STATEMENT

of the

American Medical Association

to the

U.S. Senate Finance Committee

for the record

Re: COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned

May 20, 2021

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Finance Committee Hearing on COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned

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The American Medical Association (AMA) appreciates the opportunity to provide a statement for the record to the Senate Finance Committee as part of the hearing on COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned. We welcome the opportunity to support congressional efforts to ensure patients and physicians continue to have access to valuable services that flexibilities during the COVID-19 Public Health Emergency (PHE) enabled. In particular, the AMA strongly supports congressional efforts to ensure that Medicare beneficiaries have access to telehealth services and to make permanent valuable flexibilities provided for the treatment of substance abuse services, hospital at home services, and the Medicare Diabetes Prevention Model.

Telehealth Flexibilities Should Remain in Place

Telehealth is a critical part of the future of effective, efficient, and equitable delivery of health care in the United States. Efforts must continue to build capacity and support access to care centered on where the patient is located (to the greatest extent it is clinically efficacious), and to ensure physicians and other health care professionals have the tools to optimize care delivery. The AMA has been a leader in advocating for expanded access to telehealth services for Americans because it has the capacity to improve access to care for many underserved populations and improve outcomes for at-risk patients, particularly those with chronic diseases and/or functional impairments.

In response to the COVID-19 PHE, Congress passed the CARES Act, which, among other things, provided the Centers for Medicare and Medicaid Services (CMS) the authority to waive the geographic and originating site requirements for the duration of the COVID-19 PHE, which CMS subsequently did.[1] Following these policy actions, telehealth usage among Medicare beneficiaries has expanded greatly as patients could, for the first time, access telehealth services from wherever they are located, including their home, regardless of where they reside in the country. The AMA remains deeply grateful for these flexibilities, which have allowed Medicare patients across the country to receive care from their homes. With many physician offices closed, elective procedures postponed, personal protective equipment difficult to obtain, and an ongoing infectious disease pandemic that has forced patients to stay home for

[1] Coronavirus, Relief, and Economic Security (CARES) Act, Pub L. No. 116-136, 134 Stat. 281 (2020), https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf.

their safety, the ability to provide services directly to patients regardless of where they are located via telehealth has allowed many vital health care services to continue. In addition to facilitating continuity of care for patients being treated for acute and chronic conditions, telehealth has also facilitated initial assessment of patients experiencing potential COVID-19 symptoms and those who have been in close contact with people diagnosed with COVID-19 to determine if referrals for testing or treatment are indicated while minimizing risks to patients, practice staff, and others. With this expansion of services has come a recognition from patients, physicians, and other providers that telehealth services offer effective and convenient health care in many circumstances. Congress must act now to ensure that Medicare patients can continue to access telehealth services from wherever they are located after the pandemic ends by modernizing the Social Security Act to keep pace with our digital future.

However, without further legislative action from Congress, Medicare beneficiaries who have come to rely on telehealth services during the PHE will abruptly lose access to these services completely. Under section 1834(m) of the Social Security Act (SSA), Medicare is prohibited from covering and paying for telehealth services delivered via two-way audio-visual technology unless care is provided at an eligible site in a rural area.[2] This means that, in order to access telehealth services, patients must live in an eligible rural location, and must also travel to an eligible "originating site" – a qualified health care facility – to receive telehealth services, except in the few cases where Congress has authorized provision of telehealth services in the home of an individual.[3] As a result, the 1834(m) restrictions bar the majority of Medicare beneficiaries from using widely available two-way audio-visual technologies to access covered telehealth services unless they live in a rural area, and with a few exceptions, even those in rural areas must travel to an eligible health care site.

Congress must act now to remove the origination and geographic restrictions on telehealth coverage for Medicare patients. Continued access to telehealth services beyond the PHE is critical for patient populations that have come to rely on its availability. That is why the AMA supports S. 368/H.R. 1332, the "Telehealth Modernization Act of 2021," which would eliminate the 1834(m) statutory restrictions on originating site and geographic location, thereby ensuring Medicare coverage of telehealth services regardless of where the patient is located. It is critically important that Medicare beneficiaries continue to be able to access telehealth services from their physicians without arbitrary restrictions throughout the COVID-19 public health emergency and beyond.

The PHE Has Demonstrated the Value of Telehealth

The success of telehealth technology adoption during the COVID-19 public health emergency has made it abundantly clear that geographic and origination restrictions on accessing telehealth services are outdated and arbitrary given today's technology that allows for access to digital tools from anywhere. Physicians and patients have seen the value of telehealth services and should not be forced to stop using these tools when the public health emergency ends. Some have argued that statutory changes cannot be made without additional data on how telehealth services are used, however, this has the problem backwards. More data is not necessary to determine that the underlying policy needs to be permanent, but instead can help CMS determine which services need to continue to be covered or can be safely removed from the Medicare telehealth list. In the meantime, the certainty that appropriate telehealth services will be covered would provide physicians confidence in investing in new technology and give patients peace of mind that they can continue to access services in a way that works best for them.

[2] Special Payment Rules for Particular Items and Services, 42 U.S.C. § 1395m(m), https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

[3] For example, substance abuse disorder treatment delivered via telehealth is explicitly exempted from the geographic and origination restrictions.

The rapid and widespread adoption of telehealth by physicians in 2020 was one of the most significant improvements in health care delivery in decades. The new telehealth coverage and payment policies enabled physicians to deliver valuable services they previously could not afford to provide but that their patients needed. With legislative provisions such as the establishment of the CMS Innovation Center and Medicare's Quality Payment Program, Congress has sought for many years to support physician adoption of innovations in the delivery of care. The successful adoption of telehealth throughout the country has demonstrated that, if the financial barriers are removed, physicians will adopt important innovations in the delivery of care that are necessary to improve their patients' health.

Telehealth technologies allow physicians to increase continuity of care, extend access beyond normal clinic hours, and help overcome clinician shortages, especially in rural and other underserved populations. This ultimately helps health systems and physician practices focus more on chronic disease management, enhance patient wellness, improve efficiency, provide higher quality of care, and increase patient satisfaction. Telehealth has helped increase provider/patient communication, increase provider/patient trust, and access to real-time information related to a patient's social determinants of health (i.e., a patient's physical living environment, economic stability, or food insecurity), which can lead to better health outcomes and reduced care costs. The ability to gain greater access to chronic disease management services and better assess the impact of a patient's social determinants of health will undoubtedly contribute to improved treatment and health outcomes for historically marginalized and minoritized populations as well.

Telehealth services can help patients avoid delaying care that can lead to expensive emergency department visits and hospitalizations. They also cut down on trips to the office that may be difficult or risky for patients with functional or mobility impairments, frail elderly who need a caregiver to accompany them, those who need to stay home to care for other family members, and patients who are immunocompromised or vulnerable to infection. Providing access to telehealth services creates greater safety and efficiencies for both patients and physicians, delivering value to the Medicare program.

Physician practices are ready to invest in the technology required to provide these services; however, it will be very difficult to provide the sustained financial commitment needed to incorporate delivery of telehealth services into their workflows if the coverage is only temporary. The removal of coverage and financial barriers has allowed the explosive growth in telehealth and certainty about future coverage is necessary for it to continue. It has allowed CMS to make more informed decisions about which services to cover, and, in fact, CMS has expanded coverage of telehealth services greatly during the PHE.[4] While more data behind current telehealth usage trends may be valuable to gather evidence about which particular Current Procedural Terminology® (CPT®) codes need to stay on the Medicare telehealth list, that is a much different concern than whether nationwide coverage and ability to deliver care to patients wherever they are located should be available; these determinations are already appropriately made by CMS.

While CMS has expanded coverage of telehealth services during the PHE, only Congress can assure all Medicare beneficiaries can receive equal access to those services moving forward. Delaying action, such as extending the current 1834(m) waiver authority, will only make it more expensive to change the policy permanently in the future.

[4] Medicare Physician Fee Schedule 2021, 85 Fed. Reg. 84,472 (Dec. 28, 2020), https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf.

CMS Already Makes Coverage Determinations on Telehealth Services

CMS currently has all the tools necessary at its disposal to make determinations about which telehealth services it should cover and at what payment level. For the duration of the COVID-19 PHE, CMS has added many services to the list of those that Medicare pays for when they are provided via telehealth. The newly covered services include emergency department visits, observation care, hospital and nursing facility admission and discharge services, critical care, and home care, as well as services like ventilator management that have been especially necessary for COVID-19 patients. The newly added services have greatly assisted physicians during the PHE when both patients and health professionals needed to maintain physical distance from others as much as possible. Through telehealth communications, for example, an emergency physician, potentially assisted by members of the patient's household, can diagnose, and treat emergency conditions without sick patients having to endure difficult travel and expose themselves and others to SARS-CoV-2 and other dangers. In all, CMS added interim Medicare coverage for more than 150 services for the duration of the COVID-19 PHE at payment parity with in-person services. Equivalent payment for telehealth services during the PHE was crucial to ensure physicians could cover the cost associated with offering virtual care. In future rulemaking, CMS has indicated it may extend the interim coverage for a longer period of time to help gather more evidence of how the services are used when provided via telehealth outside the context of a pandemic.

The only thing holding CMS back from expanding access to appropriate telehealth services to its beneficiaries are the outdated restrictions currently in the statute. Since telehealth is simply a modality for delivering health care, AMA continues to urge Congress and CMS to provide payment parity for two-way audio-visual services upon conclusion of the COVID-19 pandemic.

Telehealth Helps Provide Access to Health Care to Underserved Communities

Access to telehealth services can help reduce inequalities in care for underserved communities by providing access to services for patients regardless of where they are located. Patients in rural areas or underserved urban communities often have to travel long distances to access care, especially specialty services including emergency and critical care. Telehealth can also help eliminate commutes to physician offices for those with mobility or transportation difficulties.

In conjunction with expanded access to telehealth services, the AMA supports Congressional efforts to expand high-speed broadband internet access to underserved communities and increase digital literacy education efforts. Patients cannot take advantage of telehealth services if they do not have the requisite internet connection to access them or the appropriate skills to use digital technologies. Providing digital literacy skills is particularly important for non-English speaking patients and is another crucial aspect of ensuring health equity. Solving this problem requires enhanced funding for broadband internet infrastructure in rural areas and support for under-served urban communities and households to gain access to affordable internet access, as well as support for patient education on how to use digital tools.

Concerns About Fraud and Abuse and Overutilization Are Misplaced

Some have raised concerns that expanded coverage of telehealth services could lead to greater fraud and abuse or duplication of medical services. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication are of particular concern for telehealth services. Therefore, Congress should not create artificial barriers to telehealth by defining an established doctor-patient relationship inconsistently with the standard of care or otherwise creating unique and burdensome fraud and abuse requirements that would stifle access to

telehealth services. The AMA supports removing restrictions on access to Medicare tele-mental health services that were included in H.R. 133, the Consolidated Appropriations Act, 2021. Specifically, the new requirement that Medicare beneficiaries must be seen in person at least once by the physician or non-physician practitioner during the six-month period prior to the first telehealth services should be repealed. Such restrictions were not imposed on tele-mental health services covered by Medicare prior to the passage of the COVID-19 telehealth waiver, or on tele-mental health services covered by Medicare under the waiver during the PHE. Moreover, they are not supported by the data we have seen regarding the benefits of increased access and improved patient adherence to treatment in tele-mental health services and they directly conflict with the standard of care.

CMS and the Office of Inspector General (OIG) at HHS already have all of the Medicare coverage and payment and fraud and abuse authorities to monitor telehealth service compliance just as they do any other Medicare covered service. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare & Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority, or other technologies such as phone, text, or remote patient monitoring.

In recent remarks regarding the potential for telehealth fraud, Principal Deputy Inspector Grimm of OIG never mentioned any concerns with OIG's authority or ability to address concerns of fraud and abuse.[5] Instead, he described OIG's concerns with "telefraud" schemes which he distinguished from telehealth fraud, in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the televisit but instead used the sham televisit to induce a patient to agree to receive unneeded items and gather their info. In other words, whether or not the telehealth service itself is covered has no impact on these kinds of fraudulent schemes.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via the Modifier 95**.** The Modifier 95 describes "synchronous telemedicine services rendered via a real time Interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. The Modifier 95, along with listing the Place of Service (POS) equal to what it would have been for the in-person service, is also applicable for telemedicine services rendered during the COVID-19 PHE. The requirement to code with the Modifier 95 enables CMS to properly decipher and track telemedicine services, thus improving the chances of identifying and rooting out fraud, waste, and abuse.

Data analyzed by CMS since the start of the PHE shows that fears of overutilization are overblown. Data from Medicare claims from Q1 and Q2 show that less than 4% of telehealth spending was for new patient audiovisual office visits. Moreover, nothing in the data or anecdotal evidence suggests that telehealth services have been duplicative of in person services rather than used as an alternative or in addition to in person care. The AMA will continue to monitor and analyze the data as it becomes available, but this suggests that there is no reason to think better access to telehealth will lead to an explosion in unnecessary services.

[5] Principal Deputy Inspector Grimm on Telehealth (Feb. 26, 2021), https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp.

As a result, Congress should refrain from imposing new and discriminatory restrictions on the use of audio-visual communications technologies, such as restrictions on how a physician-patient relationship can be established. AMA policy, established in 2014, states that a valid physician-patient relationship may be established virtually face-to-face via real-time audio and video technology, if appropriate for the service being furnished.[6] It also allows for the relationship to be established in a variety of other ways such as meeting standards of care set by a major specialty society. All 50 states and the territories allow a physician-patient relationship to be established virtually or through other means. The exact parameters vary by state; however, many state laws are based on an AMA model law. Congress should not impose a one-size-fits-all requirement on services furnished via telehealth technology that are in direct conflict with standards of care and that do not exist for other technologies.

Gains made in access to telehealth will be greatly hampered if unique and arbitrary barriers are erected around the use of telehealth services. Such barriers will have a dramatic and negative impact on patients seeking care, particularly during the current COVID-19 pandemic, and in any future pandemic where patients need access to care without the concerns surrounding a visit to a crowded health care facility.

Audio-only Services Should Remain Covered

The AMA also strongly supports coverage for audio-only services and has called on CMS to continue this coverage after the PHE ends. There are numerous patients and entire communities that have no access to the internet connectivity necessary to utilize audio-visual telehealth services in their homes. There are also medical practices that do not have sufficient connectivity to provide audio-visual telehealth services. Patients who cannot utilize audio-visual telehealth services include those in communities lacking broadband access, those where the technological capabilities are present, but the patient cannot afford it, and others who have access to the technology and the connectivity but do not know how to use it. Inability to use audio-visual telehealth services is also a matter of health equity. Too often it is the same communities that face other barriers to good health outcomes who also face these technology barriers, such as Native Americans living on reservations and those in the rural South's Black Belt. But patients who cannot participate in audio-visual telehealth services are no less sick than those who can, and it is important to their health care to retain access to these services.

Pursuant to authority granted under the CARES Act, CMS waived the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology for certain services. This has allowed the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services. Expanded use of audio-visual telehealth services during the pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients, and those in rural and other areas with limited internet access. It would be inappropriate to prevent these patients from accessing such services. In addition, we have heard from many physicians about the need to have access to audio-only services because a number of their patients, even those who own the technology needed for two-way real-time audio-visual communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner.

Audio-only services are an important part of a fully integrated care plan and physicians should be able to permanently deliver E/M (evaluation and management) services by telephone to patients who need a telecommunications-based service in the home but who do not have access to a video connection or

[6] American Medical Association, H-480.496: Coverage of and Payment for Telemedicine, https://policysearch.ama-assn.org/policyfinder/detail/telemedicine?uri=%2FAMADoc%2FHOD.xml-0-4347.xml (last modified, 2019).

cannot successfully use one. Without access to an audio-only option, limitations in internet and/or technology access as well as lack of experience with its use will increase inequities in access to medical care and widen disparities in health outcomes.

Flexibilities for the Treatment of Substance Abuse Disorder Should be Continued

Early on in the COVID-19 Public Health Emergency, the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) put several important flexibilities in place to help DEA-registered physicians manage care for their patients with opioid use disorder (OUD). During this PHE, physicians who have a waiver allowing them to prescribe buprenorphine for the treatment of OUD can initiate and continue this treatment based on telehealth visits and audio-only visits with patients. Opioid Treatment Programs can also initiate new patients and treat existing patients being managed with buprenorphine based on telehealth and phone visits. Patients cannot be initiated with methadone treatment based on telehealth visits, but existing patients on methadone can be managed via telehealth or phone. Opioid Treatment Programs can also provide patients who are stable with take-home medication.

Based on a survey led by the American Academy of Addiction Psychiatry and conducted last summer of more than 1,000 physicians and other health professionals who treat OUD, these new flexibilities were extremely important in allowing them to continue to manage their patients' care. A major finding of the survey is that more than 80% of X-waivered survey respondents want the telehealth options to continue after the COVID-19 PHE. The AMA has written to the DEA urging that these flexibilities remain in place at least until the end of the opioid PHE and believes Congress should support these continued flexibilities.

Hospital at Home Services Flexibilities Should Remain

A number of other countries pay for delivering services equivalent to hospital inpatient care to patients in their own homes. These “hospital at home” services have been successful in allowing patients with specific types of conditions that qualify for inpatient care to receive services in the home and avoid the risks associated with an inpatient admission. The services are more intensive than can be supported through traditional home health care payments. Although some hospitals in the U.S. were delivering hospital at home care and some Medicare Advantage plans were paying for it before the PHE, the service was difficult to sustain or expand without payment support from Medicare because a minimum number of patients need to participate in order for the service to be cost-effective. During the pandemic, one of the key flexibilities that CMS now has allowed is for hospitals to deliver services to patients in their homes. It would be desirable to continue this flexibility after the national emergency ends for the subset of patients who meet the criteria used in hospital at home programs in the U.S. and other countries.

Medicare Diabetes Prevention Expanded Model Flexibilities Should be Made Permanent

Through the rulemaking process for the 2021 Medicare physician payment schedule, CMS adopted important flexibilities that are effective for the duration of the COVID-19 PHE and in future 1135 waiver emergencies that could cause a disruption to in-person MDPP services. These MDPP policies will only apply in emergency situations, however, and not on an ongoing basis. MDPP services are being significantly underutilized. If the MDPP flexibilities that have been adopted for COVID-19 and future emergencies were instead continued as regular, ongoing MDPP policies, it would significantly strengthen the effectiveness of diabetes prevention services for Medicare patients with prediabetes. The AMA strongly urges Congress to pass H.R. 2807, the PREVENT Diabetes Act.

To furnish virtual services during an emergency period, MDPP suppliers must already have preliminary or full CDC Diabetes Prevention Program recognition for in-person services. CMS continues to bar virtual-only suppliers that have achieved CDC recognition from furnishing MDPP services, even during the PHE. Under its current regulations, CMS will require MDPP providers to resume in-person services at the conclusion of the COVID-19 PHE. Against AMA urging, CMS has declined to allow virtual providers to participate in MDPP to the fullest extent either during or after the PHE. CMS regulations also prohibit patients from participating in their MDPP sessions virtually when offered by suppliers who provide both in-person and virtual services except during an emergency period. Many patients with prediabetes are unable to effectively participate in in-person MDPP sessions, often because they live far from any supplier location or because the sessions are not offered at times that are convenient for them. The MDPP should be modified to allow patients to obtain their session virtually at any time.

CMS regulations also impose a once-per-lifetime limit on patients obtaining MDPP services. During an emergency period, patients who continue their MDPP participation through virtual services will still be subject to the once-per-lifetime limit, but patients whose MDPP participation is interrupted by an emergency period will be able to restart MDPP services with the first core session after the emergency period ends. Other Medicare behavior modification programs such as tobacco cessation and obesity counseling do not have lifetime limits and there is no justification for a once-per-lifetime limit on MDPP services. This limit should be lifted for all patients, not just those who discontinue MDPP during a declared emergency.

Conclusion

The AMA thanks the Subcommittee for this hearing and for the careful consideration of the flexibilities that have been put in place for the COVID-19 PHE. We look forward to working with the Committee and Congress to seek solutions that will ensure patients can continue to benefit from these flexibilities after the end of the PHE.