REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (JUN-21)
Addressing Equity in Telehealth
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)
(Reference Committee A)

EXECUTIVE SUMMARY

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council decided to initiate a report addressing equity in telehealth, believing that additional AMA policy is needed to advocate for solutions and infrastructure that facilitate equitable telehealth access. In addition, this report specifically responds to Items (a) and (c) of the second resolve of Alternate Resolution 203 that were referred and referred for decision, respectively, at the November 2020 Special Meeting of the House of Delegates.

Existing AMA policy addressing equity in telehealth recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

The Council welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the novel coronavirus pandemic. To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 07-JUN-21

Subject: Addressing Equity in Telehealth
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council believes that additional AMA policy is needed that advocates for solutions and infrastructure that facilitate equitable telehealth access. Policy D-480.963, newly adopted at the November 2020 Special Meeting of the House of Delegates, states that our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and supports the use of telehealth to reduce health disparities and promote access to health care. This new policy provides an essential foundation upon which additional policy addressing equity in telehealth can be developed and is consistent with the AMA's recent adoption of a new, eighth enterprise value embracing equity, which states: "We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation." Furthermore, AMA's vision statement for health equity states: "The AMA's vision for health equity is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, everyone has the power to achieve optimal health, and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the health care system."

In addition, at the November 2020 Special Meeting of the House of Delegates, four potential additions to the second resolve of Alternate Resolution 203 were referred or referred for decision. The second resolve of Alternate Resolution 203-Nov-20, which is now Policy D-480.963[2] asked:

> That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:
>
> 1. provide equitable coverage that allows patients to access telehealth services wherever they are located; and
> 2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second resolve. Items (a) and (b) were referred. Items (c) and (d) were referred for decision.

a) promote continuity of care by preventing payers from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
c) provide equitable payment for telehealth services that are comparable to in-person services.
d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Items (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report specifically responds to Items (a) and (c); Council on Medical Service Report 8, also being considered at this meeting, addresses Items (b) and (d).

This report provides background on barriers to and inequities in accessing telehealth; highlights programs and pathways to augment the ability of physicians to provide telehealth to historically marginalized and minoritized communities; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

The expansion of telehealth services as a result of the novel coronavirus (COVID-19) pandemic has positively impacted patients who now have the ability to utilize telecommunication technology to access their physicians without having to navigate public transportation in densely populated urban communities, take time off from work to commute to and from the appointment, or drive lengthy distances in rural areas to attend an outpatient office visit with a specialist. In addition, telehealth provides a mechanism to overcome other barriers affecting patients' ability to access in-person services, including functional impairments that make it difficult to get to a physician's office or require a family member, friend, or caregiver to accompany the patient, and the need to find care for children or grandchildren. Importantly, the increased use of telehealth provides another pathway for physicians to learn more about the social determinants of health that may influence a patient's health and access to health care, including one's living environment, economic stability and food security.

Overall, according to a recent survey, during the first six months of the COVID-19 pandemic, one-third of adults ages 18 to 64 reported having had a telehealth visit--defined in the survey as either audio-only or two-way audio-video. Adults with multiple chronic conditions as well as those in poorer health were much more likely to report using telehealth to access care than their counterparts. Black and Hispanic adults were more likely to use telehealth than White adults, and adults living in metropolitan areas were more likely to have used telehealth than adults living outside metropolitan areas. At the same time, patients reported going without a telehealth visit despite wanting one; adults in fair or poor health, those with chronic conditions, and Hispanic adults were more likely to report going without wanted telehealth care.[1] Of the Medicare fee-for-service population, more than 9 million beneficiaries received a telehealth service during the period ranging from mid-March through mid-June of 2020. More than 20 percent of Medicare beneficiaries residing in rural areas used telehealth services during that time, with 30 percent of beneficiaries in urban areas accessing telehealth services.[2]

Examining outpatient visits and telehealth use in a database of 16.7 million commercially insured and Medicare Advantage enrollees, a study showed that 30.1 percent of all visits from

March 18, 2020, to June 16, 2020, were provided via telehealth. During this period, the weekly number of telehealth visits among the population studied increased to 397,977 visits per week, up from 16,540 visits per week during the period from January 1, 2020, to March 17, 2020. However, not all of these services were distributed evenly across different population groups. Notably, the percentage of total visits provided via telehealth was smallest among those ages 65 and older. In addition, health plan enrollees residing in counties with the lowest percentages of residents with incomes below the federal poverty level, and percentages of White residents had a greater proportion of total visits delivered via telehealth from March to June 2020 when compared with counties with higher percentages of these residents. In addition, a lower percentage of care was provided by telehealth in rural counties than in urban counties.[3]

Other studies also have reported inequitable access to telehealth services during the COVID-19 pandemic, as well as potential reliance on or preference for audio-only visits over two-way audio-video visits. For example, a cohort study of patients with appointments for primary care and specialty ambulatory telehealth visits during March through May of 2020 at a large academic health system showed that older adults, patients with limited English proficiency, Medicaid beneficiaries, and Asian patients had lower rates of telemedicine utilization. The study also found that Black, Hispanic, lower-income, female and older patients had lower rates of two-way audio-video utilization.[4] In addition, a claims-based analysis of approximately 7 million commercially insured patients found that, in the early stages of the pandemic in March and April of 2020, zip codes with 80 percent or more residents of historically minoritized racial/ethnic communities had smaller reductions in the use of in-person office visits, and smaller increases in the use of telehealth, than zip codes with 80 percent or more White residents.[5] CMS has estimated that of the Medicare fee-for-service beneficiaries who accessed a telehealth service in the early months of the pandemic, 30 percent used audio-only telephone technology,[6] with other studies showing higher rates of utilization of audio-only visits among low-income patients.[7]

BARRIERS TO TELEHEALTH ACCESS FOR PATIENTS

Telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities that have been impacted disproportionately by the COVID-19 pandemic. However, far more emphasis needs to be placed on ensuring that telehealth solution functionality, content, user interface, and service access are designed in an equity-centric participatory fashion with and for historically minoritized and marginalized communities, including addressing culture, language, digital literacy ability, and broadband access. In addition to assessing how solutions are designed, it is also critical that an upstream lens is used to understand the root causes of barriers to optimal use of telehealth services within historically marginalized communities, namely systemic racism and inequitable resource allocation impacting infrastructure development and access to economic and education opportunities.

In 2019, 25 million individuals in the US did not have internet access at home, and 14 million did not have equipment capable of playing video--essential for two-way audio-video telehealth--such as a smartphone, tablet, computer or other connected device.[8] Not all home internet services are equal; speed and bandwidth issues may continue to serve as obstacles to accessing telehealth services even for patients who have internet access at home. In addition, patients who only have a smartphone and solely rely on their phone's data plan and capacity for internet access may confront data and bandwidth challenges in accessing two-way audio-video telehealth visits.

There are, notably, racial and ethnic inequities in access to the internet, with a larger percentage of Black and Hispanic individuals not having internet access at home. Individuals residing in rural

areas are less likely to have access to the internet at home than those in urban areas. Age-related disparities also exist, with older individuals being less likely to have internet access at home. Significantly, Medicare and Medicaid beneficiaries make up two-thirds of those who lack internet access at home, and the uninsured make up 15 percent.[9]

In addition, the continued use and expansion of telehealth rely on equitable design to meet the need for varying levels of patient digital literacy, and how the availability of telehealth services is communicated to patients. Individuals without access to a computer or smartphone may be left out of telehealth service offerings. Even among patients with equitable access to devices and to the internet, there remain exclusionary and suboptimal design issues requiring patients to navigate email, fill out a form online or find a website--significant barriers to participating in a two-way audio-video telehealth visit. Requiring the use of a patient portal for accessing telehealth services can serve as another barrier for patients. Furthermore, the lack of transparency and equity in the design of privacy and security policies and practices in many telehealth solutions cause hesitancy among some patients as to the safety and security of telehealth visits with their physicians.

AUGMENTING THE ABILITY OF PHYSICIANS TO PROVIDE TELEHEALTH TO HISTORICALLY MARGINALIZED AND MINORITIZED POPULATIONS

To help close the digital divide in access to telehealth services, initiatives at the state and federal levels can serve as examples of, and first steps towards, what needs to be done to address some of the upstream barriers to equity in telehealth--including ensuring affordable access to needed technology to engage in two-way audio-video telehealth and investing in broadband capacity in underserved communities. Patient access to telehealth is inextricably linked to whether and how such services are covered by their health plans, including whether they can use telehealth to access care from their regular physician. Barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only.

Federal and State Initiatives Addressing Equity in Telehealth Service Delivery and Access

Increased investments in telehealth service delivery and access are essential to ensure patients can maintain needed access to health care regardless of where they are and augment the ability of physicians to provide telehealth to populations who cannot currently access telehealth services. Federal initiatives have recently been launched to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. In addition, many states have leveraged available Medicaid authorities to provide technology and care coordination support to augment the ability of Medicaid beneficiaries to access telehealth services during the COVID-19 pandemic.

Connected Care Pilot

Under the auspices of the Federal Communications Commission (FCC), the Connected Care Pilot Program is a temporary program that will provide up to $100 million over a three-year period to defray the costs faced by selected health care providers in providing connected care services, prioritizing providing these services to low-income or veteran patients. The Connected Care Pilot will cover 85 percent of the eligible costs incurred by selected pilot programs of patient broadband internet access services, health care provider broadband data connections, other connected care information services, and certain network equipment. Provider eligibility for the Connected Care]Pilot Program is limited to public and nonprofit providers, including community health and mental

health centers; local health departments; rural health clinics; skilled nursing facilities; not-for-profit hospitals; and other entities.[10]

COVID-19 Telehealth Program

The COVID-19 Telehealth Program was established by the FCC in response to the COVID-19 public health emergency to assist health care providers in providing connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. The FCC adopted the Program in a report and order released in April 2020. Through this program, the FCC will distribute the $200 million appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, providing immediate support to eligible health care providers--limited to public and nonprofit providers like the Connected Care Pilot--responding to the COVID-19 pandemic. The FCC has outlined the following examples under the auspices of the three main categories of eligible services related to the delivery of connected care that could be funded under the Program:

- Telecommunications Services and Broadband Connectivity Services: Voice services for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equipment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.[11]

Emergency Broadband Benefit Program

In February 2021, the FCC formally adopted a report and order to establish the Emergency Broadband Benefit Program, a program with $3.2 billion in federal funding aimed at providing financial assistance to qualifying households to help cover the costs of broadband and device ownership. Broadband access and device ownership are critical building blocks to enable more equitable patient access to telehealth. Under the program, eligible households can receive discounts of up to $50 per month for broadband service, up to $75 if the household is on Tribal lands. Eligible households will also be eligible for a one-time discount of up to $100 for the purchase of a computer or tablet. Households eligible for assistance under the Emergency Broadband Benefit Program include those that participate in an existing low-income or pandemic relief program offered by a broadband provider; Lifeline subscribers, including those who are Medicaid beneficiaries or receive Supplemental Nutrition Assistance Program (SNAP) benefits; households with children receiving free or reduced-price school meals; Pell grant recipients; and those who have lost jobs and experienced reductions in their income in the past year.[12]

Medicaid Appendix K Waivers

Medicaid Appendix K is a stand-alone appendix that states can use during emergencies, such as the COVID-19 pandemic, to request amendment to approved 1915(c) home and community-based waivers. During the COVID-19 pandemic, states have used Medicaid Appendix K authority to provide needed technology and care coordination support to targeted beneficiaries. For example, New Mexico was approved to provide up to $500 to select Medicaid beneficiaries who do not

currently have access to a computer, tablet or other device to purchase such a device to support their access to telehealth, including two-way audio-video as well as needed training.[13] Kansas was approved under Medicaid Appendix K authority to provide remote monitoring technology and requisite training to beneficiaries with chronic diseases.[14]

Covering Telehealth Services by Patients' Physicians

Referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting was to "promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice." Patient access to telehealth is inextricably linked to whether telehealth services provided by their physicians--the physicians with whom they have a relationship--are covered by their health plan. The AMA has been highly active on the state and federal levels to ensure that health plans allow all contracted physicians to provide care via telehealth, and that cost-sharing is not used to incent care from other providers. Prior to the COVID-19 pandemic, many health plans established a separate network for telehealth or select telehealth providers, which did not always include contracted physicians who provide in-person services. As a result of the pandemic, adoption of telehealth has increased dramatically and is more likely to be available from an individual's physician. AMA advocacy on the state and federal levels has underscored that the pre-pandemic separation of telehealth and in-person visits can no longer be justified based on low levels of adoption that no longer exist. In addition, the AMA has stressed that the perpetuation of separate networks is confusing for patients and threatens continuity of care and the patient-physician relationship.

For example, AMA model state legislation addressing this issue, the Telemedicine Reimbursement Act, states that "each carrier offering a health plan in this state shall provide coverage for the cost of health care services provided through telemedicine on the same basis and to the same extent that the carrier is responsible for coverage for the provision of the same service through in-person treatment or consultation. Coverage must not be limited only to services provided by select corporate telemedicine providers." In addition, in an April 2020 comment letter in response to a proposed rule on the Medicare Advantage program, the AMA stated that "the rapid deployment of telehealth services by physicians in response to the COVID-19 pandemic is significantly changing the practice of medicine in ways that are likely to last long after the pandemic. Many patients are now having office visits with their regular physicians via telehealth. The AMA strongly encourages MA plans to cover telehealth visits and other services, at a minimum for those on the Medicare telehealth list, with their physicians. The AMA is aware that some plans contract with telehealth providers and encourage their enrollees to use these other services instead of covering telehealth services provided by the patients' regular physicians. Patient advocates have made it very clear that what is most important to patients is for all members of the patient's health care team to be involved in, and adhere to, the patient's treatment plan. This continuity of care will not be possible if patients are directed to separately contracted telehealth providers even when the patients' regular physicians are able to provide the services via telehealth themselves."[15]

In addition, AMA advocacy has underscored that the cost-sharing for services provided via telehealth should not vary based on the telehealth provider. Reducing cost sharing for select telehealth providers who do not also provide in-person care inappropriately steers patients away from their current physicians, fragmenting the health care system and threatening patients' continuity of care. Importantly, the AMA has stressed that health insurers should ensure transparency in coverage and patient cost-sharing of services provided via telehealth, and health care professionals should effectively communicate information about the scope of telehealth visits to patients.

