



January 31, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

Thank you for your ongoing leadership to ensure Medicare beneficiaries retain access to telehealth. We write to you today regarding the consideration of new telehealth codes as proposed by the American Medical Association (AMA) in 2023.¹ While we appreciate the work and intent of the AMA in putting forth new coding for telehealth services, we believe these codes will ultimately undermine the broader efforts of the administration to ensure equitable access to the full spectrum of Medicare services.

As you likely know, the AMA Relative Value Scale Update (RUC) Committee in May proposed 17-20 new telehealth codes to be considered in the Centers for Medicare and Medicaid Services (CMS) Medicare Telehealth Services List. It is our understanding that the intent of this effort was to ensure greater access to telehealth services, unfortunately we do not believe this is the impact these codes would ultimately have. We oppose the adoption of these codes by the Medicare program.

The proposed telehealth codes offer four primary problems:

- (1) Telehealth is a modality of care, not a different service. It is therefore inappropriate for CMS to adopt multiple codes for the same service.** The proposed Evaluation and Management (E/M) codes already exist in the Medicare Physician Fee Schedule. We also believe that the current reimbursement structure, which values the service being provided rather than the modality of care is the correct approach for Medicare. For this reason, in-person visits and video visits should be reimbursed equally as it is clinically equivalent and requires the same effort and medical decision-making by the clinician. The complexity and clinical effort of the visit is already captured in the level of service coding and does not further vary whether the service was provided via video-or in-person.

- (2) Telehealth has expanded access to care for underserved and rural populations. The complexity and potential payment variation created by duplicate codes would hinder CMS's health equity priorities.** Underserved communities often lack equal access to health care. According to [research](#) from the Assistant Secretary for Planning and Evaluation (ASPE), individuals who identify as Hispanic or Latinx, Black, and Asian were more likely to use telehealth, specifically audio-only

¹ <https://www.ama-assn.org/system/files/cpt-summary-panel-actions-may-2023.pdf>



telehealth. Audio-only telehealth helps ensure a more equitable care delivery system.²³ The proposed codes may lead to more providers force patients to go back to in-person care for either reimbursement or complexity reasons, which may deter these populations from accessing necessary medical care due to barriers including transportation, language barriers, and others.

(3) The 17 new codes would leave out 200 services and outpatient codes which telehealth is currently used as a modality for. While we appreciate the intent of the 17 new codes, we believe they would create an incentive for either massive additional code proliferation from AMA or for diminished access to the other telehealth services which can be offered through in-person or telehealth modalities due to additional confusion.

(4) There could be significant patient access and operational impacts as the new codes are adopted. These new codes would introduce additional change and uncertainty during a time in which the full coverage of Medicare telehealth services is already in question due to statutory deadlines. Providers are already accommodating significant risk in operating telehealth programs with the uncertainty of Medicare telehealth looming ahead of them. Additionally, it would impose a significant burden on clinicians, practices, coders, billers, and others, as the codes cannot be automatically cross-walked on the backend based on its modality. A dramatic change in coding and reimbursement for these services may cause some providers to instead force patients to go back to in-person care, for which coverage and reimbursement is reliable and clear.

The Alliance and our members strongly urge CMS not to incorporate these codes into the Medicare program. Telehealth is simply a modality for providing health care, it is not a different service or type of care. Creating a new code for a service that has already been deemed by CMS to have clinical value a second time is redundancy and is holding telehealth to a higher standard than other care.

Thank you for your consideration of this request and for your ongoing work to ensure beneficiary access to needed telehealth services. Please contact Chris Adamec (cadamec@connectwithcare.org) with any questions about this letter.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac".

Krista Drobac
Executive Director
Alliance for Connected Care

² <https://www.nejm.org/doi/full/10.1056/NEJMp2118292>

³ <https://www.auajournals.org/doi/10.1097/UPJ.0000000000000301>