Statement for the Record
American College of Physicians
Hearing before the House Energy and Commerce Subcommittee on Health
"The Future of Telehealth: How Covid-19 is Changing the Delivery of Virtual Care"
March 2, 2021

The American College of Physicians (ACP) is pleased to submit this statement and appreciates that Chairwoman Eshoo and Ranking Member Guthrie are holding this hearing to examine the importance of telehealth and its role in health care delivery during the COVID-19 pandemic and beyond. We also hope that this important discussion will provide a platform to act on bipartisan solutions to improve the nation's capacity to confront the ongoing national public health emergency (PHE) caused by COVID-19 but also promote telehealth as an essential part of health care in the future. We are pleased to offer our perspective and suggestions, as detailed below, on specific aspects of telehealth as they relate to the delivery of primary care and the patient-physician relationship.

The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

TELEHEALTH DURING THE COVID-19 PANDEMIC

According to initial data from 2020, the role of telehealth as a method of health care delivery has taken on greater significance as a result of the COVID-19 pandemic where social distancing now permeates every aspect of our daily lives. Routine health care in urban and rural areas alike has moved into the virtual realm of telehealth, in varying degrees, largely out of necessity, as we desperately try to gain a foothold on containing this deadly virus. In an October 2020 report from the Centers for Disease Control and Prevention (CDC), during the first quarter of that year, the number of telehealth visits increased by 50 percent, compared with the same period in 2019, with a 154 percent increase in visits noted in surveillance week 13 in 2020, compared with the same period in 2019. Data for this analysis were provided to CDC from four large national telehealth providers as part of partner engagement to monitor and improve

25 Massachusetts Avenue, NW, Suite 700, Washington, DC 20001-7401 | 202-261-4500, 800-338-2746 | www.acponline.org
190 N Independence Mall West, Philadelphia, PA 19106-1572 | 215-351-2400, 800-523-1546 | www.acponline.org

outcomes during the COVID-19 pandemic.[1] A recent survey of 1,594 physicians and other qualified health care professionals from across the U.S. also revealed that only a small percentage reported not having used telehealth for patient care.[2]

In addition, a February 2021 study in *Health* Affairs examined data of 16.7 million commercially insured and Medicare Advantage enrollees from January to June 2020 and noted that telemedicine use was lower in communities with higher rates of poverty (31.9 percent versus 27.9 percent for the lowest and highest quartiles of poverty rate, respectively). Across specialties, the use of any telemedicine during the pandemic ranged from 68 percent (endocrinology), to 35 percent (primary care), to 9 percent (ophthalmology).[3]

As noted in another recent study, health equity in medicine is also a real issue and there are disparities in access to telehealth technology. For those in rural and underserved communities, the nearest clinic may be hours away. Unfortunately, rural communities also suffer from more limited access to broadband internet, which restricted the ability of many in rural communities to access telemedicine pre-pandemic. Additionally, research shows that Black and Hispanic Americans own laptops at lower rates than White Americans, further dividing pre-pandemic access to telemedicine.[4] Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. Congress should provide support for further broadband deployment to reduce geographic and sociodemographic disparities and access to care.[5]

TELEHEALTH AND PRIMARY CARE

ACP supports the expanded role of telehealth as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. Telehealth can be most efficient and beneficial between a patient and physician with an established, ongoing relationship and can serve as a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area. Primary care physicians have had to convert in-person visits to virtual ones in response to the COVID-19 PHE, and practices are experiencing huge reductions in revenue while still having to pay rent, meet payroll, and meet other expenses without patients coming into their practices.

During this pandemic, internal medicine specialists continue to deliver care to their patients with the expanded utilization of telehealth made possible by new policies enacted by Congress,

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[1] Centers for Disease Control and Prevention, Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020 (cdc.gov), October 30, 2020

[2] COVID-19 Healthcare Coalition, Telehealth Impact - Physician Survey Analysis (c19hcc.org), November 16, 2020

[3] Health Affairs, Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States | Health Affairs, February 1, 2021

[4] 2020-state-telemedicine-report.pdf (doxcdn.com), September 2020, p. 12

[5] American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, Joint Letter to Congress on Telehealth Principles - July 1, 2020 (aafp.org)

and implemented by the U.S. Department of Health and Human Services (HHS), as well as private payers. However, many of the telehealth flexibilities and policy changes made by Congress and HHS are due to expire at the conclusion of the PHE, wherein patients and physician practices would be expected to revert to primarily face-to-face services without any type of risk-based assessment for gradually reopening medical practices and health systems to care for non-COVID and non-acute patients.[6] This quick reversal in policy does not take into account patients' comfort level in returning to physician offices to seek necessary care, as well as changes in office workflow and scheduling practices to mitigate spread of the virus within practices resulting in substantially lower volume of in-person visits for as long as the pandemic is with us. Therefore, the quick reversal in policy is not an effective way to recover from the PHE, nor prepare for possible future outbreaks.

The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. In order to address the many barriers to patient access and physician adoption and use of telehealth prior to the COVID-19 pandemic, and properly assess how to foster and strengthen longitudinal, patient-centered care delivery, ACP believes that the following existing PHE flexibilities and waivers should be continued—and not allowed to expire—to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded:

- Pay Parity for Audio-Only and Telehealth Services
- Geographical Site Restriction Waivers
- Telehealth Cost-Sharing Waivers
- Flexibilities in Direct Supervision by Physicians at Teaching Hospitals
- Revised Policies for Remote Patient Monitoring Services
- Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports many actions taken by the Centers for Medicare and Medicaid Services' (CMS) to provide additional flexibilities for patients and their doctors by providing payment for telephone services. During the PHE, Medicare has covered some audio-only services and will reimburse for both telehealth services and audio-only services as if they were provided in person. These changes in payment policy address some of the biggest issues facing physicians as they struggle to make up for lost revenue and provide appropriate care to patients.

[6] Doherty R., Erickson S., Smith C., Qaseem A. "Partial Resumption of Economic, Health Care and Other Activities While Mitigating COVID-19 Risk and Expanding System Capacity." American College of Physicians, May 6, 2020: https://www.acponline.org/acp_policy/policies/acp_guidance_on_resuming_economic_and_social_activities_2020.pdf

Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue and while still providing appropriate care to patients. ACP is discouraged to learn that CMS will not continue coverage of telephone evaluation and management (E/M) services beyond the PHE, despite mounting evidence about the effectiveness of expanding coverage for these services. While ACP has supported the Agency's actions to provide coverage and payment parity for such telephone services, the College is very concerned about the impact of reversing these changes at the conclusion of the PHE.

Evidence shows that patient visits to ambulatory practices have declined significantly and despite a rebound, visits remain 30 percent lower than they were pre-pandemic[7], with utilization for practice areas such as adult primary care declining by well over 60 percent.[8] As the need to contain the virus and maintain appropriate social distancing protocols continues throughout the year, and likely beyond, it is unlikely that in-person visits to practices will return to pre-pandemic levels as patients remain uncomfortable with making these in-person visits and physicians schedule fewer patients to be seen in the office. **ACP believes that existing PHE flexibilities and waivers should be continued, and not be allowed to expire—including pay parity for audio-only phone calls—to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded. We also urge removal of the requirement for the use of two-way, audio/video telecommunications technology so that telephone E/M services can continue to be provided to Medicare beneficiaries.**

Additionally, the HHS Office of Civil Rights (OCR) announcement regarding enforcement discretion around non-HIPAA-compliant technologies during the PHE has shown to be useful in allowing physicians to quickly shift their predominately in-person practices to more virtual care, as well as allowing increased access by patients to more widely available technologies. **Due to the long-lasting effects of the pandemic, and the need for physician practices to maintain the ability to provide care virtually, ACP recommends Congress urge OCR to maintain this enforcement discretion after the PHE is lifted.**

As part of the 2021 Physician Fee Schedule Final rule, CMS instituted a new permanent code describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit which can be conducted via audio-only technology similar to a virtual check-in. ACP does not

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[7] Mehrotra, A., Chernew, M., Linetsky, D., Hatch, H., & Cutler, D. (2020, May 19). What Impact Has COVID-19 Had on Outpatient Visits? Retrieved June 03, 2020, from https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits

[8] FAIR Health. Healthcare Professionals and the Impact of COVID-19, A Comparative Study of Revenue and Utilization. June 10, 2020. https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/Healthcare%20Professionals%20and%20the%20Impact%20of%20COVID-19%20-%20A%20Comparative%20Study%20of%20Revenue%20and%20Utilization%20-%20A%20FAIR%20Health%20Brief.pdf

agree that the establishment of G2252 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion) on an interim basis is the solution to providing an alternative to telephone E/M visits. ACP strongly disagrees with CMS' conflation of virtual check-ins, of any duration, with audio-only (telephone) E/M services, which are completely different. As the College has noted, telephone E/M services are not just a longer virtual check-in service, it *is* an E/M service. A more detailed explanation as to why ACP does not support use of G2252 as a replacement for telephone E/M visits can be found in its February 2021 comment letter to the Agency.[9]

Geographical Site Restriction Waivers

ACP strongly supported CMS' policy changes to pay for services furnished to Medicare beneficiaries in any health care facility and in their home — allowing services to be provided in patients' homes and outside rural areas. ACP has long-standing policy in support of lifting these geographic site restrictions that limit reimbursement of telehealth services by CMS to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas.[10] While limited access to care is prevalent in rural communities, it is not an issue specific to rural communities alone. Underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social determinants of health such as lack of transportation or paid sick leave, or sufficient work schedule flexibility to seek in-person care during the day, among many others. The experience with COVID-19 suggests many patients are at higher overall risk of mortality and morbidity due to these types of social determinants and racial and ethnic characteristics, particularly for African-Americans.[11] Such patients are more likely to reside in these underserved communities that fall within the metropolitan statistical areas that are normally not included in Medicare telehealth reimbursement outside of the waivers offered through the PHE.[12] Research has shown the extensive role that social drivers play in health and health equity,[13] and the pandemic has highlighted how providing expanded access to telehealth services within underserved communities, rural and urban, is an important aspect for infection control as well as addressing social determinants that exist outside of the pandemic. Moreover,

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[9] American College of Physicians, ACP Comments on 2021 Final Physician Fee Schedule and Quality Payment Program Rule (acponline.org), February 1, 2021, p. 14

[10] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

[11] Webb Hooper M, Nápoles AM, Pérez-Stable EJ. "COVID-19 and Racial/Ethnic Disparities." JAMA. Published online May 11, 2020. doi:10.1001/jama.2020.8598

[12] Robert Wood Johnson Foundation. "Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America." Princeton: Robert Wood Johnson Foundation; February 2008. Accessed on 11 May 2017at: www.rwjf.org/content/dam/farm/reports/reports/2008/rwjf22441

[13] Daniel H, Bornstein S, Kane G. "Addressing Social Determinants to Improve Patient Care and Promote Health Equity." American College of Physicians, April 17, 2018: https://www.acpjournals.org/doi/10.7326/M17-2441

the funding provided through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to the Federal Communications Commission (FCC), and other efforts through the FCC to expand access to telehealth services, offer the opportunity to provide the technologies and broadband needed for these underserved patient populations to utilize these services. **Accordingly, it is essential to maintain expanded access to and use of telehealth services for these communities, as well as rural communities, and ACP recommends that Congress permanently extend the policy to waive geographical and originating-site restrictions after the conclusion of the PHE.**

Telehealth Cost-Sharing Waivers

ACP appreciated the flexibility provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. At the same time, we call on CMS or preferably Congress to ensure that they make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding these physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining treatment. This critical action has led to increased uptake of telehealth visits by patients. **At the conclusion of the COVID-19 PHE, ACP recommends that Congress or CMS continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service. This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they are. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded.**

Flexibilities in Direct Supervision by Physicians at Teaching Hospitals

CMS has noted that in instances where direct supervision is required by physicians and at teaching hospitals, the agency will allow supervision to be provided using real-time interactive audio and video technology through the calendar year 2021. The College welcomes this decision by the agency to allow attending physicians and residents/fellows the ability to communicate over interactive systems asynchronously by waiving the in-person supervision requirement. This important step promotes efficient patient care and allows physicians and supervisees to work together unencumbered by social distancing restrictions. **We encourage Congress or CMS to maintain these modifications, and not allow them to expire.**

Revised Policies for Remote Patient Monitoring (RPM) Services

CMS finalized policy stating that following expiration of the COVID-19 PHE, there must be an established patient-physician relationship for RPM services to be furnished – ending its interim policy permitting RPM services to be furnished to new patients. The Agency also finalized

policies allowing consent to receive RPM services to be obtained at the time RPM services are furnished and noted that practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions.

RPM services have been a critical component of care, especially during the COVID-19 pandemic. ACP is pleased to see the Agency finalized a number of policies that will be beneficial to both patients and their care teams. These changes expand access to services at an important time, as patients and their care teams need additional resources to meet current challenges. These changes will help relieve physician burden and allow physicians more time to treat complex patient issues that require more than remote monitoring. **We continue to believe that Congress or CMS should extend the interim policy to allow RPM services to be furnished to patients without an established relationship. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded. The College continues to request the same for CMS' interim policy allowing RPM services to be reported for periods of less than 16 days, but not less than two days, so long as the other requirements for billing the code are met. While CMS did not take any action on these recommendations, we look forward to working with CMS to understand the need for additional policy changes in this regard.**

Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action

ACP supports a streamlined approach to obtaining several medical licenses that would facilitate telehealth services across state lines while allowing states to retain individual licensing and regulatory authority.[14] **We appreciated CMS' temporary waiver allowing physicians to provide telehealth services across state lines, as long as physicians meet specific licensure requirements and conditions. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded.** These waivers offer an opportunity to assess the benefits and risks to patient care in addressing the pandemic as well as the ability to maintain longitudinal care for patients who move across state lines. While these waivers do not supersede any state or local licensure requirements, they provide the opportunity to promote state-level action that may further promote more streamlined licensure requirements across the country. ACP also supports the Temporary Reciprocity to Ensure Access to Treatment Act or the "TREAT Act" (S. 168/H.R. 708), which would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

[14] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

In conclusion, we appreciate this opportunity to offer our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies to continue telehealth expansion beyond the PHE. Thank you for considering our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Should you have any additional questions, please contact Jonni McCrann at jmccrann@acponline.org.