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March 6, 2022

The Honorable Mariannette J. Miller-Meeks, M.D.
U.S. House of Representatives
Washington, DC 20515

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

The Honorable H. Morgan Griffith
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Miller-Meeks, Kelly, and Griffith:

On behalf of the Association of American Medical Colleges (AAMC), I appreciate the opportunity to respond to the Healthy Futures Task Force Modernization Subcommittee Request for Information (RFI) on how technology can improve health care. AAMC members including major teaching hospitals, medical schools, faculty practice plans, and their associated teaching physicians and scientists are at the forefront of technology and cutting-edge care, and in particular telehealth. By developing and embracing technological advances, academic medicine is better able to improve the health of their communities and ensure their patients have access to the care they need. We are happy to share this knowledge and collaborate with you as you develop an agenda to modernize the health care system in the United States.

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC member teaching hospitals, faculty physicians, and other providers have responded to the COVID-19 public health emergency (PHE) by rapidly implementing telehealth in their hospitals and practices in order to provide continued access to medical care for their patients. Telehealth provides both patients and providers with a variety of benefits and both maintains and expands access to care, especially to those in rural, urban, and other underserved areas. Specifically, we have seen that:

- **Increased Access to Telehealth for Patients Improves Care**: Early in the pandemic, telehealth proved invaluable to ensuring patient access to care, with physician faculty practices providing approximately 50% of their ambulatory visits via telehealth in March

and April 2020.[1] This is consistent with reports from CMS regarding telehealth services provided to Medicare beneficiaries during that time frame.[2] Although the use of telehealth has declined from its peak in March and April 2020, the use of telehealth services still remains high at roughly 20% of ambulatory visits. This reflects a recognition by providers and a demand by patients that care delivered via telehealth is here to stay, and with good reason. It improves access for many and directly supports high value care.

- **Telehealth is not causing a significant increase in health care utilization.** [3] Data from 73 faculty physician practice members of the Clinical Practice Solutions Centers (CPSC), indicate that these practices, despite increasing their usage of telehealth, have not seen a dramatic increase in the number of visits overall – suggesting that telehealth visits have been used to replace in person care, not add to the number of visits.[4]

- **Continued coverage of audio-only telehealth visits is crucial.** As the COVID-19 pandemic has shifted the landscape for faculty practice services, telehealth has become an essential means for delivering care, providing an opportunity to increase access for all patients. Audio only visits have been particularly crucial for the Medicare patient population, with 62% of evaluation and management (E/M) telehealth visits conducted via audio at the peak of the pandemic, compared to 32% and 25% for Medicaid and Commercial patients, respectively. As telehealth volumes leveled off over the course of the pandemic, audio visits have remained at a steady average of 36% for Medicare patients. This demonstrates the clear importance of maintaining coverage of audio only visits in order to maintain access to care for older patient populations.[5]

- **Telehealth has Increased Access to Specialist Care:** The use of telehealth enables specialists, such as pediatric specialists, cancer specialists, and critical care physicians, to bring their skills to rural areas and other areas that may not have subspecialty care in their communities. Immediate availability of a pediatric infectious disease specialist or a stroke critical care physician via telehealth can be life saving for those in remote, rural, or small size communities. In addition, telehealth can be used effectively to provide asynchronous consultation for front line providers. Patients can benefit from more timely access to the specialist's guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist.

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[1] The Clinical Practice Solutions Center (CPSC), owned by the Association of American Medical Colleges and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.
[2] Health Affairs, Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. July 15, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/
[3] Reed M, Huang J, Graetz I, Muelly E, Millman A, Lee C. Treatment and Follow-up Care Associated With Patient-Scheduled Primary Care Telemedicine and In-Person Visits in a Large Integrated Health System. JAMA Netw Open. 2021;4(11):e2132793. doi:10.1001/jamanetworkopen.2021.32793
[4] AAMC analysis of physician and non-physician claims billed by Faculty Practice Plan members of the Clinical Practice Solutions Center.
This analysis included data from 73 faculty practices.
[5] AAMC analysis of physician and non-physician claims billed by Faculty Practice Plan members of the Clinical Practice Solutions Center. This analysis included data from 83 faculty practices.

- **Patients are Highly Satisfied with Telehealth:** Analyses of surveys of more than 30,000 patients conducted by Press Ganey for services in March and April 2020 show that patients feel overwhelmingly positive about their virtual interactions with health care providers.[6] According to a recent *Health Affairs* article, 79% of patient respondents reported satisfaction with their telehealth visit and 78% felt that their health concern could be addressed via telehealth.[7]

The AAMC appreciates the work that Congress and the Centers for Medicare and Medicaid Services (CMS) have done to provide important flexibilities to ensure that providers can continue to deliver quality health care for patients during the PHE. Many of these flexibilities have proven to expand access to care and should continue to be integrated into the health care system beyond the end of the PHE, but Congressional action is needed. The AAMC believes telehealth is an important method to deliver health care in many circumstances and urges Congress to make legislative changes that would preserve these new practices and the gains we have made in telehealth to date, and to ensure that reimbursement remains at a level that supports the infrastructure needed to provide this level of telehealth services.[8]

