AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 30, 2023

The Honorable Brian Schatz
United States Senate
722 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Mike Thompson
United States House of Representatives
268 Cannon House Office Building
Washington, D.C. 20515

Dear Senator Schatz and Representative Thompson:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write to thank you for your ongoing leadership to advance telehealth and to provide policy recommendations to inform reintroduction of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act.

As the usual source of care for patients across the lifespan, family physicians are uniquely trained to practice across care settings and meet the needs of their communities, including offering care by their patient's preferred and most appropriate modality. This has more frequently included care delivered via telehealth, which has seen increased utilization as a result of the pandemic. Telehealth claims have jumped from 0.1% in 2019 to about 5% at the end of 2021.[i] According to a recent AAFP survey, 9 in 10 family physicians practice telehealth today. The AAFP supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes, and decrease costs when utilized as a component of, and coordinated with, longitudinal care.

Any permanent expansion of telehealth benefits should be structured to not only increase access to care but also promote high-quality, comprehensive, continuous care, as outlined in the joint principles for telehealth policy put forward by the AAFP, the American Academy of Pediatrics and the American College of Physicians. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

Unfortunately, many patients and physicians still encounter regulatory, financial, and other barriers in accessing and delivering appropriate, high-quality care through telehealth. More work must be done by Congress to address the structural barriers to virtual care, particularly for low-income, chronically ill, rural, and patients from other marginalized communities. **The Academy therefore advocates for the increased standardization of reimbursement policy among payers, and for the close monitoring of outcomes to ensure that broadened telehealth and telemedicine protocols don't lead to wider health disparities among vulnerable populations.** It is with these goals in mind that the AAFP offers the following feedback on ways to improve the CONNECT for Health Act.

Recommended new provisions:

The Academy appreciates that the legislation currently includes provisions that aim to address and amend Medicare's geographic and originating site restrictions. However, **we encourage that the language be revised to permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access care at home.** The COVID19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

The AAFP supports the removal of remaining telehealth restrictions on alternative payment models. Currently, telehealth flexibility is limited to a narrow set of Accountable Care Organizations (ACOs) with downside risk and prospective assignment – even though other tools apply to all ACOs. Since all participants in the Medicare Shared Savings Program are being held accountable for quality, cost, and patient experience, they should all have the flexibility to use telehealth tools to deliver care. Within the CONNECT for Health Act, Congress should eliminate current requirements that limit participation and instead allow all ACOs to participate.

In an effort to improve access to integrated tele-mental and behavioral health care in primary care settings, **the AAFP encourages Congress to establish a new program for adults that mirrors the Pediatric Mental Health Care Access Program (PMHCA) at the Health Resources and Services Administration (HRSA)**. This program, which began in 2018 and was most recently reauthorized in 2022, promotes behavioral health integration into pediatric primary care by using telehealth. Specifically, PMHCA provides grants to support the establishment or expansion of statewide or regional networks of pediatric mental health teams to provide teleconsultation, training, technical assistance, and care coordination support services for pediatric primary care and other providers to recognize pediatric behavioral health conditions and to diagnose, treat and refer children with such conditions. The goal of the program is to use telehealth modalities to provide high quality and timely detection, assessment, treatment, and referral of children and adolescents with behavioral health conditions, using evidence-based practices and methods.[ii]

PMHCA has helped address increased mental and behavioral health needs in light of ongoing workforce shortages by meeting children and adolescents where they are. In Fiscal Year 2020, approximately 3,000 children and adolescents in 21 states were served by pediatric primary care providers who contacted the pediatric mental health team. Two out of every three of these patients lived in rural and underserved counties.[iii] Both clinicians and patients have reported high satisfaction with the program as well.[iv] However, more than one-third of the U.S. population lives in areas that are underserved by mental health professionals, and more than half (56%) of adults with a mental illness currently receive no treatment.[v,vi]

Family physicians frequently share concerns and frustration that when they refer their patients for mental or behavioral health care, their patients are not always able to find a clinician in-network or one accepting new patients. As a result, family physicians see patients with exacerbated behavioral health systems and are sometimes forced to send them to the emergency department when there are

no other acute care options. Given the well-documented shortage of mental and behavioral health clinicians and the growing demand for specialized care, a HRSA-funded program that provides primary care clinicians with virtual access to specialists could increase timely access to care for adult patients.

Potential guardrails and beneficiary protections:

The AAFP strongly urges Congress to ensure that the policies contained within this legislation do not inadvertently provide a pathway for direct-to-consumer telehealth vendors to disrupt the comprehensive and longitudinal relationships between patients and their primary care physicians. We have significant concerns about the rapid proliferation of direct-to-consumer (DTC) telehealth vendors and the resulting interference with the established physician-patient relationship. Studies have shown that DTC telehealth can lead to increased utilization and may ultimately increase overall health care spending. For example, one study found patients with initial DTC telemedicine visits for acute respiratory infections were more likely to obtain follow up care within seven days after the DTC encounter when compared with patients with initial in-person visits.[vii] This suggests that seeking initial care from a DTC setting may lead to avoidable higher spending on follow up care.

The AAFP has also previously cited concerns with potential fraudulent behavior by DTC telehealth vendors. In July 2022, the OIG released a Special Fraud Alert regarding fraud schemes where telemedicine companies offer kickbacks for prescribing medically unnecessary items and services for individuals with whom the clinician often does not have a relationship. As noted by the OIG, “These types of volume-based fees not only implicate and potentially violate the Federal and anti-kickback statute, but they also may corrupt medical decision-making, drive inappropriate utilization, and result in patient harm.”

Our concerns have only become more heightened following recent reports and ongoing federal investigations into these telehealth platforms and the rise in DTC pharmaceutical advertising that encourages patients to seek prescriptions on specific telehealth platforms. These companies have engaged in potentially unnecessary and inappropriate prescribing practices that fail to prioritize patient safety and lead to care fragmentation.

In the current digital landscape, a patient may face a barrage of pharmaceutical advertisements in any given place when accessing care virtually: when they log in for a telehealth visit, send a message to their provider, or check their medical records. The AAFP believes that it is inappropriate for pharmaceutical advertising of any kind to occur in electronic health records (EHRs), patient portals, and other digital point-of-care environments. Congress should establish protections that would prohibit direct-to-consumer pharmaceutical advertising within digital point-of-care environments, including telehealth platforms, patient portals, and EHRs.

In light of these concerns, the AAFP supports the implementation of telehealth coverage guardrails to protect the quality and continuity of care delivered virtually, such as requiring an established patient relationship for some telehealth services. Ensuring beneficiaries receive telehealth services from a clinician that knows them and can access their health record will help ensure patients receive appropriate care, including in-person services when needed. A recent report from the HHS Office of the Inspector General found that 84 percent of Medicare fee-for-service

telehealth visits are already being provided by clinicians who have an established relationship with the beneficiary. Other studies indicate patients prefer telehealth services provided by their usual source of care. Implementing additional guardrails would help ensure high-quality services are being delivered to beneficiaries without unduly restricting access to care, while also safeguarding program integrity.

Measuring domains of telehealth quality, including care that is safe, effective, patient-centered, timely, efficient, and equitable:

The AAFP has supported legislative proposals to analyze telehealth utilization and patient outcomes broken down by race and ethnicity, geographic region and income level. We have called for the collection and reporting of this data, as well as data stratified by gender and language, in order to fully understand the impact that the expansion of telehealth during the COVID-19 public health emergency (PHE) has had on different patient populations. We encourage the legislation to incorporate data collection with these elements.

While the rapid expansion of telehealth has yielded many benefits for patients and clinicians, not everyone has benefited equally. Without sufficient investment and thoughtful policies, telehealth could actually worsen health disparities. Prior to the COVID-19 pandemic, evidence suggested that telehealth uptake was higher among patients with higher levels of education and those with access to employer-sponsored insurance.[viii,ix] Another study found that patients with limited English proficiency utilized telehealth at one-third the rate of proficient English speakers.[x] Anecdotes from family physicians suggest that the same trend may hold true during the public health emergency — that those benefitting most from telehealth are those who already had better access to care. Unfortunately, most of the current Medicare studies on telehealth utilization aren't granular enough or don't stratify by these demographic data points to illustrate the impact of expanded telehealth access and use across patient populations.

The AAFP also strongly recommends that any studies of telehealth utilization analyze volume, patterns and patient outcomes for visits provided by a patient's usual source of care versus one-off visits provided by a clinician with whom the patient has no relationship. There is ample evidence that greater care continuity leads to higher quality of care and lower health care utilization and costs.[xi,xii,xiii]

Addressing disparities in telehealth utilization:

Permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs. The lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are 10 times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits. A report from the Assistant Secretary for Planning and Evaluation (ASPE) also found that Black, Latino, Asian, and elderly patients, as well as those without a high-school diploma, were more likely to rely on audio-only telehealth visits. **The available data clearly indicate that coverage of and fair payment for audio-only services is essential to facilitating equitable access to care after the PHE-related telehealth flexibilities expire.** The Academy therefore recommends that the legislation codify the ability for CMS to permanently cover and pay for audio-only telehealth services to bridge gaps in access to care.

In addition to ensuring audio-only services are covered and paid for, permanent telehealth coverage and payment policies should be designed to enable patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Audio-only visits should be adequately paid so physicians can provide equal access to all types of telehealth services and patients can access care through the modality that best suits their needs and preferences**. Congress should create policies that strengthen patients' relationships with their primary care physician, and physicians should not be paid less for providing patient-centered care.** Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

Congress should also expand investments in federal programs that provide all patients with the resources needed to successfully conduct video visits or access their EHRs, including the Lifeline Program, the Emergency Broadband Benefit Program, and the Affordable Connectivity Program. However, it is not enough to simply expand access to broadband. **Congress must ensure that patients in need can access end-user devices, such as tablets, to connect to digital health tools and invest in training and assistance so patients can confidently use those tools to ensure we don't further marginalize and disenfranchise them.**

To achieve this aim, the AAFP has called on Congress to also create a digital health equity pilot program at HRSA to fund digital health literacy programs for patients, digital health navigators, point-of-care interpretive services, digital tools with non-English language options, and tools with assistive technology. Such a program could award grants to federally qualified health centers (FQHCs), rural health centers (RHCs), and community health centers to fund activities and services to increase digital health literacy, support digital health navigation, and to purchase and utilize digital health tools that are linguistically and culturally appropriate. Such a program should also include a robust evaluation to identify successful interventions that can be brought to scale across other federal programs to serve other low-income or at-risk patients.

Enhancing tele-mental health for beneficiaries:

The AAFP has continuously advocated for and supported legislative proposals to permanently remove CMS' in-person requirement for tele-mental health visits in order to facilitate access to behavioral health services, including for services furnished by FQHCs and RHCs. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[xiv,xv] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients. Arbitrarily requiring an in-person visit prior to coverage of tele-mental health services will unnecessarily restrict access to behavioral health care. Removing the in-person requirement for FQHCs and RHCs would improve equitable access to care for low-income patients and those in rural communities. We note that our position on in-person visit requirements is unique to tele-mental health services.

Ways to support telehealth education and training for providers and beneficiaries:

Within this legislation, Congress could consider expanding the mandate of the Office for the Advancement of Telehealth at HRSA and require it to develop tools and resources on telehealth services that can be distributed to small healthcare practices, patients, and consumer organizations. Additionally, there may be opportunities to explore partnerships with leading consumer and patient organizations to educate seniors about telehealth services, including the use of technology and how to verify the identity of a healthcare provider.

Approaches to facilitate providers seeking to deliver telehealth out-of-state:

Patients with an established relationship, who are traveling, should be allowed to be treated by their primary care physician, so long as the physician is licensed in the state in which the patient receives their usual care. The Interstate Medical Licensure Compact (IMLC) offers an expedited pathway for physicians to apply for and receive licenses from participating states. We encourage states to engage in reciprocity compacts for physician licensing like the IMLC, especially to permit the use of telehealth. While the IMLC helps to expedite the licensure process, family physicians report that it is still burdensome and costly. Physicians must apply to participate in the IMLC, provide additional information to states to obtain licensure, and regularly renew each individual state license. According the IMLC website, physicians are required to pay a $700.00 application fee to participate in the IMLC in addition to state licensing and renewal fees for each state they wish to be licensed in.

The AAFP supports efforts to improve and streamline the IMLC to support family physicians providing virtual care to *all* their established patients across state lines. We urge Congress to consider federal policy options to:

- Subsidize the cost of the IMLC application fee and state licensing fees;
- Improve the sharing of licensure and other relevant information between states in order to reduce the burden of application and renewal on physicians and reduce licensing wait times; and
- Encourage all states to participate in the IMLC and create streamlined licensure or waiver processes for physicians in other states caring for patients with whom there is an established patient-physician relationship.

Opportunities for continued data collection and analysis:

As mentioned above, the Academy recommends data collection on a variety of demographic data elements to analyze telehealth utilization and patient outcomes. We encourage continued studies and analyses on the data and evidence on the use of telehealth services, how physicians can be best financially and technologically supported to provide this modality of care, and the impact of telehealth and broadband on health care access and equity by ensuring data collection and evaluation include key demographic factors.

Additionally, **Congress should consider studying the rise in inbox messaging and other digital health tools and the resulting burden on physicians, clinicians, and their staff**. During the pandemic, patient messaging increased by more than 50%, requiring a substantial amount of uncompensated clinician time.[xvi] Physicians should be appropriately compensated for treating patients and providing medical advice through both audio-video and audio-only visits, as well as these asynchronous methods. There must be appropriate payment for electronic communication and

evaluations that physicians provide for the medical management of their established patients, such as the time and work spent engaging in inbox messaging through EHRs.

Optimizing access to telehealth in Medicare Advantage:

The AAFP again reiterates our call on Congress to facilitate patients' access to telehealth services from their usual source of care, including for Medicare Advantage (MA) enrollees. As previously noted, telehealth offered by a patient's usual source of care can expand timely access to care while also improving care continuity and quality. For example, primary care physicians often connect patients to community-based services to address unmet health-related social needs and coordinate care across various physicians and other clinicians. Standalone telehealth services, such as those provided by DTC companies, are not connected with resources in patients' communities nor are they positioned to follow-up with other clinicians involved in a patient's care.

We previously expressed concerns that standalone telehealth services would result in care fragmentation for Medicare beneficiaries and opposed a CMS proposal to provide MA plans with credit toward meeting network adequacy requirements if covered telehealth services were available. The AAFP has urged CMS to modify current MA network adequacy standards to clarify that plans can only receive additional credit toward network adequacy standards for clinicians offering both telehealth and in-person care in the network. Direct-to-consumer telehealth services cannot serve as a substitute for comprehensive, longitudinal, person-centered primary care.

Finally, **the Academy encourages inclusion of language or a study on measuring equitable access to and utilization of telehealth specifically for MA plans.** Of the nearly 63 million beneficiaries enrolled in at least one part of Medicare in 2019, MA enrollees were disproportionally lower-income, Black or Latino, dually enrolled in Medicaid, and had multiple chronic conditions.[xvii] We echo many of our concerns already expressed above on disparities in telehealth utilization and the potential for them to be exacerbated if structural barriers are not addressed. Given the growing number of low-income and underserved beneficiaries enrolled in MA plans, Congress must ensure that they are able to access and use telehealth services.

Thank you for the opportunity to provide feedback on this draft legislation. We look forward to continuing to work with you both to improve equitable access to telehealth services. Should you have any questions, please contact Erica Cischke, Director of Legislative and Regulatory Affairs at ecischke@aafp.org.

Sincerely,

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