April 27, 2021

The Honorable Lloyd Doggett
Chair
House Committee on Ways and Means
Subcommittee on Health
2307 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Devin Nunes
Ranking Member
House Committee on Ways and Means
Subcommittee on Health
1013 Longworth House Office Building
Washington, D.C. 20515

Re: MGMA written comments – House Ways and Means Health Subcommittee hearing on "Charting the Path Forward for Telehealth"

Dear Chair Doggett and Ranking Member Nunes:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing on "Charting the Path Forward for Telehealth" and we appreciate the opportunity to provide the physician practice perspective on this topic. Throughout the COVID-19 pandemic, MGMA members have embraced the telehealth flexibilities to safely care for their patients. In late March 2020, 97% of MGMA members reported that their practices expanded telehealth access amid COVID-19.[1] MGMA supports congressional efforts to ensure that Medicare beneficiaries have greater access to telehealth services, but would like any future legislation to take into account the importance of the patient-physician relationship.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations as the Subcommittee and lawmakers consider legislation to potentially extend telehealth flexibilities past the conclusion of the COVID-19 PHE.

Medicare telehealth policy recommendations for consideration:

I. Preserve the patient-physician relationship to promote high-quality care

MGMA supports the expansion of telehealth access, but believes it is critical to develop policies that would preserve and promote the patient-physician relationship. Policies should bolster care continuity and not promote fragmented care in the form of patients seeking services from multiple independent vendors, which may also drive overutilization of telehealth services. Those providing care via telehealth should have access to a patient's medical history and the ability to follow-up in-person if appropriate—critical elements of care that vendors not associated with an existing physician-patient relationship will not be

[1] MGMA Stat, March 31, 2020

able to deploy. Vulnerable Medicare patients must look to telehealth to support, not disrupt, the continuity of care they receive from their trusted physicians.

II. Remove geographic and originating site restrictions

To successfully expand telehealth services to Medicare beneficiaries, the geographic and originating site restrictions under current section 1834(m) should be permanently removed. Before the COVID-19 PHE, in 2016, only 0.25% of beneficiaries in fee-for-service Medicare utilized telehealth services.[2] After the telehealth waivers went into effect, from March 17, 2020 through June 13, 2020, over 9 million beneficiaries had received a telehealth service.[3] Without removal of existing geographic and originating site restrictions, telehealth utilization will drop significantly to the detriment of millions of Medicare beneficiaries who would otherwise continue to benefit from increased access to their physicians.

Transportation and mobility challenges existed before the COVID-19 PHE and will remain after it ends. Transportation barriers lead to missed appointments and delayed care, resulting in poorer health outcomes. Studies show this is particularly the case for those with lower incomes and those who are under or uninsured.[4] The elimination of geographic and originating site restrictions paired with broadband expansion will improve access to care for many underserved areas of the country.

III. Allow permanent coverage of audio-only services

Audio-only visits can provide a lifeline to patients who are unable to attend visits in person or participate in telehealth visits due to lack of broadband access or necessary equipment to facilitate the visits. Throughout the COVID-19 PHE, MGMA has received feedback from group practices on the incredible value of audio-only services. In an August 2020 poll conducted by MGMA, 82% of respondents reported that they had billed an audio-only service during the public health emergency.[5] MGMA members report that in some cases, these services are the only means of treating certain patients virtually. One MGMA member in Oregon, reported that 80% of the practice's virtual visits were audio-only due to much of the population not having access to video capabilities. In many cases, practices try to facilitate a video visit, but due to internet or other technical difficulties, the visit ultimately becomes an audio-only one. A MGMA member from North Carolina reported that in 2020, 68% of her gastroenterology practice's video visits transitioned to audio-only visits because the video component failed.

A 2019 Federal Communications Commission (FCC) report estimates that over 21 million individuals do not have access to broadband.[6] Further, researchers have estimated that 41% of Medicare patients lack access to a desktop or laptop computer with a high-speed internet connection at home.[7] The need for these services will not disappear upon the conclusion of the COVID-19 PHE, but the ability to deliver them to Medicare beneficiaries will without congressional action.

IV. Reimburse telehealth visits equally to in-person visits

Outside of the COVID-19 PHE, telehealth visits are reimbursed at the "facility rate" in Medicare, which represents a significant reduction in practice expense payments for overhead costs. MGMA has heard

[2] "Information on Medicare Telehealth," Centers for Medicare & Medicaid Services, Nov. 15, 2018
[3] "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19," Seema Verma, Health Affairs, July 15, 2020
[4] "Traveling Towards Disease: Transportation Barriers to Health Care Access," Samina Syed, Ben Gerber, Lisa Sharp, J Community Health, Oct. 2013
[5] MGMA poll, Physician Fee Schedule Q&A, Aug. 26, 2020
[6] FCC, "2019 Broadband Deployment Report," May 19, 2019
[7] Eric T. Roberts, PhD1; Ateev Mehrotra, MD, MPH, "Access Among Medicare Beneficiaries and Implications for Telemedicine," JAMA Internal Medicine, Aug. 3, 2020

from member practices that the cost and administrative burden of providing care to patients is not significantly reduced when care is furnished via telehealth. Practices still must schedule visits, virtually check-in patients, facilitate and document the visits, and schedule follow-up appointments. There is also the added expense of HIPAA compliant IT infrastructure costs and troubleshooting technical issues. Practices have struggled to establish multiple workflows to accommodate both virtual and in-person visits. MGMA believes that for telehealth to be a viable option following the conclusion of the COVID-19 PHE, reimbursement should account for the many factors and costs that are involved in facilitating a telehealth visit.

Conclusion

We thank the Subcommittee for its leadership on this critical issue. We look forward to working with you and your congressional colleagues to craft sustainable telehealth policies that will allow medical group practices to continue providing virtual care to vulnerable patient populations following the COVID-19 PHE.

Regards,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs