AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Andrew Stolfi
Chair
Health Innovations (B) Working Group
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001-1512

Re: AMA comments on mechanisms to resolve disparities through improved access to care

Dear Members of the NAIC Health Innovations Working Group:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I write to express our appreciation for the National Association of Insurance Commissioners' (NAIC) Health Innovations (B) Working Group (Working Group) efforts in studying mechanisms to resolve disparities by improving access to care. Ensuring equitable access to health care is one of the AMA's top priorities. We believe the NAIC has a unique role in bringing insurance commissioners together to identify actionable solutions that can lead to real change at the state level. We are encouraged by the findings summarized in the memo to the Members of the Special (EX) Committee on Race and Insurance (Special Committee), specifically related to telehealth and alternative payment models, and offer the following comments on each area for further consideration as the Working Group finalizes their memo.

Telehealth

The AMA strongly agrees with the Working Group's sentiment that telehealth has the promise to alleviate and break down barriers to access. We know based on past and current systemic racism present in our communities and our health care system, that we need to take particular care in considering policies as they are developed to ensure they do not promote or allow future barriers. Similar to NAIC, AMA has approached this work by using an upstream lens to identify the root causes of these barriers, such as systemic racism, insurer coverage and payment policies, and lack of infrastructure. The Working Group appropriately identified some of the leading barriers to health equity which can be ameliorated with telehealth, including physical access to care and access to culturally competent care.

The Working Group has also aptly identified challenges and limitations to this population including broadband, privacy, and digital literacy. Below are AMA's comments on each, including additional solutions that NAIC and insurance regulators are uniquely positioned to implement and which the Working Group may consider adding to their existing framework.

Access to care: The AMA agrees that telehealth holds the promise of increasing access to care, particularly in rural areas. To this end, as the Working Group has identified, ensuring coverage and payment of telehealth is key. When clinically appropriate, telehealth is just one of the ways physicians can provide care to their patients. The AMA, therefore, encourages the Working Group to:

- Support coverage of services provided via telehealth on the same basis as comparable services provided in-person.
- Support fair and equitable payments, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person to ensure telehealth is available to all patients.
- Support policies that ensure all patients have the opportunity to access in-person care when appropriate, including policies that do not allow the use of telehealth-only providers to meet network adequacy requirements.

Cost-sharing: The Working Group has identified favorable cost sharing for telehealth as a potential solution. The AMA believes that any cost-sharing structure should apply equally to all network physicians. Since the onset of the pandemic, we have seen an increase in the number of physicians who have implemented telehealth in their practices. Separate telehealth networks, or efforts by health plans to steer or incentivize patients to seek care from a specific telehealth provider is no longer justified. Similarly, favorable cost-sharing or other incentives for patients to seek care from a select telehealth-only provider may steer patients away from their regular physician. These policies could lead to fragmented care and may further exacerbate inequities, particularly for patients with complex health care needs or multiple chronic conditions. Similarly, supporting favorable cost sharing for telehealth over in-person care could also unintentionally steer patients away from in-person care when appropriate or preferred, leading to further disparities in health care. While finalizing the memo to the Special Committee, we encourage members of the Working Group to consider the following:

- Ensure patients have equal access to telehealth for all in-network physicians.
- Ensure any cost-sharing structure for telehealth applies equally to all network physicians.
- Support patient choice in accessing care via telehealth or in-person care as needed or preferred.
- Consider the impact of favorable cost-sharing policies on equity and further refine such policies to ensure they do not unintentionally exacerbate inequitable access to high-quality telehealth or patient access to in-person care.

Culturally competent care: We are encouraged that the Working Group identified access to culturally competent care through telehealth as a way to bridge access to care. We believe there are real solutions here that fall squarely within the purview of NAIC and insurance commissioners, including the following:

- Support coverage for interpreter services for those with limited English proficiency.
- Encourage health plans to support telehealth platforms that are available in multiple languages and are designed with and for historically marginalized and minoritized patients, older adults, and individuals with disabilities.

Broadband access, privacy, and digital literacy: We are also encouraged that the Working Group identified broadband access, privacy, and digital literacy as additional challenges and limitations to this population. The AMA shares these concerns and has identified broadband internet access as a social determinant of health. As mentioned in the memo, broad swaths of the country currently lack broadband access, which impacts both patients and physicians. Additionally, some patients may have broadband access but may not be able to afford it in their homes or may have limited data plans, restricting their ability to access care via telehealth. Identifying these challenges is important and we encourage the Working Group to recognize that there are some steps insurance regulators and policymakers can take to address these challenges, such as:

- Launching campaigns to ensure patients know telehealth is available and accessible and that such services are available from their regular physician.

- Promoting policies that help improve digital literacy, such as supporting coverage and payment for programs to train patients to use digital tools.
- Increase transparency in privacy and security practices around telehealth and digital tools, thereby recognizing and addressing patient concerns with privacy and use of their data – which causes hesitancy among some patients to use telehealth, including historically marginalized and minoritized communities.

Alternative Payment Models (APMs) and Value-Based Payments (VBPs)

The AMA very much appreciates that the Working Group is addressing both the potential of APMs and VBPs to address health disparities, as well as the fact that some models can exacerbate such disparities. We agree with the Working Group that greater monitoring of health insurers' use of APMs and VBPs is important, so that intervention is sought when needed to ensure a measure, tool, or program does not exacerbate inequities.

We also appreciate the Working Group's recognition of both the importance and limitations of risk adjustment mechanisms. It is important to pay physicians adequately so that they can devote the resources needed to achieve good health outcomes for historically minoritized and marginalized patients and communities, and risk adjustment programs that account for social and structural drivers of health will promote this result. At the same time, we also agree with the Working Group that risk adjustment is not a singular solution.

Below we offer examples of additional proactive measures that may be of interest to regulators as they work with health insurers, physicians, and other stakeholder towards APM and VBP models that reduce health disparities.

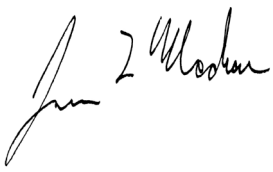
Ensuring adequate resources and funding: All patients do not have equal opportunities to achieve good health outcomes, so one-size-fits-all APM and VBP models are likely to widen disparities. APMs, however, have the potential to be designed with flexibility to compensate for care that may not traditionally be reimbursed and therefore, present an opportunity to reduce health disparities. As such, APMs should provide adequate resources and funding to help practices achieve better health outcomes for high-risk patient populations. APM payments and performance measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. APM payment methodologies should be designed to support and encourage practices to address patients' social needs, including by providing care management services and coordinating services across interprofessional teams.

Investment in care transformation: Physician practices, particularly small and rural practices and those serving marginalized patients, often do not have financial reserves available to fund practice changes in advance of shared savings payments or to pay penalties to payers if their patients need expensive care. Regulators could consider the value start-up funding to APM participants, particularly those in underserved areas and who serve marginalized communities, so that they can invest in data analytic capabilities, care managers, training, and other practice changes needed to improve care delivery and facilitate successful APM participation. We also urge that APMs be designed with "on-ramps" that give participants time, as well as resources, to transform their practices before being expected to take on downside risk.

Physician engagement: As state regulators and other policymakers further engage in this space, it will be critically important to incorporate the input of their state's physician community, especially those physicians in rural practices and those serving historically marginalized communities. States may consider working with physicians to develop a common set of priorities for APMs and a coordinated process for developing, testing, and implementing priority models. Physician feedback on existing models, including gaps in data, funding, and other resources that may result in greater health disparities should also be regularly and systematically sought.

Thank you for the opportunity to provide our comments. We look forward to future engagement with NAIC on this important work and welcome the opportunity for more in-depth discussions with the Chair and members of the Working Group on these issues at future meetings. If you have any questions or would like additional information, please contact Kimberly Horvath, JD, Senior Attorney, AMA Advocacy Resource Center at kimberly.horvath@ama-assn.org or Emily Carroll, JD, Senior Attorney, AMA Advocacy Resource Center at emily.carroll@ama-assn.org.

Sincerely,



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Attachment: AMA State Telehealth Policies Issue Brief