American Hospital Association™
Advancing Health in America

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February 11, 2021

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Chernew:

At its January meeting, as well as in several prior meetings, the Medicare Payment Advisory Commission (MedPAC, or the Commission) discussed the future of telehealth policy following the COVID-19 public health emergency (PHE). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks that as you continue to consider this issue, you bear in mind the following considerations, which significantly impact patients' access to telehealth services and the ability of hospitals, health systems and other providers to furnish those services.

The AHA strongly supports MedPAC's continued conversations of the post-pandemic future of telehealth policy. The increased use of telehealth since the start of the PHE is producing high-quality outcomes for patients, closing longstanding workforce gaps and those that arose as a result of a sickened and exhausted provider corps, and protecting access for patients too vulnerable to risk infection. This shift in care delivery could outlast the PHE if the appropriate statutory and regulatory framework is established. To do so, stakeholders must have time to conduct in-depth analyses of how providers have used the telehealth flexibilities available during the pandemic and the quality of patient care provided through those flexibilities. Given that the pandemic is ongoing and that the Biden administration has suggested it will maintain the PHE declaration through the end of 2021, considerably more data points on the quality and cost effectiveness of telehealth services will be developed this year. **Thus, we strongly urge the Commission to not put forth recommendations on this topic until it can conduct a thorough review of the vast array of virtual services employed during the pandemic, as well as the experiences of both providers and patients, and only then develop evidence-based policy recommendations.**

Our detailed comments are below.

Delivery of Telehealth across the Nation. As MedPAC is well aware, one of the most salient benefits of telehealth is the access to care it creates for broad swaths of patients. Telecommunications technology connects patients to vital health care services through videoconferencing, remote monitoring, electronic consults and wireless communications. It increases patients' access to physicians, therapists and other practitioners. This is especially important in areas of the country where recruiting and retaining providers is challenging, such as in rural areas, and in areas where vulnerable populations often lack an entrance point to the health care system.

During the pandemic, our members have utilized critical flexibilities that the Centers for Medicare & Medicaid Services (CMS) established to allow telehealth services to reach even more patients. As an example of the impact made by pandemic-borne flexibilities, one of our members reported a 10-fold increase in access to specialists while reaching 39% more zip codes in their state using telehealth. They also received extremely high patient satisfaction ratings; one such patient, a farmer, relayed how he conducted a visit with his physician via his smartphone while on his tractor, a process that would normally take three hours if in person. Many other AHA members also indicated they observed greatly improved health outcomes for patients who no longer cancelled or missed their appointments due to the ability to connect with their providers remotely.

The COVID-19 pandemic spurred another of our members to set up a virtual hospital with significant telehealth capabilities when the pandemic first hit. The program's original objectives were to provide proactive management of COVID-19 patients across the care continuum, keep significant numbers of patients out of emergency departments (EDs) and hospitals, and preserve and increase inpatient bed capacity for those who needed it. These objectives were met with great success: nearly 18,000 patients were treated in the virtual hospital as of August 2020, with only 3% requiring transfer to a brick-and-mortar site. A significant number of hospitalizations were avoided, making the program very cost effective.

What's more, the patients who were transferred were often able to bypass busy EDs, and by the time they arrived at the facility, the hospital already had their essential information due to their prior virtual care. Patients were extremely satisfied with the program, including the 97% of patients who remained at home and whose anxiety about this novel disease was very well-managed due to regular connection with a provider. Every patient discharged from the virtual hospital was set up with a follow-up appointment with a primary care provider, the majority of which were completed virtually. For many of these patients, that primary care visit was the jumping off point to ongoing access to care they never had before. This member is now expanding its virtual hospital beyond COVID-19 care to assist those with chronic conditions.

Given these and the millions of other successful telehealth encounters that have occurred since COVID first hit – and in the years prior – the AHA strongly urges the Commission to recommend elimination of the 1834(m) geographic and originating site restrictions, which would allow all patients to receive telehealth

services in their homes, residential facilities and other locations. Without this change, much of the progress that has been made over the past months to significantly increase patient access to care will disappear, since the status quo limits telehealth to rural areas of the country and requires patients to be at certain types of facilities to receive care. The PHE clearly demonstrated the need for access to telehealth in non-rural areas including in the safety of patients' homes, and the importance of being able to reach patients who are completely removed from the health care system, such as homeless individuals in shelters. **Thus, we urge the Commission to ensure that its recommendations for federal policy reflect the realities of today's health care environment.**

We also wish to underscore that any expansion of telehealth should be implemented with the explicit goal of addressing health equity and reducing health disparities. We are mindful that even though our recommended actions would protect access to care for millions of patients, challenges remain for the nation's minority communities. As such, telehealth must be employed with supporting policies, such as access to broadband and end-user devices, to reach underserved populations.

Coverage and Reimbursement for Audio-only Services. MedPAC has also frequently discussed the continuation of Medicare coverage and payment for audio-only services. During the PHE, CMS established separate payment for audio-only evaluation and management (E/M) services described by previously non-covered CPT codes 99441-99443. CMS also temporarily waived the requirement that telehealth services be provided by two-way, audio/video communication technology so as to add the audio-only E/M services to the Medicare telehealth list of services and permit other services on the list to be delivered via audio-only connection.

The AHA enthusiastically supports coverage and reimbursement for audio-only services and encourages MedPAC to recommend its continuation. This flexibility has enabled our members to maintain access to care for numerous patients who do not have access to broadband or video conferencing technology. It has also protected the continuity of care when a video connection fails, a situation with which the nation is now intimately familiar due to the COVID-19 pandemic. In those situations, if a provider and patient are connected via audio/video technology, and their video connection fails, they can default to an audio-only visit and pick up right where they left off. Additionally, audio-only behavioral health services have become extremely popular with patients who are more comfortable without face-to-face visits.

Payment for Telehealth Services. **For providers to be able to continue delivering improved patient care through telehealth and other virtual services, they need adequate reimbursement for the substantial upfront and ongoing costs of establishing and maintaining their virtual infrastructure, including secure platforms, licenses, IT support, scheduling, patient education and clinician training.** Without adequate reimbursement of these costs, providers may be forced to decrease their telehealth offerings, thus returning many patients to the previous system of unequal access to care. Adequate reimbursement for virtual services also is key to

ensuring providers have the means to invest in HIPAA-compliant technologies and to deliver these services with high quality of care.

Specifically, to best support providers' ability to deliver high-quality care and improved patient outcomes, there must be a thorough and complete accounting of the costs that go into providing virtual visits and how such expenses relate to the need to maintain capacity for in-person services. There are, in fact, significantly more actions that hospital staff and providers must take to execute a virtual visit than they do for an in-person visit. For example, before the visit takes place, the hospital must first equip providers with the hardware they need, such as laptops and webcams, and acquire professional licenses for the virtual platform they choose to use, such as Zoom. If the hospital staff is at home, hospitals may also purchase additional software to protect the privacy of personal phone numbers and redirect staff to focus exclusively on helping providers and patients execute virtual visits.

Next, other dedicated staff work to set patients up on Zoom or another platform, communicate with patients before the visit to complete pre-registration, obtain patients' verbal consent to telehealth and then manually record that consent, and provide several pre-visit points of communication to ensure patients have the correct link for their telehealth visit. For in-person care, many of these functions can occur at the same time as the visit when the patient interacts with registration staff while waiting for a provider. However, via phone and video, they must be completed in advance of the visit, requiring significant manpower. And, this process is even more complicated for a service such as group therapy, which involves more than one patient.

When the time of the visit arrives, clinical staff admit a patient from a virtual waiting room or call the patient if they do not present to the waiting room. The clinical staffperson then completes an intake process and notifies the provider that he or she can enter the virtual visit. If any consent or release forms are required, the clinical staff obtain verbal authorization and note that in the patient's documentation, a two-step process that, when completed in person, requires only the single step of a patient signature. At the end of the visit, when a provider would normally send a patient to check-out to schedule any follow-up visits, the provider must conduct this follow-up planning him or herself because there is no way to do a warm handoff on that provider's license to a staffperson, as the provider needs the license for the next patient. And, finally, once the visit is over, hospital staff must send patients their visit summaries via a patient portal or via mail for patients not on the portal; a step that, in person, consists of simply handing the patient their summary sheet.

Without funding to cover these numerous added steps, it will be difficult-to-impossible for hospitals and health systems to provide telehealth at the level at which patients are demanding. The goal of expanding telehealth should be integrated care across modalities to achieve the most appropriate and efficient care for patients. **Therefore, we strongly urge MedPAC to recommend CMS carefully consider the costs of providing telehealth and ensure sufficient reimbursement to cover those costs.** And, CMS actually has a means to do this accounting – the practice expense

methodology. Specifically, CMS could create a practice expense value for telehealth services that is unique to those services, taking into account their intensity and complexity as well as the costs of the necessary infrastructure and labor described above. This would generate a payment for telehealth that reflects the inputs for delivering this service, obviating the need for artificial reductions to telehealth payment simply because it is a different modality of care.

Again, we thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Shira Hollander, senior associate director of payment policy, at 202-626-2329 or shollander@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development