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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

On

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

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Chairman Wyden, Ranking Member Crapo and members of the Committee: I am Dr. Kisha Davis, a member of the American Academy of Family Physicians (AAFP) Commission on Federal and State Policy, and I am honored to be here today representing the 133,500 physician and student members of the AAFP.

I am a practicing family physician and the Vice President of Health Equity at Aledade. In addition to seeing patients in Baltimore, Maryland, through my role at Aledade, I support physicians in private practices and community health centers across the country. I have experienced the impact of the COVID-19 pandemic and resulting federal policy changes firsthand as a frontline physician and I have had the opportunity to observe them on a broader scale.

Many of the emergency flexibilities that the Centers for Medicare and Medicaid Services (CMS) made available during the COVID-19 pandemic have improved patients' access to primary and preventive care, bolstered the physician workforce in rural and underserved communities, and alleviated administrative burdens on clinicians, enabling us to focus on patient care. As Congress considers whether to extend these flexibilities beyond the public health emergency and how to build upon recent advances, **it is vital that Medicare and Medicaid policy changes are designed to advance health equity, protect patient safety, and enable clinicians to provide the right care at the right time.**

The AAFP offers the following recommendations.

- **Adopt telehealth policies that enhance the physician-patient relationship rather than disrupt it, and incentivize coordinated, continuous care provided by the medical home.**

- **Adopt payment models that support patients' and clinicians' ability to choose the most appropriate modality of care and ensure appropriate payment for care provided.**

- **Permanently remove geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth care at home.**

- **Require Medicare to cover audio-only evaluation and management services beyond the public health emergency to ensure equitable access to care.**

- **Permanently cover telehealth services provided by Federally Qualified Health Centers (FQHCs) and rural health clinics and ensure adequate payment.**

- **Monitor the impact of telehealth on access and equity by ensuring that data collection and evaluation include race, ethnicity, gender, language, and other key factors.**

- **Invest in infrastructure to promote digital health equity.**

- **Mandate Medicaid coverage of all Advisory Committee for Immunization Practices (ACIP) –recommended vaccines for all adults.**

- **Permanently allow physicians to provide direct supervision and teaching services via telehealth to expand access to primary care services and increase training opportunities.**

- **Reduce the volume of prior authorization requirements to decrease unnecessary administrative burden on physicians.**

- **Grant HHS the authority to waive reporting and other administrative requirements for the Quality Payment and Medicare Shared Savings programs in future public health emergencies without rulemaking to enable physicians to focus on patient care during emergencies.**

- **Restore Medicare and Medicaid physician supervision requirements to safeguard patient safety and maintain access to appropriate, high-quality care.**

Over the last year, family physicians rapidly changed the way they practice to meet the needs of their patients amid a global pandemic. Arguably, the most dramatic shift was the unprecedented uptake and increase of telehealth services. Last spring, out of necessity, physicians quickly pivoted from providing a majority of care in-person to caring for their patients virtually to promote social distancing and infection control. This would not have been possible without the swift legislative and regulatory action that expanded coverage, increased payment, and added flexibility for telehealth services.

Prior to COVID-19 — due in large part to Medicare restrictions and inadequate reimbursement — fewer than15% of family physicians were providing virtual visits to their patients, and during the public health emergency that number surged to more than 90%. Despite technical challenges on the part of patients and physicians, both quickly came to realize the value of virtual care. According to a recent survey of AAFP members, seven in ten family physicians want to continue offering more virtual visits in the future.

Telehealth benefit expansions must increase access to care and promote high-quality, comprehensive, continuous care. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care and expand access to care for under-resourced communities and vulnerable populations. As outlined in our Joint Principles for Telehealth Policy, in partnership with the American Academy of Pediatrics and the American College of Physicians, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. 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. In fact, a recent nationwide survey found that most patients prefer to see their usual physician through a telehealth visit, feel it is important to have an established relationship with the clinician providing telehealth services, and believe it is important for the clinician to have access to their full medical record.

Telehealth can enable timely, first-contact access to care and supports physicians in maintaining long-term, trusting relationships with their patients, both of which are central to continuity of care. Allowing physicians to provide telehealth services from their home enables them to extend their availability beyond traditional office hours for patients who, due to work or childcare constraints, are unable to take time off work for an appointment. This not only advances equitable access to care but also can prevent unnecessary trips to urgent care or the emergency room. Telehealth can also be a tool to help alleviate physician burnout by facilitating better work-life balance. One example: Some employers allow physicians to be on “telehealth duty” in the period leading up to and following their maternity leave.

Given these benefits, patients and physicians agree that some current telehealth flexibilities should continue beyond the public health emergency.

Congress should permanently remove the section 1834(m) geographic originating site restrictions to ensure that all Medicare beneficiaries can 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 accessibility for patients who may be homebound or lack transportation. It can also offer opportunities to engage distant family members and caregivers. Telehealth visits allow physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit. This helps us to identify environmental factors that may be affecting their health, and to develop more personalized treatment plans.

Transitional care management (TCM) services are another example of how permanently eliminating geographic and originating site requirements could improve utilization of high-value care and ultimately improve care coordination and patient outcomes. TCM services are provided after a patient is discharged from a hospital stay, with the goal of ensuring care continuity once they return home. Prior to the public health emergency, patients were hesitant to come into the office after just being discharged from the hospital. Once TCM services were available to all Medicare patients via telehealth, many more received TCM services, allowing me as their primary care physician to check on them, update their medications, schedule follow-up visits with specialists, and prevent hospital readmissions.

There are many more examples of how telehealth visits can be used to promote prevention through conducting Medicare Annual Wellness visits as well as for monitoring and treatment of chronic diseases such as diabetes and hypertension for patients in their home thereby increasing accessibility for patients who may be homebound or lack transportation and create opportunities to engage distant family and caregivers.

Require Medicare to cover audio-only Evaluation and Management (E/M) services beyond the public health emergency. Coverage of audio-only E/M services is vital for ensuring equitable access to telehealth services for patients who may lack broadband access or be uncomfortable with video visits. In September, after using telehealth for several months due to the pandemic, more than 80% of family physicians responded to an AAFP survey indicating they were using phone calls to provide telehealth services. Together with ongoing reports from physicians that phone calls are vital to ensuring access for many patients, this survey data indicate that phone calls are more accessible for many patients than video visits. This may be particularly true for Medicare beneficiaries. According to the Pew Research Center, only about 53% of patients over the age of 65 own smartphones, while 91% own any type of cell phone. Recent studies of telehealth utilization by patients with limited English proficiency show that non-English speakers have used telehealth far less than English-speakers. Many physicians routinely use telephone translation services to provide linguistically appropriate care, and these services can be more seamlessly integrated into telephone visits, whereas integrating translation services into audio-video platforms can be costly and complex. Outside of the PHE, Medicare allowed physicians to bill for brief phone calls as "virtual check-ins." During the PHE we conducted telephone visits, realizing that we would not get reimbursed appropriately, but did so because it was the right thing for our patients. Unfortunately the payment rate for those services does not adequately reflect the level of time and effort required, and often the cost to bill the services exceeds that amount.

Payment should support patients' and clinicians' ability to choose the most appropriate modality of care (i.e., audio-video, audio-only or in-person) and ensure appropriate payment for care provided. Some patients and some cases are better suited to virtual care, and others require in-person care; some issues can be effectively treated through a phone call, whereas others require a visual examination. As a physician, I want telehealth to be a tool in my toolbox, and I want to choose when and how to deploy it based on my clinical judgment, not based on

whether I will get paid.

Permanently ensure that beneficiaries can access telehealth services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). FQHCs and RHCs serve as the primary source of care for millions of low-income and underserved patients across the country. In order to promote care continuity and ensure that beneficiaries have access to affordable, comprehensive care, Medicare should permanently cover telehealth services provided by these health centers. Medicare and Medicaid payment methodologies should also be modified to provide appropriate and timely payment to community health centers for telehealth services.

In order to make long-term investments in telehealth platforms and workflow modifications, physician practices need advanced notice of changing Medicare and Medicaid telehealth policies. While more data will be needed to make determinations on whether to permanently continue certain telehealth services, temporary policies should be avoided for well-established, high-value telehealth services such as E/M office visits and mental health services.

The AAFP is supportive of broadly expanding access to telehealth services. However, we recognize that Congress and CMS are concerned about preventing waste, fraud, and abuse and considering policy options to reduce those risks. In addition to promoting the use of telehealth within the medical home, we also recommend relying on existing Medicare policies to minimize confusion and administrative burden imposed on physician practices. For example, Medicare defines an established patient as one that has received professional services from a clinician in the same practice and of the same medical specialty within the last three years. This definition should be repurposed in any new telehealth policies, instead of creating a new definition for an established patient that could conflict with current coding guidelines.

While the rapid expansion of telehealth has yielded many benefits for patients and clinicians, not everyone has benefited equally. Without sufficient investment and thoughtful policies, telehealth could actually worsen health disparities. Prior to the COVID-19 pandemic, evidence suggests that telehealth uptake was higher among patients with higher levels of education and those with access to employer-sponsored insurance. Another study found that patients with limited English proficiency utilized telehealth at one-third the rate of proficient English speakers. Anecdotes from family physicians suggest that the same trend may hold true for the past year — that those benefitting most from telehealth are those who already had better access to care. **As the Committee seeks additional studies to inform the direction of permanent telehealth policies, you should ensure the collection and reporting of data stratified by race, ethnicity, gender, language, and other key factors.**

One in three households headed by someone over the age of 65 do not have a computer, and more than half of people over age 65 do not have a smartphone.[vi] Children in low-income households are less likely to have access to a computer, and 30% of Black or Hispanic children do not have a computer, compared to 14% of whites. Digital literacy also varies with age, income and ethnicity. **In order to achieve the full promise of telehealth, Congress must act to address these structural barriers to virtual care.** The AAFP supports the creation of a pilot program to fund digital health navigators; development of digital health literacy programs; and deployment of digital health tools that provide interpretive services at the point of care, are available in non-English languages, easily and securely integrate with third-party applications and include assistive technology. Such a pilot should include a robust evaluation to demonstrate how the interventions addressed gaps in care or increased access for underserved populations.

Beyond telehealth, CMS implemented several other flexibilities to facilitate access to care and prevent the spread of COVID-19. We recommend making several of these flexibilities permanent, while others should remain in place only during this and future public health emergencies.

Congress took several actions to secure access to the COVID-19 vaccine for free for most Medicare, Medicaid, and CHIP beneficiaries. We recommend that Congress explore further actions to facilitate affordable, equitable coverage of routine adult immunizations. Currently, only 43% of state Medicaid agencies cover all recommended adult vaccines, and overall adult utilization remains low. **The AAFP believes that all public and private insurers should include as a covered benefit immunizations recommended by the ACIP without co-payments or deductibles.**

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.

Medicare and Medicaid both waived prior authorization requirements for durable medical equipment (DME) and other services early on during the public health emergency. While these requirements have since been reinstated, **Congress should permanently reduce the volume of prior authorization requirements across Medicare and Medicaid payers.** Prior authorization requirements delay care for patients and contribute to alarming rates of physician burnout. Commonsense solutions are needed to preserve and strengthen our physician workforce. For example, prior authorization should not be required for most DME ordered by a primary care physician for an established patient, regardless of whether it is ordered during a telehealth or in-person visit.

Family physicians were relieved when CMS took swift action to delay and/or waive reporting requirements for the Quality Payment Program, Medicare Shared Savings Program, and other programs. However, many practices were frustrated that CMS delayed the implementation of the extreme and uncontrollable circumstances policy for the 2020 performance year. **This policy, along with other waivers, should be quickly applied in future PHEs so physicians can focus on providing patient care with minimized administrative tasks without fearing negative financial repercussions.** The AAFP also has urged CMS to update measure benchmarks used across various programs to account for changes in utilization of health care services during the pandemic.

CMS waived requirements for physician supervision, including requiring certain services to be ordered by a physician, in Medicare, Medicaid, and the VA system. To safeguard patient safety and maintain access to appropriate, high-quality care, these waivers and flexibilities should *not* be made permanent, because patients are best served by a physician-led care team. Family physicians are particularly qualified to lead the health care team because they possess distinctive skills, training, expertise and knowledge that allow them to provide medical care, health maintenance and preventive services for a range of medical and behavioral health issues. While certain flexibilities during the PHE addressed the historic nature of the pandemic, **flexibilities to**

loosen supervision requirements should be restricted by Congress to ensure continuity of care and high-quality, accessible health care for all patients.

Thank you for the opportunity to discuss with this Committee the impact of health care regulatory flexibilities made available during the current public health emergency on family physicians and the AAFP's recommendations for permanent policy to advance accessible, equitable, high-quality health care beyond the pandemic.

Founded in 1947, the AAFP represents 133,500 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% 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, the AAFP's positions on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit www.aafp.org/media. For information about health care, health conditions and wellness, please visit the AAFP's award-winning consumer website, www.familydoctor.org.