089/tmj.2023.0168. Epub ahead of print. PMID: 37624656.

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only the only accessible telehealth modality. Audio-only services have been vital to many underserved communities. Racial and ethnic minorities, and individuals who are low-income, have been found to be more likely to use audio-only services.[4, 5] This is likely due to many of the social determinants listed above that limit their access to in-person and audio-visual services. Some stakeholders have argued that availability of audio-only services may drive inequities by making a "less preferred" mode of care more available. Our physicians would always prefer to see a patient in-person, or via audio-visual technology, but audio-only services can allow some patients to access care in instances when they may otherwise forgo care. Limiting access to audio-only services through reduced payment could harm this population, and efforts should be made to improve access to in-person and audio-visual services for those that face barriers. **As we work to develop policy solutions to improve access to broadband, access to smartphone technology, and address the barriers that prevent patients from seeking care, audio-only services should continue to be available to the patients that need them.**

Practice Models and the Typical Patient

We urge CMS to remain consistent with the practice of defining a service and corresponding payment based on the "typical patient". Relying on what is "typical" will ensure that physician practices are paid appropriately for their services and not disadvantaged in an effort to reduce payment rates to account for a small number of providers in virtual-only models, whose services are often not longitudinal nor provided in settings that entail the same practice expense costs as physician practices.

According to a recent physician survey 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.[6] These findings suggest that physicians in telehealth-only practice models comprise a very small minority of telehealth providers and overall telehealth visits. Additionally, services provided by telehealth-only providers are most commonly provided to commercially insured patients and for less complex visits (although there are some notable exceptions, as in the case of many mental and behavioral health providers). However, telehealth-only practice models account for a very low share of physicians, and this small minority of visits should not dictate payment to all practices providing vital telemedicine services, especially when considering that 77% of small and solo practices, and 72% of mid-size practices across the country offer telehealth services to their patients. Most physician practices offer hybrid models, predominantly offering care in-person, but also making virtual care available to patients that may need it. Under these models, physicians will need dedicated spaces to conduct telehealth visits over the course of their day, maintain their overall practice expense, and incur additional expenses which we elaborate on below. **We urge CMS to base payment on the true work and cost inputs for the typical encounter.**

Service Inputs

Maintaining parity for telehealth and in-person visits is essential, as for the typical practice, the work, practice expense, and malpractice costs for services remains the same regardless of whether a service was provided in-person or via telehealth. The AOA has heard overwhelmingly from our members that the work of seeing patients via telemedicine is equivalent to the work of seeing patients in-person. The various levels of E/M services are selected on the basis of

[4] 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.

[5] HHS Assistant Secretary for Planning and Evaluation. "Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)." April 2023.

[6] Kane, C. "Policy Research Perspectives, Telehealth in 2022: Availability Remains Strong but Accounts for a Small Share of Patient Visits for Most Physicians." American Medical Association. 2023.

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time or medical decision making (MDM). These factors do not change when the service is provided via telemedicine. When selecting an E/M based on MDM, the MDM "includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option" and is defined by three key elements: (1) number and complexity of the problem(s) addressed during the encounter; (2) the amount and/or complexity of data to be reviewed or analyzed; and (3) the risk of complications and/or morbidity or mortality of patient management. MDM and the basis for selecting levels of E/M services do not change when a service is provided in-person or via telehealth services.

Additionally, during a visit, a physician will review records, take a history, evaluate the patient, formulate a diagnosis and plan, communicate next steps, and write a note. **This work is the same whether done for an in-person visit or a telemedicine visit, and these considerations apply to both audio-visual and audio-only services.**

In addition to performing equivalent work in telehealth visits, practices that have adopted a hybrid model (which encompasses the majority of physician practices, as noted above) maintain the same practice expense as when they provided all services in-person. The AOA greatly appreciated CMS acknowledging this in the CY2024 MPFS final rule, where the agency stated:

> 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.

What CMS acknowledges continues to be true for many office-based specialties that offer telehealth services. These hybrid practices will continue to maintain their office, equipment, supplies, and clinical staff overhead when they shift some of their patient volume to telehealth. While there may be subtle differences in how clinical staff spend time before, during, and after a telehealth encounter, or in the equipment and supplies used, the total expense for each visit is equivalent. For example, while a telehealth encounter may not use some of the supplies used during in-person visits (an exam table, sanitizing materials, etc.), there are various practice expense inputs for audio-visual telehealth services that are not fully accounted for under current methodologies, including telehealth software and additional licenses for staff, as well as cybersecurity technology. Ultimately, while there may be subtle differences in what comprises total PE for in-person and telehealth visits, the total PE is equivalent, with many costs absorbed by practices not currently accounted for in the PE methodology. **CMS should establish PE for telehealth visits as equivalent to in-person services, as reducing PE RVUs for telehealth visits would leave small and independent practices at a disadvantage and potentially restrict their ability to offer these services.**

Last, we would like to highlight that malpractice risk is the same for telemedicine visits as it is for in-person visits, and **CMS should maintain values of this input for telehealth services as equivalent to corresponding in-person services.**

Coding Considerations

The AOA supports CMS' adoption of the newly created CPT codes for telehealth evaluation and management services (9X075-9X091). The agency has the authority to set payment in a manner that will promote access and sustainability of telehealth services, particularly among small and independent community-based providers. Adoption of the code set may also support CMS efforts to vary payment rates to appropriately reflect costs in different settings. **AOA**

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supports full adoption of the new code set so long as it is done with appropriate payment rates that provide parity to in-person services for non-facility based physicians.

Once again, the AOA appreciates the chance to provide input to CMS as it begins developing the MPFS proposed rule for 2025. Should you have any questions regarding our comments or recommendations, please contact Gabriel Miller, Senior Director of Regulatory Affairs, at gmiller@osteopathic.org. Thank you again for considering the AOA's feedback as you continue your rulemaking effort.

Sincerely,

John-Michael Villarama

John-Michael Villarama, MA
Vice President, Public Policy, AOA