Ensuring Fair and Equitable Payment for Two-Way Audio-Video and Audio-Only Visits

Relevant to Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, several states enacted Executive Orders early in 2020 requiring payers to provide equivalent payment for two-way audio-video visits, and sometimes audio-only visits, as compared to in-person visits. Through the end of the COVID-19 public health emergency, CMS will continue to pay for telehealth visits equivalent to in-person office visits. In the Final Rule for the 2021 Medicare Physician Payment Schedule, CMS stated that audio-only visits, described by CPT codes 99441-99443, will not be payable after the conclusion of the COVID-19 public health emergency. CMS will allow payment, however, for brief communication technology-based services (e.g., virtual check-in), described by codes G2251 and G2252, at 2021 payment rates of $15 and $27 respectively.

During the COVID-19 public health emergency, two-way audio-video visits are reported with existing Current Procedural Terminology (CPT) codes for office visits. Prior to the COVID-19 public health emergency, payment for two-way audio-video telehealth visits was typically equivalent to an office visit provided in a facility setting (e.g., outpatient hospital clinic), where the physician is presumed to incur no direct costs (clinical staff, medical supplies and equipment). During the COVID-19 public health emergency, payment for two-way audio-video visits was paid equivalent to an office visit provided in a non-facility setting (e.g., physician's office). It is likely that the CPT Editorial Panel will receive an application to modernize the CPT codes describing audio-only services to address the CMS concerns and to align with the temporary G codes. After such an action, the AMA/Specialty Society RVS Update Committee would review the resources typically required to perform these services.

RELEVANT AMA POLICY

Newly adopted at the November 2020 Special Meeting of the House of Delegates, Policy D-480.963 states that our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-CoV-2; (2) will advocate that the federal government, including CMS and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Policy H-478.996 states that it is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology.

Relevant to referred-for-decision Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy D-480.965 states our AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. Established by Council Report 7-A-14, Policy H-480.946 outlines principles to guide

the coverage and payment of telemedicine services. Regarding payment for audio-only visits, Policy H-390.889 states that our AMA supports and advocates with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; and continues to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services.

Relevant to referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy H-480.946 states that patients seeking care delivered via telemedicine must have a choice of provider; and that telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. Policy D-155.987 advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information or other plan designs that may affect patient out-of-pocket costs.

DISCUSSION

While the AMA has foundational policy pertaining to the coverage and payment for telehealth, Policy D-490.963, adopted at the November 2020 Special Meeting, serves as an essential step forward in developing policy specific to addressing equity in telehealth. The new policy, as well as Policy H-478.980, recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit. As such, the Council recommends reaffirmation of Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

In addition, it is essential for physicians to serve as leading partners in efforts to improve the access of historically marginalized and minoritized communities to telehealth services. The Council

welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. However, eligibility of physician practices for these programs remains quite limited, and the Council sees tremendous potential in expanding eligibility for these programs so that physicians are able to help their patients engage with and access telehealth services.

To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Policy D-480.969 provided a policy foundation in this regard, advocating for telemedicine parity laws that do not limit coverage only to services provided by select corporate telemedicine providers, relevant to the emergence of companies including Amazon expanding in the telehealth space. The Council is concerned that physicians are being prevented from, or facing barriers to, providing covered services via telehealth to their patients. In addition, cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network. Such incentives could also include creating separate cost-sharing requirements or structures for in-person care and care provided via telehealth.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. The expanded use of audio-video telehealth services during the COVID-19 pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients and those in rural and other areas with limited internet access. In addition, some patients, even those who own the technology needed for two-way real-time audio-video communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Fair and equitable payments will help ensure that patients are able to receive the right care, via the most appropriate and accessible modality, at the right time.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy)

3. That our AMA recognize access to broadband internet as a social determinant of heath. (New HOD Policy)

4. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy)

5. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (New HOD Policy)

6. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. (New HOD Policy)

7. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD Policy)

8. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (New HOD Policy)

9. That our AMA support expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)

10. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. (Reaffirm HOD Policy)

11. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth. (New HOD Policy)

12. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (New HOD Policy)

13. That our AMA advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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