As you develop an agenda to modernize health care, the AAMC urges you to consider the following recommendations around telehealth and the Acute Hospital Care at Home waiver program:

TELEHEALTH

Remove Patient Location Restrictions and Rural Site Requirements

The AAMC strongly supports changes made by Congress that waived patient location restrictions that applied to telehealth service during the PHE. These changes have enabled CMS to pay for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home, during the PHE. We also thank Congress for including changes in the Consolidated Appropriations Act, 2021 that permanently allow patients to receive mental health services via telehealth regardless of the geographic location requirements ordinately applicable to Medicare telehealth services.

These changes have allowed patients to remain in their home, reducing their exposure to COVID-19 and reducing the risk of exposing another patient or their physician to COVID-19. Maintaining such a change even after the threat of the pandemic is contained would allow patients who find travel to an in-person appointment challenging to receive vital care, especially for patients with chronic conditions or disabilities who need regular monitoring. The AAMC encourages Congress to remove the rural site requirements and allow the home to be an originating site.

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[6] Press Ganey, T*he Rapid Transition to Telemedicine: Insights and Early Trends.* May 19, 2020. https://www.pressganey.com/resources/white-papers/the-rapid-transition-to-telemedicine-insights-and-early-trends?s=White_Paper-PR

[7] "Congress: Act Now To Ensure Telehealth Access For Medicare Beneficiaries, " Health Affairs Blog, May 10, 2021. https://www.healthaffairs.org/do/10.1377/hblog20210505.751442/full/.

[8] Understanding a Video Visit at the Health System Level https://www.aamc.org/media/58731/download?attachment

Ensure Providers are Paid the Same Amount for Telehealth Services as Services Delivered In-Person

The AAMC strongly recommends that providers be paid the same for furnishing telehealth services as services delivered in person. The quality and cost of care delivered is not different if the patient is seen via telehealth. We recommend Congress provide a facility fee under the outpatient prospective payment system for telehealth services provided by physicians that would have been provided in the provider-based entity.

Teaching hospitals and faculty practice plans have highlighted significant infrastructure costs to fully integrate their electronic health record systems with HIPAA-compliant telehealth programs. Physicians and hospitals employ medical assistants, nurses, and other staff to engage patients during telehealth visits and to coordinate care, regardless of whether the services are furnished in person or via telehealth. Before the virtual visit occurs, the physicians and other health care professionals must be provided the technology they need and acquire a platform to use for the visits. Other staff will contact patients to complete registration, obtain consent for a telehealth visit, and ensure that the patient receives the email with a link to participate in the virtual visit. In addition, staff will educate the patients on the use of technology as needed to ensure they are able to participate in the visit.

On the day of the visit, clinical staff reach out to the patient to provide intake services (e.g. ask for chief complaint, symptoms, weight, temperature and help the patient identify a review of current medications and therapies) prior to the patient visit with the physician or health care professional. The patient then participates in the visit with the physician, and at the conclusion of the visit, the physician must arrange any follow-up plan for the patient related to their care. Staff will follow-up as needed to schedule any additional visits for the treating physician or subspecialty referral, tests, or laboratory studies.

Without sufficient reimbursement, providers may no longer be able to continue to provide the current level of telehealth services to their patients.

Allow Payment for Audio-Only Services

CMS established a separate Medicare payment for specific audio-only services to provide reimbursement at the same rates as in-person visits. However, the final 2021 physician fee schedule rule stated that this separate payment will no longer exist after the PHE ends, since CMS does not have the statutory authority to allow coverage and payment for telephone evaluation and management services.

Audio-only calls improve access to virtual care for patients who do not have access to the devices or broadband for audiovisual calls, are not comfortable with digital technology, or do not have someone available to assist them. During the PHE, coverage and payment for audio-only calls has been critical to ensure access to care for many patients. Physicians have been able to provide a wide array of services efficiently, effectively, and safely to patients using the telephone.

Data from the CPSC shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient. CMS data show that nearly one-third of Medicare beneficiaries received telehealth by audio-only telephone technology from March through June 2020,[9] which is consistent with CPSC data.

Many factors contribute to the high use of audio-only services. Patients in rural areas or those with lower socioeconomic status are more likely to have limited broadband access and may not have access to the technology needed for two-way audio-visual communication. The Pew Research Center found that about a third of adults with household incomes below $30,000 per year do not own a smartphone and about 44% do not have home broadband services.[10]

Some providers report that even when their patients have access to technology that would allow for audio-visual communication, they may be unable to use the technology without assistance, thus limiting them to telephone use. For these patients, the only option to receive services remotely is through a phone. Without coverage and payment for these audio-only services, there will be inequities in access to services for these specific populations. We urge Congress to permanently make changes to allow coverage and payment for audio-only services.

