AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

TELEHEALTH DURING THE COVID-19 PANDEMIC

AAFP Position

Telehealth services have allowed patients to maintain access to their usual source of primary care during the COVID-19 pandemic. Through telehealth, patients can consult their primary care physician on COVID-19 screening, testing, and immunizations, as well as general health care, medication management, and counseling – all without risking virus exposure through traditional in-person care.

Given these benefits, patients and physicians alike have indicated some telehealth flexibilities should continue beyond the public health emergency (PHE). Any permanent expansion of telehealth services should be done in a way that increases access to care and promotes high-quality, comprehensive, continuous care, and benefits should be designed to strengthen the patient-physician relationship rather than disrupt it. Studies of telehealth utilization during the PHE should assess the impact of virtual services provided by patients' usual source of care versus a provider with whom they have no prior relationship and should stratify analysis by key demographic factors to identify inequities.

Physicians should receive adequate payment for services that are reasonable, safe, effective, and medically necessary – not based on the technology used. The AAFP advocates for policies that protect patients' and physicians' freedom to choose the most appropriate modality of care. The AAFP supports permanent removal of geographic and originating site restrictions for Medicare beneficiaries, permanent coverage of audio-only Evaluation and Management (E/M) services, and standardized coverage and payment of telehealth services across payers, including required coverage of services provided by any in-network provider. The Academy also urges Congress to ensure federally qualified health centers, critical access hospitals, and rural health clinics can furnish telehealth services after the PHE.

Physician Satisfaction with Telehealth During the Pandemic

Physicians expressed similar levels of satisfaction with telehealth both before and during the COVID-19 pandemic. A survey of AAFP members conducted in May 2020 indicated more than 80 percent of family physicians began offering virtual visits during COVID-19 and nearly 70 percent would like to provide more virtual care in the future. Additionally, in response to a survey of 1,594 physicians and other health care professionals, more than 75 percent of respondents said telehealth enabled them to provide care for patients with COVID-19 as well as chronic disease management, acute care, follow up for emergency care, care coordination, preventive care, and behavioral health.[1] Over half of the respondents also noted improved patient health, job satisfaction, and timeliness of care.

Federal Action to Expand Telehealth Access in Response to COVID-19

To address the COVID-19 pandemic, Congress enacted several legislative packages to introduce various telehealth flexibilities. In March 2020, then-Department of Health and Human Services (HHS) Secretary Alex Azar issued a blanket Section 1135 waiver to expand coverage of Medicare telehealth services, waive licensure requirements for physicians with out-of-state licenses, and allow out-of-state physicians to provide care for Medicaid enrollees. The Consolidated Appropriations Act of 2021 permanently allowed Medicare coverage of tele-mental health services for beneficiaries in their own home. The CARES Act allowed health savings account-eligible high deductible health plans to cover telehealth services pre-deductible for plan years beginning on or before December 31, 2021.

[1] "Telehealth Impact: Physician Survey Analysis." (2020). *COVID-19 Healthcare Coalition.* Web.

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HHS also paused enforcement of HIPAA technology requirements to enable physicians to provide telehealth services using everyday communication technologies (e.g. Skype, FaceTime). Other flexibilities allow physicians and other practitioners to conduct telehealth visits from their homes, deliver care to both established and new patients through telehealth, and bill for telehealth services as if they were provided in person, depending on the state. HHS also allowed reduced or waived cost-sharing for telehealth visits for beneficiaries of Medicare, Medicaid, and CHIP.

State Actions and Flexibilities

Under the PHE, states, health care facilities, and clinicians can utilize waivers and other flexibilities to maintain access to health care.

Waivers

States have used Section 1115 Medicaid demonstration waivers, Section 1135 emergency waivers, and disaster-related State Plan Amendments (SPAs) to change requirements for health care delivery. While almost all states submitted waivers to modify telemedicine requirements in response to COVID-19, 18 states (AR, CA, GA, HI, IN, IA, KY, LA, MO, NV, NC, OK, PA, TX, UT, WA, WV, WY) and DC still have active waivers as of September 2021.[2] Many other state waivers became inactive after the state PHE expired. While all 50 states and DC received approved Section 1135 waivers, 11 states (AK, CA, CT, MA, MD, MI, MO, NC, NY, SD, TN) used this mechanism to allow entities to deliver care outside of licensed facilities, including via telehealth.

Telehealth Definitions

Under normal circumstances, eligible telehealth services require the use of two-way face-to-face synchronous interaction between providers and patients, which excludes audio-only telephone calls. However, during the pandemic, all states and DC made temporary changes to Medicaid requirements to include audio-only telephone visits for at least some services in the definition of telehealth, allowing clinicians and others to be adequately paid. In most states, the inclusion of telephone services in the definition of telehealth is set to end when the PHE ends.

Reimbursement and Pay Parity

Several states introduced bills that would require telehealth visits to be paid at the same rate as in-person visits, ensuring that physicians are compensated fairly during the pandemic during a time when in-person care is a risk. Forty-three states and DC introduced flexibilities into their Medicaid programs to provide pay parity for at least some telehealth services as compared to in-person services.[3]

Licensing and Scope of Practice Flexibilities

All fifty states and DC have introduced legislation to allow flexibility in licensure requirements for health care practitioners of telehealth services and allow out-of-state physicians with equivalent licenses to practice across state lines.[3]

Most states that typically do not allow independent practice by nurse practitioners waived or loosened collaboration agreements or supervision requirements to meet the demand for health care during the pandemic. Eighteen states (AR, IN, KS, KY, LA, ME, MA, MI, MO, NE, NJ, NY, SC, TN, TX, VA, WV, WI) temporarily allowed nurse practitioners to practice independently or with less supervision during the pandemic. Twenty-one states (AL, AZ, DE, HI, IA, ID, IL, IN, LA, ME, MI, MN, MT, ND, NJ, NY, RI, SD, TN, TX, VA) and DC waived or suspended all or some supervision requirements for physician assistants during the pandemic, and 44 states loosened other practice restrictions for physician assistants, including restrictions on telemedicine practice.

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[2] "U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19." (2021). *Federation of State Medical Boards.* Web.

[3] KFF. (2021). "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19." Web.