AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance Subcommittee on Healthcare

On

# Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency

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Dear Chairman Cardin and Ranking Member Daines:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership to address issues impacting family physicians and their patients through today's hearing entitled "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency."

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.

As telemedicine services are expanded and utilized to achieve the desired aims, it is also imperative that outcomes are closely monitored to ensure disparities in care are not widened among vulnerable populations. Policies should acknowledge the geographical and socioeconomic disparities that exist and could be exacerbated by the improper adoption of telehealth if not explicitly addressed. Access to broadband is a social determinant of health. All patients and practices should have broadband access to support delivery of telehealth services in accordance with AAFP's policy on Health Care for All. It is with these considerations in mind that the AAFP offers the following policy recommendations in response to today's hearing:

**Promoting Patient-Physician Relationships**

Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities and vulnerable populations. As discussed in the Academy's comments on the CY24 Medicare Physician Fee Schedule proposed rule and our aforementioned joint principles, **the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship**.

Telehealth should also enable higher-quality, more personalized care by making care more convenient and accessible for patients. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the central value offered by a usual source of primary care, a continuous and comprehensive patient-physician relationship,

increase fragmentation of care, and lead to the patient receiving suboptimal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care.

**The AAFP strongly believes telehealth is most appropriate when provided by a patient's usual source of care.** We have significant concerns about the rapid proliferation of direct-to-consumer (DTC) telehealth vendors and the resulting interference with the established patient-physician relationship. In the last several years we've seen new and different types of DTC telehealth vendors emerge, including many for-profit start-ups that market themselves in ways that lead a consumer to believe they are providing true, person-centered health care. The dangers of these types of companies extends beyond disrupting the established patient-physician relationship but can range from misusing patient data to making patients vulnerable to medical misinformation and can even lead to patient harm.

Studies have shown that DTC telehealth can lead to increased utilization and may ultimately increase overall health care spending. Meanwhile, in July 2022, the Office of the Inspector General (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."

The AAFP remains concerned about the lack of regulation and transparency DTC telehealth companies are subject to and how that might impact patient care and outcomes. DTC telehealth cannot replace in-person care and is not an adequate replacement for a longitudinal patient-physician relationship, especially for patients with complex medical conditions.

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 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.

**Removal of Existing Medicare Restrictions**

**The Academy has advocated in support of permanently removing the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can continue to access care at home**. The COVID-19 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.

Further, **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.

**Telehealth for Mental and Behavioral Health**

The COVID-19 public health emergency (PHE) transformed access to mental and behavioral health care via telehealth, making it possible for many patients to be connected to appropriate clinicians and treatment that had otherwise been unavailable to them due to financial, geographic, coverage, or other barriers. **As PHE flexibilities end, we strongly urge that Congress implements policies to minimize disruptions in access to tele-mental and behavioral health care.**

The AAFP has consistently advocated to Congress to permanently remove the in-person requirement for tele-mental health services for Medicare beneficiaries. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[ii] 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 telemental health services will unnecessarily restrict access to behavioral health care.

As acknowledged in the AAFP's recent comments to the Drug Enforcement Administration (DEA), the in-person connection between a physician and patient can provide a valuable touchpoint for patients receiving Medications for opioid use disorder (MOUD) and other opioid use disorder (OUD) treatment services. However, existing shortages of clinicians prescribing buprenorphine for OUD, as well as numerous other barriers faced by patients with OUD, will prevent many patients from being able to obtain an in-person visit, particularly within the DEA's proposed 30-day timeframe. **To that end, we strongly urge against requiring an in-person exam for prescribers of buprenorphine for treatment of OUD, given evidence in support of telehealth, limited access to OUD treatment prescribers, and relatively lower rates of buprenorphine diversion.**

While an in-person evaluation may be necessary for other primary care treatment (and as noted above, the AAFP encourages their requirement for certain other services), data shows that buprenorphine prescribing is particularly well-suited for virtual-only visits. Telehealth initiation of and continued treatment with buprenorphine has shown greater treatment retention, reduced illicit opioid use, improved access to treatment, greater patient satisfaction, and reduced healthcare costs.[iii,iv,v]

Nearly 160 million individuals live in a mental health professional shortage area, and many more have mental health professionals in their area that do not accept the patient's insurance or require unfeasible cost sharing.[vi] Nearly 99 million individuals live in a primary care health professional shortage area and would be unable or challenged to receive MOUD without telehealth and audio-only visits.[vii] This difficulty in access to care for patients is compounded by transportation, time, and childcare challenges, as well as trauma and stigmatization from past experiences with the health care system. All of which makes virtual visits critically important for initiating and maintaining OUD treatment.

**Coverage of and Payment for Audio-Only Services**

Telehealth can be a lifeline for many rural residents, who may encounter significant barriers such as distance, financial, insurance coverage, or lack of transportation to easily access in-person care. However, existing barriers continue to hinder the ability for individuals in rural communities to access quality telehealth services, as well. 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 ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits.[viii]

In many instances, family physicians have reported that some of their patients, particularly seniors, are most comfortable with or can only access audio-only telehealth visits. One recent study of Federally Qualified Health Centers (FQHCs) found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[ix] **Therefore, permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs.**

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables 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. Congress should implement 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.

To that end**, the AAFP strongly urges Congress to pass the Protecting Rural Health Access Act (S. 1636 / H.R. 3440), which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services.** The available data clearly indicates 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. This legislation would also permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home, which – as noted above – the AAFP has supported.

Thank you again for your continued bipartisan leadership to promote and protect access to high-quality care across modalities, and the AAFP looks forward to working with you and your colleagues to advance permanent solutions. Should you have any questions, please contact Anna Waldman, Associate of Legislative Affairs at awaldman@aafp.org.

Sincerely,

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American Academy of Family Physicians, Board Chair

*Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.*

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[i] Shaver J. The State of Telehealth Before and After the COVID-19 Pandemic. Prim Care. 2022 Dec;49(4):517-530. doi: 10.1016/j.pop.2022.04.002. Epub 2022 Apr 25. PMID: 36357058; PMCID: PMC9035352.

[ii] Pew Trust. (2021, December 14). State Policy Changes Could Increase Access to Opioid Treatment via Telehealth | The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-andanalysis/issuebriefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth

[iii] Vakkalanka, J.P., Lund, B.C., Ward, M.M. et al. Telehealth Utilization Is Associated with Lower Risk of Discontinuation of Buprenorphine: a Retrospective Cohort Study of US Veterans. J GEN INTERN MED 37, 1610–1618 (2022). https://doi.org/10.1007/s11606-021-06969-1

[iv] Congressional Research Service, "Broadband Loan and Grant Programs in the USDA's Rural Utilities Service." March 22, 2019. Accessed online: https://sgp.fas.org/crs/misc/RL33816.pdf

[v] "Ensuring The Growth Of Telehealth During COVID-19 Does Not Exacerbate Disparities In Care", Health Affairs Blog, May 8, 2020. DOI: 10.1377/hblog20200505.591306

[vi] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022 available at https://data.hrsa.gov/topics/healthworkforce/shortage-areas.

[vii] Ibid.

[viii] Kelly A Hirko, Jean M Kerver, Sabrina Ford, Chelsea Szafranski, John Beckett, Chris Kitchen, Andrea L Wendling, Telehealth in response to the COVID-19 pandemic: Implications for rural health disparities, Journal of the American Medical Informatics Association, Volume 27, Issue 11, November 2020, Pages 1816–1818, https://doi.org/10.1093/jamia/ocaa156

[ix] Uscher-Pines L, McCullough CM, Sousa JL, et al. Changes in In-Person, Audio-Only, and Video Visits in California's Federally Qualified Health Centers, 2019-2022. JAMA. 2023;329(14):1219–1221. doi:10.1001/jama.2023.1307