Allow Patients to Access Telehealth Services Delivered Across State Lines

As part of the COVID-19 response, Congress and CMS have allowed providers to be reimbursed by Medicare for telehealth services across state lines. This waiver creates an opportunity to improve patient access to services and to help improve continuity of care for patients who have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment under federal programs, states need to act to allow practice across state lines to occur.

The AAMC urges Congress to pass the Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, H.R. 708, S. 168). This bipartisan, bicameral legislation would expand care for patients by creating a temporary uniform licensing standard for all practitioners and professionals that hold a valid license in good standing in any state to be permitted to practice in every state – including in-person and telehealth visits – during the COVID-19 public health emergency.

Allow for Virtual Supervision of Resident Physicians

During the PHE, CMS has allowed resident physicians to furnish telehealth services that are virtually supervised by the teaching physician. In the physician fee schedule final rule, CMS states that this policy regarding telehealth will be allowed on a permanent basis only in rural sites.

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[9] ASPE Issue brief: Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic (7/18/2020); Health Affairs Blog; Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19. July 15, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/abs

[10] Pew Research Center, Digital divide persists even as lower-income Americans makes gains in tech adoption. May 7, 2019. https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

Resident education is a required, fundamental step of professional development before autonomous clinical practice and requires varying levels of faculty supervision depending on where the resident is in training and developing competency. As part of this development, it is essential for residents to have experience with telehealth visits while supervised as they will be providing them in the future to their patients when they practice autonomously.

The AAMC recommends that CMS allow residents to provide telehealth services permanently while a teaching physician is present via real-time audio-visual communications technology after the PHE ends in all regions of the country. This change to CMS policy will improve patient access to care while also enhancing the resident's skills.

Allow "Authorized Practitioners" to Prescribe Buprenorphine via Telehealth
The AAMC supports the Substance Abuse and Mental Health Services Administration's and Drug Enforcement Agency's temporary change to allow "authorized practitioners" to prescribe buprenorphine to new and existing opioid use disorder patients for maintenance or detoxification treatment via telehealth examination without the need for a prior in-person visit. We urge Congress to make this change permanent to ensure this important expansion is not limited solely to the current PHE.

Take Steps to Improve Access to Broadband Technology
We appreciate Congress' bipartisan efforts to improve broadband access as part of the Infrastructure Investment and Jobs Act (IIJA, P.L. 117-58). In many parts of the country, providers and their patients have limited access to broadband connectivity, which has been a major barrier to use of telehealth. This is particularly true for rural areas and underserved communities. The Federal Communications Commission has reported that 30% of rural residents lack broadband services.[11] Also, racial and ethnic minorities, older adults, and those with lower levels of socioeconomic status are less likely to have broadband access. In order to expand access to telehealth and other important online services, we recommend that Congress continue to build on the IIJA and make additional investments by increasing funding for broadband access and infrastructure development.

ACUTE HOSPITAL CARE AT HOME PROGRAM WAIVER

The Centers for Medicare and Medicaid Services (CMS) launched the Hospital Without Walls program in March 2020 to allow hospitals to provide services beyond their existing walls to help address the need to expand care capacity and to develop sites dedicated to COVID-19 treatment. The Acute Hospital Care at Home (AHCAH) program waiver is an expansion of this initiative that allows eligible hospitals to have regulatory flexibility to treat certain patients, who would otherwise be admitted to the hospital, in their homes and receive Medicare payment under the Inpatient Prospective Payment System.

AHCAH launched with six health care systems that had experience with providing acute hospital care in a patient's home. To date, 202 hospitals within 92 systems located in 34 states – including

[11] Federal Communications Commission, 2018 Broadband Deployment Report, February 2, 2018. https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report

many teaching hospitals – have received waivers from CMS to participate in the program.[12] The increase in hospital participation underscores the critical need for continued flexibility to meet the health care needs of certain patients without having to admit them into the inpatient setting. As teaching hospitals have surged to meet the capacity demands imposed on them by the PHE, AHCAH programs have become a valuable resource to both alleviate capacity issues and provide patients access to care.

AAMC member teaching hospitals report positive outcomes and high patient satisfaction from their AHCAH patients. Hospitals have made robust investments in their programs with some viewing their AHCAH programs as a long-term solution to ongoing capacity issues. However, teaching hospitals and their patients face uncertainty regarding the future of the program due to its reliance on the consistent renewal of the PHE. The AAMC urges Congress to extend this waiver for at least two years after the PHE to ensure that hospitals that patients' access to this program is not interrupted, and that hospitals' investments in the program do not come to a halt.

Thank you for considering our recommendations for modernizations to improve access to care for patients and communities across the country. We look forward to continuing to engage with you on these and other critical issues. If you have any additional questions, please do not hesitate to contact me directly or Ally Perleoni, Manager, Government Relations (aperleoni@aamc.org).

Sincerely,

Karen Fisher, JD
Chief Public Policy Officer
Association of American Medical Colleges

[12] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources