AMERICAN ACADEMY OF FAMILY PHYSICIANS

March 9, 2022

The Honorable Mariannette J. Miller Meeks, M.D.
U.S. House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

The Honorable Mike Kelly
U.S. House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
U.S. House of Representatives
2202 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Miller-Meeks, Kelly, and Griffith:

On behalf of the American Academy of Family Physicians (AAFP), which represents 127,600 family physicians and medical students across the country, I write in response to the Healthy Future Taskforce Modernization Subcommittee's request for information (RFI) with general recommendations on design considerations for potential legislation to increase access to care and promote high-quality, comprehensive, continuous care through technology.

Telemedicine Expansion

Which Flexibilities created under the COVID-19 public health emergency should be made permanent?

The Centers for Medicare and Medicaid Services' (CMS) temporary expansion of Medicare coverage and payment for telehealth during COVID-19 has enabled physicians to maintain quality care continuity through virtual visits with their patients**.** A return to pre-COVID telehealth policies would threaten access to telehealth services for millions of Medicare beneficiaries. Protecting and promoting continuity of care is essential to realizing the care quality improvements and cost reductions with the integration of telehealth.

Congress should ensure permanent access to audio-only telephone visits, in addition to virtual check-ins, to preserve telehealth access for patients who may lack broadband access, have limited technological literacy, or for whom a video visit may be impractical or undesirable. New data confirm that these barriers disproportionately impact adults over 65, those without a high school diploma, and Latino, Asian, and Black individuals, who are more likely to rely on audio-only visits to access care. Until universal access to broadband is a reality, telephone visits will be essential for ensuring that telehealth expands access to care for vulnerable populations and does not worsen health disparities.

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Congress should pass legislation eliminating the section 1834(m) geographic and originating site restrictions to allow Medicare beneficiaries to continue accessing all types of care at home - beyond the public health emergency. The COVID-19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home helps to reduce patients' and clinicians' risk of exposure and infection and increase accessibility for patients who may be homebound or lack transportation.

Telehealth visits also allow physicians to identify environmental factors – within the home – that may be affecting a patient's health, and to develop more personalized treatment plans.

As Congress considers long-term changes to telehealth policy, it is critical to recognize that telehealth is one modality of providing care but cannot and should not fully replace in-person primary care. Expanding telehealth services in isolation, without regard for previous physician-patient relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal 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. Telehealth can enable timely, first-contact 24/7 access care supported by the medical record. Telehealth can also support physicians in maintaining long-term, trusting relationships with their patients which is central to continuity of care. Outsourcing services to independent direct-to-consumer telehealth providers undermines the medical home and can result in fractured relationships and care.

Additional Recommendations to Preserve Telehealth Access Beyond COVID-19

Coverage Parity Between Virtual and In-Person Care

Insurance coverage should support the patient's freedom of choice in the modality of care (i.e., copays should not force patients to a specific modality, nor should lower copays force patients into a specific source of care – such as virtual only vendors).

Congress should pass the Primary and Virtual Care Affordability Act to give employers and health plan sponsors the flexibility to waive the deductible for primary care and telehealth services through December 31, 2023, for patients covered by HSA-eligible high-deductible health plans. This legislation would ensure that patients can access primary care—both in-person *and* virtually to keep patients out of the hospital, manage chronic conditions, address lapses in care, and catch them up on missed routine and preventive services. There are many services that cannot be delivered virtually and failing to address financial barriers that prevent people from seeking timely in-person care will negatively impact outcomes].

Reimbursement

Payment for telehealth must account for costs associated with the integration of telehealth into the medical home. Family physicians report that there are unique costs associated with integrate telehealth into their practices. These include purchasing and integrating telehealth software into existing clinical workflows and electronic health record (EHR) technology - while maintaining

patient privacy, hiring additional staff or increasing staff compensation to implement these new technologies, covering both in-person and virtual visits, assisting patients with telehealth utilization, and ensuring physician malpractice or liability insurance covers telehealth. Telehealth payment rates must account for these additional costs and support integration into the medical home.

Coverage and reimbursement should be standardized across all payers to ensure physicians continue providing virtual care to their patients. Additionally, payment models should support the physician's ability to direct the patient toward the appropriate service modality (i.e., provide adequate reimbursement) in accordance with the current standard of care. Family physicians rank coverage for telehealth services by insurers and level of reimbursement in the top three factors critical to practicing telehealth.

Payers should cover telehealth services provided by any in-network provider and Congress should prohibit telehealth "carve outs" that only cover care provided by separately contracted, virtual-only vendors to protect patient's choice of provider and promote care continuity. Many commercial payers temporarily expanded coverage and waived costs associated with telehealth in response to COVID-19 and flexibility provided by the CARES Act; however, coverage varies by insurance product and in some cases is limited to telehealth services delivered by preferred vendor partners. **Congress should ensure that permanent telehealth coverage and payment policies facilitate patients' access to telehealth within the medical home.**

Health Equity

Ensure telehealth is advancing health equity, not exacerbating health disparities.

- The AAFP urges Congress to pass the Evaluating Disparities and Outcomes in Telehealth (EDOT) Act (H.R. 4470), which directs the Secretary of Health and Human Services to further study telehealth utilization in the Medicare and Medicaid program, including analysis of utilization and patient outcomes by race and ethnicity, geographic region and income level. This data will be critical for informing long-term policy decisions.

Ensure access to telehealth services for Federally qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

- FQHCs and RHCs are essential sources of primary care for patients in underserved communities, including low-income individuals and those living in rural areas. Before the COVID-19 pandemic, FQHCs and RHCs could only serve as distant sites and were not able to provide telehealth services to patients if they were located in their homes. During the pandemic FQHCs and RHCs have made significant investments in order to integrate telehealth into their practice models and ensure equitable access to telehealth services for their patient populations. In order to ensure care continuity and equitable access for FQHC and RHC patients, Congress should pass legislation to ensure that federally qualified health centers (FQHCs) and Rural Health Clinics can provide telehealth services beyond the public health emergency.

Invest in infrastructure to promote digital health equity.

- Congress should create a pilot program to fund digital health literacy programs for patients, digital health navigators, point-of-care interpretative services, digital tools with non-English language options and tools with assistive technology. Such a program would equip clinicians who serve patients in underserved communities with the tools to help them access virtual care.
- Congress should also continue to invest in in modern broadband technology to ensure that all Americans have access to affordable, high-speed broadband.

- Congress should expand access to modern technology itself (i.e., smartphones, tablets, computers, etc.) within underserved communities and invest in culturally competent education and guidance to improve confidence, comfort, and trust for underserved consumers.

Recommendations for Wearable Technologies

Remote Patient Monitoring (RPM) Codes

While RPM codes have been added to the Medicare Physician Fee Schedule, utilization of the codes is burdensome, and the payment is low. **Congress should urge CMS to accelerate the adoption of prospective payment models that align incentives with delivering better care and provide physicians more time with patients.**

Standardize Data

Wearable technologies may provide primary care physicians with additional data about a patient's health. However, data generated by devices are not standardized nor are they structured or formatted to support physicians' medical decision-making. This prevents it from being shared with physicians, integrated into EHRs, and acted upon. **Congress should promote the standardization of data from these devices and the deployment of application programming interfaces (APIs) in EHRs to accept these data.**

Support Equity for Underserved Patients

Congress should establish programs that support equity for undeserved patient populations facing challenges that hinder the adoption of wearables. Wearables require significant time investments by practices and physicians to deploy within their patient populations. Efforts to adopt wearables in a practice would require a physician to provide technical assistance to patients using the devices and sharing their data with the practice. Additionally, many patients cannot afford the cost of wearables.

Additional Recommendations for leveraging technology to enhance patient care beyond the PHE

Support Virtual Supervision and Teaching Services

CMS should allow physicians to provide direct supervision and teaching services via synchronous audio/video communication nationwide. During the public health emergency, CMS

allowed this to improve access to care in areas with physician shortages and prevent the transmission of COVID-19. The flexibility to provide these services virtually had clear benefits, as evidenced by CMS's recent decision to permanently allow virtual teaching and supervision in rural areas. If made permanent nationwide, it would increase training opportunities in rural and other underserved communities and improve patients' access to comprehensive, continuous care. A similar permanent policy was finalized for all levels of E/M office visits provided at a primary care center during the PHE: Teaching physicians can permanently use video conferencing to supervise residents providing primary care in rural areas. The AAFP is supportive of this policy being made permanent, and we believe that, applied nationwide, it would bolster primary care training opportunities and improve access to primary care in other underserved areas. The rural designation may not capture many areas of the country that are experiencing primary care shortages.

The AAFP looks forward to working with the Healthy Future Task Force to develop policy solutions that invest in the future of primary care, and ultimately improve the health of our entire nation. If you have questions or would like to discuss our feedback in greater detail, please contact David Tully, Vice President of Government Relations, at dtully@aafp.org

Sincerely,

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians