



# **STATEMENT**

**of the**

**American Medical Association**

**U.S. House of Representatives  
Energy and Commerce Committee  
Health Subcommittee**

**The Future of Telehealth: How COVID-19 is Changing the  
Delivery of Virtual Care**

**Presented by: Jack Resneck, MD  
Member, AMA Board of Trustees**

**March 2, 2021**

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The American Medical Association (AMA) appreciates the opportunity to provide testimony to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing on The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care. The AMA strongly supports congressional efforts to ensure that Medicare beneficiaries have access to telehealth services. We welcome the opportunity to support congressional efforts to ensure all Medicare beneficiaries continue to have access to covered telehealth benefits after the COVID emergency ends.

The AMA believes that 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 cost-effective, and to ensure physicians and other health care providers 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 believes that it has the capacity to improve access to care for many underserved populations and improve outcomes for at-risk patients, particularly those with chronic disease and impairments.

Telehealth usage has expanded tremendously during the COVID-19 pandemic, helping Americans access health care services while maintaining social distancing and reducing strain on hospitals and physician clinics. 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.

### **Section 1834(m) of the Social Security Act Limits Access to Telehealth Services**

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.<sup>1</sup> 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 limited select cases where Congress has authorized provision of telehealth services in the home of an individual.<sup>2</sup> 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.

Two-way audio-visual technology is the only communication modality on which Medicare places such a prohibition. Other communication technologies, including remote patient monitoring, do not meet the definition of a telehealth technology and services furnished via these technologies are not subject to the 1834(m) geographic and originating site restrictions and go through regular Medicare coverage and payment processes.

While these restrictions may have made sense given the limited technologies available when they were first instituted in the Balanced Budget Act of 1997,<sup>3</sup> two-way audio-visual technology is now widely available and relatively inexpensive.

In response to the COVID-19 public health emergency (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 origination requirement for the duration of the COVID-19 PHE, which CMS subsequently did.<sup>4</sup> Telehealth usage among Medicare beneficiaries has since surged 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, and patients as well as many physicians, other health professionals, and practice staff required to stay at home for a long period of time, 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.

However, without intervention from Congress, Americans that have come to rely on telehealth services during the PHE will abruptly lose access to these services completely. 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.

### Telehealth Usage Has Increased Dramatically During the PHE

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<sup>1</sup> Special Payment Rules for Particular Items and Services, 42 U.S.C. § 1395m(m), [https://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm](https://www.ssa.gov/OP_Home/ssact/title18/1834.htm).

<sup>2</sup> For example, substance abuse disorder treatment delivered via telehealth is explicitly exempted from the geographic and origination restrictions.

<sup>3</sup> Pub. L. No. 105–33, 111 STAT. 251, (1997).

<sup>4</sup> 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>.

Telehealth usage has expanded tremendously during the COVID-19 pandemic. According to the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (HHS), before the public health emergency (PHE), 14,000 patients received a Medicare telehealth service in a week, while over 10.1 million patients received a Medicare telehealth service from mid-March through early-July. Telehealth visits accounted for 43.5 percent of all primary care visits for Medicare beneficiaries.<sup>5</sup>

Other early analyses paint a similar picture. For example, according to one analysis of data by FAIR Health, telehealth claim lines rose almost 3,000 percent from November 2019 to November 2020, from .20 percent of all medical claim lines to just over six percent.<sup>6</sup> A recent survey on telehealth use among U.S. adults age 50-80 by the University of Michigan showed that the percentage of older adults who had ever participated in a telehealth visit rose from four percent in May 2019 to 30 percent in June 2020, including a rise from six percent before March 2020 to 26 percent having had a telehealth visit in the period between March to June 2020.<sup>7</sup>

Patient's views on telehealth are shifting as well. While most respondents in the survey who had participated in a telehealth visit perceived in-office visits as providing a higher quality of care (54 percent), telehealth visits were perceived as more convenient by the majority of respondents (56 percent). Similarly, an analysis done by McKinsey showed that 76 percent of consumers are now interested in telehealth while only 11 percent reported interest in 2019.<sup>8</sup> According to J.D. Power, overall satisfaction for telehealth services is "among the highest of all healthcare, insurance and financial services."<sup>9</sup>

Physicians and other health care providers are also growing more comfortable using telehealth services. In a recent survey of physicians and other qualified health care professionals conducted between July 13 and August 15, 2020, 60 percent reported telehealth has improved the health of their patients and 55 percent said that telehealth has improved the satisfaction of their work. In addition, more than 80 percent reported that patients have reacted favorably to using telehealth and that telehealth has improved the timeliness of care for their patients. As a result, over two-thirds of respondents reported that they are motivated to increase telehealth use in their practices.<sup>10</sup>

However, concerns remain about continued reimbursement and patient access after the end of the PHE. The COVID-19 Healthcare Coalition survey of physicians shows that over 73 percent of respondents cited low or no reimbursement as a barrier to maintaining telehealth usage after COVID-19. Over 64 percent responded that they anticipated technology challenges for their patients to be a barrier as well.<sup>11</sup>

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<sup>5</sup> Assistant Secretary for Planning and Evaluation, Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the COVID-19 Pandemic (July 28, 2020), <https://aspe.hhs.gov/system/files/pdf/263866/hp-issue-brief-medicare-telehealth.pdf>.

<sup>6</sup> See FAIR Health, "Monthly Telehealth Regional Tracker," <https://www.fairhealth.org/states-by-the-numbers/telehealth>.

<sup>7</sup> Telehealth Use Among Older Adults Before and During COVID-19 (Aug. 2020), <https://www.healthagingpoll.org/report/telehealth-use-among-older-adults-and-during-covid-19>.

<sup>8</sup> McKinsey & Company, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" (May 2020), <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Telehealth%20A%20quarter%20trillion%20dollar%20post%20COVID%2019%20reality/Telehealth-A-quarter-trillion-dollar-post-COVID-19-reality.pdf>.

<sup>9</sup> Press Release, Telehealth Patient Satisfaction Surges During Pandemic but Barriers to Access Persist, J.D. Power Finds, <https://www.jdpower.com/business/press-releases/2020-us-telehealth-satisfaction-study> (Oct. 1 2020).

<sup>10</sup> The COVID-19 Healthcare Coalition Telehealth Impact Study Work Group, Telehealth Impact Study (last updated 21 Dec., 2020), <https://c19hcc.org/telehealth/physician-survey-analysis/>.

<sup>11</sup> Id.

## 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 ought to be covered or not. 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 the services in a way that works best for them.

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.

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, 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 invest in incorporating delivery of telehealth services into their workflows if the coverage is only temporary and its future uncertain. 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.<sup>12</sup> 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

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<sup>12</sup> 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>.

different concern that whether nationwide coverage and ability to deliver care to patients wherever they are located should be available, and such determinations are 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 increase the cost of making this necessary and overdue policy change.

### 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. For the duration of the COVID-19 PHE, CMS has added many services to the list of 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 be 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. 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.

### Telehealth is a Key Component to the Future of Medicare

Furthermore, increased access to telehealth services is urgently needed to effectively address the looming demographic health demands driven by the Baby Boom that will be placed on the Medicare program, health care providers, caregivers and the nation in the near future. The U.S. Census Bureau has projected that by 2030—in a mere 9 years—more than 20 percent of U.S. residents will be 65 and over.<sup>13</sup> During this same timeframe, the unofficial safety net of family providers and caregivers will continue to shrink markedly. From 2010 to 2030, the caregiver ratio (defined as the number of potential caregivers aged 45–64 for each person aged 80 and older) declines sharply from 7.2 to 4.1, and the caregiver ratio is expected to continue to decrease from 4.1 to 2.9 from 2030 to 2050.<sup>14</sup> In addition, as the Baby Boomers moves into retirement and global aging trends accelerate, the labor force in the U.S. (and around the globe) will shrink and strain funding for safety net programs like Medicare.<sup>15</sup> In light of the foregoing, national strategic planning is needed across society right now to develop and scale a sustainable infrastructure to center care where the patient is located to the greatest extent it is clinically efficacious and cost-effective, and to ensure physicians and other health care providers have the tools to optimize care delivery. Telehealth and related services will become an even more essential cost effective and reliable means to

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<sup>13</sup> Given current aging and fertility trends, by 2050 developed economies will have twice as many older persons as children. No Ordinary Disruption: the Four Global Forces Breaking All the Trends, Richard Dobbs, James .

<sup>14</sup> The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers, AARP Public Policy Institute, In Brief B213, August 2013.

<sup>15</sup> No Ordinary Disruption: the Four Global Forces Breaking All the Trends, Id.

expand capacity in a health care system marked with significant and persistent specialty shortages and geographic disparities.

### 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 also can 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. Patients cannot take advantage of telehealth services if they do not have the requisite internet connection to access them. Solving this requires enhanced funding for broadband internet infrastructure in rural areas and support for underserved urban communities and households to gain access to affordable internet access.

### 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.

CMS and the Office of Inspector General (OIG) at HHS have all of the typical 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.

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 Public Health Emergency. 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 public health emergency 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.

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.<sup>16</sup> 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 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 visiting a crowded health care facility.

#### States Must Continue to Play a Central Role in Licensing Physicians

State medical boards play a pivotal role in protecting the safety of patients through physician licensure, regulations, and disciplinary action. At the start of the COVID-19 pandemic, there was some concern that state licensing requirements would limit physicians' ability to quickly move into those areas hardest hit by COVID-19 and meet the workforce demands on the ground and via telehealth. In response to this concern, the states acted quickly to temporarily allow physicians to practice across state lines by waiving licensure or creating a streamlined licensure or registration processes in response to the COVID-19 emergency.

The AMA believes that it is essential to ensure that physicians and other health care providers are licensed in the state where the patient is located to provide telemedicine services in a secure environment. The AMA opposes proposals that would change which state is responsible for overseeing the physician from the state where the patient is located to the state where the physician is located. This changes which state practice and scope laws apply to the care rendered and raises serious enforcement issues as states do not have interstate policing authority and cannot investigate incidents that happen in another state. This is inconsistent with AMA policy.

Instead, AMA believes efforts should be made to increase membership in the Interstate Medical Licensure Compact (IMLC), a one stop-shop for physicians who are in good standing with their state medical boards to seek a license to practice in multiple jurisdictions in an expedited process. This maintains state-based licensure and the ability of state medical boards to protect the safety of patients, while allowing for greater sharing of information between states and expediting the licensure process for physicians who want to move between states or practice in more than one jurisdiction.

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<sup>16</sup> 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).



## Conclusion

The AMA thanks the Subcommittee for this hearing and for careful consideration of the current landscape of telehealth coverage and the best ways to ensure patients can continue to access telehealth services anywhere in the country from wherever they are located after the end of the PHE. We welcome the opportunity to work with the Subcommittee and Congress to seek solutions moving forward.