July 13, 2020

Re: NCQA Taskforce on Telehealth Policy Request for Stakeholder Input on Telehealth Policy

All Members of the NCQA Taskforce on Telehealth Policy:

The Physicians Advocacy Institute (PAI) appreciates the opportunity to provide comments in response to the requests made by the National Committee for Quality Assurance’s (NCQA) Taskforce on Telehealth Policy for stakeholder input on existing telehealth policies during the COVID-19 pandemic.

PAI is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients. As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and to educate policymakers about these challenges. PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine. PAI’s Board of Directors is comprised of CEOs and former CEOs from nine state medical associations: California Medical Association, Connecticut State Medical Society, Medical Association of Georgia, Nebraska Medical Association, Medical Society of the State of New York, North Carolina Medical Society, South Carolina Medical Association, Tennessee Medical Association, and Texas Medical Association, and a physician member from Kentucky. As a physician-based organization, PAI is equipped to provide comments and insight into many of the challenges facing the medical profession.

Recently, the NCQA Task Force for Telehealth Policy released a request for stakeholder input on several policy-related questions addressing telehealth and remote patient monitoring, as well as the impact of such services during COVID-19, and the potential barriers and opportunities associated with such services once the COVID-19 pandemic ends. Below, please find PAI’s input on specific questions solicited.

Expanding telehealth and its effects on total cost of care

What have we learned about telehealth utilization during the pandemic? Telehealth remains a vital component of the U.S. healthcare system’s response to COVID-19. The flexibilities instilled by the Centers for Medicare and Medicaid (CMS), Office of the Inspector General (OIG), and respective State agencies across the country, as well as current funding opportunities through Health Resources and Services Administration (HRSA) and Federal Communications Commission (FCC), have drastically grown the U.S. telehealth platform. While it remains to be seen what specific health outcomes stem from virtual care (in lieu of face-to-face care), we have seen a notable growth in telehealth visits reimbursed. As of late April 2020, a Merritt Hawkins report indicates that 48% of physicians are now providing some form of telehealth services (up from 18% in 2018), and the American Telemedicine

Association indicates that, as a whole, 46% of Americans have replaced a cancelled in-person healthcare visit with a telehealth service during the pandemic. These trends are being realized almost universally across the U.S. and across payers as many physician practices have migrated their services to virtual platforms to maintain care continuity and as well as financial viability (to the upmost extent possible).

Notably, despite the increased uptake in telehealth, the overall utilization of physician practice services remains well below the baseline. A Commonwealth Fund report indicates that there has been a cumulative deficit of nearly 40% in outpatient visits experienced over the last 3 months (March 15-June 20). While uptake of telemedicine has somewhat mitigated this trend, utilization rates of physician services remains significantly lower than before the pandemic.

Several barriers and challenges still remain that impede utilization of telehealth— and, thus, impede the utilization of general physician services. First, infrastructure, staff training, and compliance policies and investments that must be made for telehealth services can be costly and time consuming and therefore barriers, especially for smaller physician practices, as well as given the uncertainty around the permanency of the telemedicine reforms. Second, reports indicate that anywhere from 35 to 42 million Americans still lack access to general broadband connection (wireless and non-wireless). Third, despite increases in Medicare reimbursement, many commercial health insurers continue to reimburse telehealth services at lower rates than in-person services, and some require the use of pre-approved platforms that may be costlier when compared to alternative platforms. Lastly, there remain several ancillary and related professional concerns surrounding telehealth and general care during COVID-19 that have yet to be formally addressed, such as: lack of federal professional liability protections for non-volunteer physicians treating COVID-19 patients (or suspected patients); potential malpractice risks associated with telemedicine platforms; and virtual platform capacity issues experienced among certain physicians, especially for practices within rural and underserved communities.

We have also learned the importance and need to ensure that audio only technology can be used for telemedicine services. Older populations, especially those who are more complex and/or homebound, are often unable to employ video technology. For these patients, allowing for the continuation of audio only services, at comparable reimbursement levels as audio and visual services, is critical not just during a PHE but at other times as well. During times of crisis, for example, allowing for audio only technology to be used for telehealth services would ensure access to care.

There is also a need for the continued support of greater telemedicine adoption and use for psychotherapy and other mental and behavioral health conditions, without arbitrary limitations on frequency. It is important that these patients receive as many services, on a daily, weekly, or monthly basis, as needed and appropriate. We also believe it would be important to further research and develop policies and best practices for using telemedicine for medication prescriptions for mental and behavioral health conditions.

Furthermore, we believe that the adoption of newer and more advanced technology and service opportunities, across specialties, should be encouraged and incentivized. For example, we believe there is the potential to allow the use of RPM technologies to satisfy the technology requirement for telehealth services. RPM services include critical features that, if combined with an audio and/or video component,

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could help deliver high-quality care, and it would be valuable to further research and explore this opportunity and the positive effect it could have on care delivery.

Flexibilities and reimbursement rates must continue post-COVID-19, as many physician practices and the patients they serve will remain heavily reliant on telehealth services for the immediate future (if not longer). This will also increase access to physicians and physician services, especially for vulnerable and underserved, urban, and rural patient populations. Additionally, to preserve continuity of care, it is important that, when available, patients maintain their choice of physicians or otherwise have access to seek treatment from a physician in their local communities. However, it is important that these policies not:

i) Relieve insurers of their obligation and responsibility to offer adequate provider networks within a reasonable geographic proximity to their insureds, or

ii) Expand the scope of practice of non-physician health care professionals beyond that supported by their licensure, education, and training prior to the PHE

**How should federal budgeting models adapt to reflect expanded telehealth access?**

While there has been a drastic increase in telehealth services provided and reimbursed, there are still certain shortcomings and telehealth has not completely replaced in-person services. There is still a significant general deficit in total physician services being provided in the U.S. currently. As such, in the short run, it is important that budgeting models account for the significant decrease in overall physician service expenditures that is currently experienced across the U.S. Furthermore, due to the nature of the pandemic it is unclear if telehealth services will be utilized complementary to, or mutually exclusive to, in-person services post-COVID-19. This relationship will be key to informing any future budgetary projections. The ability for telehealth to “replace” in-person physician services will differ dependent on physician specialty and patient acuity. Furthermore, while many patients report increased access to telehealth services during the pandemic, the frequency of telehealth service utilization (e.g., frequency of telehealth E/M services per month) in comparison to the frequency of in-person service utilization (e.g., frequency of in-person E/M services per month) remains unobservable. Thus, as we transition to a post-PHE environment and a new normal, it is important to ensure there is appropriate reimbursement and coverage for telehealth services.

Additionally, there needs to be appropriate funding for telehealth/virtual platforms, operational capacity building, data and interoperability capacity building. Physician practices are among the most vulnerable stakeholders in the health care industry during COVID-19, from both a physical and financial health perspective. While the demand for services may renew post-PHE, the investment requirements and upfront risks necessary to scale virtual/data platforms will remain a debilitating financial/regulator stress for practicing physicians, especially those in small and independent practices.

It will be critical that policymakers continue to financially support such stakeholders to ensure practices can perform at the best of their ability and can remain viable amidst competing health systems and hospitals. This funding could look similar to the Health Information Technology (HITECH) Administrative funding for state Health Information Exchange (HIE) activities through the Medicaid Electronic Health Records (EHR) Incentive Program as authorized by the American Recovery and Reinvestment Act of 2009 (ARRA) at 90 percent match rate for design and development costs through 2021.

Further, similar to concerns raised with electronic health records (EHRs) and other interoperability technology, it is important that the costs of telemedicine technologies are not passed on downstream to physicians and patients. For example, currently some hospitals and facilities are charging physicians an
additional facility fee to cover their costs for telemedicine technologies like monitors. We are concerned that post-PHE, the costs from telemedicine technologies may be passed on to physicians and patients and become a barrier to accessing care.

*What is needed to determine the effect of telehealth expansion on prevention, urgent care, post-acute care, etc.?*

We believe it would be valuable to have government-funded studies evaluating and determining the effect of telehealth expansion. Findings from these studies could further inform telemedicine care delivery models, including best practices as well as telemedicine quality indicators.

*What principles should inform telehealth pay vs. in-person care and do these vary by service/mode of telehealth?*

PAI believes that payment parity for in-person and telehealth services should continue post-PHE. Reimbursement should remain informed by service type, as opposed to setting of care—to the most reasonable extent possible. Physicians should continue to have the flexibility to make a clinically-informed decision about whether a telehealth or in-person visit would be most beneficial for a patient, and they should have this flexibility without unnecessary and/or disconnected pricing incentives. The benefits and challenges of telehealth versus in-person care is dependent on several patient factors, both medical and non-medical.

To this end, we believe that telehealth and in-person care should be reimbursed at generally equal rates, with the exception of certain facility and resource-based adjustments when applicable, and that the ultimate differentiator in physician reimbursement should be dependent on the service type as well as value/quality of care provided.

**Enhancing patient safety and program integrity in remote care services**

*General Input*

PAI emphasizes the need for greater transparency is critical across the board, for billing, documentation, and process requirements, as well as greater communication and education to help physicians and patients make more informed care decisions. It is important that physicians continue to ensure the delivery of safe, high-quality, patient-centered care by applying and complying with the same or similar processes for telehealth services as in-person services.

Greater clarity is necessary for documentation guidelines surrounding telemedicine. One issue we have heard from physicians in the field is how to document the delivery of telemedicine services and what information to include in the medical record (e.g., a link to a recording of the telemedicine service or just a note that the service was provided via telemedicine technology, how the time for the service should be documented and used to support the correct billing level). Relatedly, more uniform guidance is necessary around billing and coding practices for telemedicine services. While there has been clarification on which modifier should be billed, there is still much variation across payers, for example, how telemedicine can be used to meet prior authorization requirements for procedures and treatments to prevent delays in treatment. Furthermore, physicians should have the opportunity to correct and rectify any inadvertent mistakes, especially during the transition period out of the PHE.
Data Flow, Care Integration and Quality Measurement.

General Input

Even though COVID-19 spurred greater adoption of telehealth services across healthcare, ongoing education and support will still be essential to ease the transition for many physicians, particularly for small practices. Additionally, greater support and continuity will be essential in value-based programs, quality measures, and for remote patient monitoring and communications-based technology services. These are described in detail below.

Telehealth services should count toward performance in value-based programs and related patient alignment/attribution as well as quality measure performance. It is important to extend and expand the flexibilities currently afforded during the PHE, e.g., including services provided via telehealth as primary care services under the Medicare Shared Savings Program, post-PHE. It is expected that patients will continue to seek telemedicine services after the end of the PHE, and we must take this shift in patient preference into consideration of our quality and other value-based efforts across specialties. For example, patients newly engaging with providers through telehealth may want to keep continuity with those providers and calls for that option likely will permeate future discussions on the issue.

Remote Patient Monitoring (RPM) and Communication Technology-Based Services (CTBS) (such as e-visits, virtual check-ins, and telephone assessments via smart phones, tablets, applications, etc.) have increased physicians’ abilities to provide additional care and care management services in addition to traditional telehealth and telemedicine services. During the PHE, CMS has relaxed flexibilities related to consent for these services, so that while consent is still required and must be documented, it is no longer an obstacle to patients receiving immediate attention and necessary care. RPM has historically played a critical role in the management of chronic diseases. As we transition out of the PHE, it is vital that we continue to expand access to RPM services for underserved and vulnerable populations, including but not limited to rural and urban patient populations, hospice and home care patients, and other long term care and rehabilitation facilities and locations. Furthermore, CTBS, and any other asynchronous communication services, will remain a vital touch point for underserved populations who may lack the resources to capitalize on telehealth platforms available.

Policymakers should extend flexibilities for RPM and other CTBS, including waivers of established relationship requirements and more flexible consent requirements. As well, policymakers should include incentives to ensure that patients are receiving care from local physicians and practices in their communities to preserve the patient-physician relationship.

Broader Policy Questions

What should criteria be for which emergency regulatory changes to keep vs. default to pre-COVID rules? As the U.S. recovers from the COVID-19 pandemic, the demand for health care services will continue to normalize (likely increase), as shown in recent trends; however, it remains to be seen how the public’s stance will evolve as it relates to the prioritization of in-person versus virtual care. From the physician perspective, we believe that it is paramount for current flexibilities in telehealth to be extended to maintain care continuity as we transition to a post-COVID-19 landscape. However, we also believe that certain safeguards should remain or be re-instilled to ensure that local and community-based physicians remain a central component of care delivery.
Therefore, when establishing any criteria for determining what changes to keep, we urge policymakers to consider extending policies that maintain or expand patient access to physician services without devaluing the role of local and in-person physician services that remain a crucial component of value-based care and care management/coordination.

**What role can federal and state policy play in giving patients and providers tools and technical assistance to meet telehealth needs?**

Federal and state policies play a critical role in expanding and/or establishing necessary funding streams to improve telehealth capacities of both physicians and patients. Current and future federal and state initiatives should focus on providing the necessary financial supports needed to help standup and expand physician platforms, as well as improve access to such platforms for patients (i.e., expanding broadband connection and funding tech capacity building initiatives), especially among rural and underserved regions.

**What have we learned during the pandemic that can be applied to policy on access, quality, safety, cost effectiveness, and outcomes?**

This pandemic has highlighted several opportunities and concerns within the U.S. health care system that can inform future policy. The following list represents the key issues and policy priorities that policymakers should consider post-COVID-19:

1. **To improve access,** policymakers should continue flexibilities for telehealth, remote patient monitoring (RPM), and communication technology-based services (CTBS), as well as continue increased reimbursement for telehealth services in Medicare, to ensure continued access to necessary services. However, to protect access to quality/effective care, these policies should not relieve insurers of their obligation and responsibility to offer adequate provider networks within a reasonable geographic proximity to their insureds. Such policies should also not expand the scope of practice of non-physician healthcare professionals beyond that supported by their licensure, education, and training prior to the PHE.

2. **To improve quality and cost-effectiveness,** policymakers should consider how current value-based payment initiatives, and associated quality metrics, should be modified, updated, postponed, tailored, or introduced to account for the ongoing shift to virtual settings of care. Furthermore, policymakers should extend the reporting and cost-sharing requirements for certain physician alternative payment models (APMs), as the COVID-19 PHE extends into the Fall of 2020.

3. **To improve access and quality,** it will remain critical that policymakers continue to financially support physician practices as they work to standup and expand telehealth/virtual platforms, as well as optimize operational and data interoperability capacities.

4. **To improve safety,** policymakers must develop and continuously work to improve our U.S. national stockpile, as well as timely allocation to those first line of defense community physicians and community health centers. It is especially critical to improve the stockpiling and distribution of necessary PPE among small and individual physician practices. This strategy must include consideration and engagement of states and state-level medical authorities.

5. **To maintain access,** policymakers should ensure all physicians impacted by a PHE are supported financially with disaster relief funding consistent with their entire practice profile, especially when they are treating some of the most medically vulnerable patient populations. It is important that there is equitable treatment and distribution of relief fund and reimbursement payments for those caring for the most vulnerable populations, e.g., Medicaid and Dual-Eligible patients, recognizing that many of these patients could have experienced increased severity of illness.
during the PHE. Specifically, additional funding, in addition to disaster relief funding and existing telehealth grants, should be provided to improve the virtual capacity and infrastructure of physician practices so they may continue to provide high-touch services to vulnerable patients (including funds to improve the technological capabilities of patients and caregivers).

6. To maintain access and prepare for future pandemics, policymakers should: establish a National Roadmap to inform state policies for how to safely continue physician services, screenings, etc. during any future surge/PHE; eliminate financial barriers to services for patients, including deductibles/cost-sharing and other insurance policy exclusions/requirements to ensure coverage for appropriate services, while also insuring appropriate physician reimbursement; establish policies that enhance insurance portability in the case of job loss and economic distress and also that make coverage for services needed to address the pandemic during an emergency period; and, improve price transparency requirements so that all patients and physicians are aware of cost-sharing obligations (or lack thereof) tied to certain services during a PHE (e.g., policymakers should mandate that cost-sharing obligations relating to certain services are displayed publicly and communicated effectively to both p

We reaffirm our belief that opportunities exist to improve the health system by enacting new policies and modernizing antiquated regulations that promote responsible expansion of physician services through telehealth and other communication technology-based services. We believe in fostering innovative technology-enabled approaches to physician service delivery that will continue to improve access to invaluable physician care, especially among rural and underserved communities most vulnerable to the global and systematic impact of the COVID-19 pandemic.

If you have any questions, please contact Kelly C. Kenney, PAI’s Executive Vice President and CEO, at k2strategiesllc@gmail.com.

Sincerely,

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President, Physicians Advocacy Institute