AAPM&R Collaborates with Peer Societies to Advocate for COVID-19 Telehealth Coverage, Response Tools, Waiving Requirements, and More

As a member of the Council of Medical Specialty Societies (CMSS), AAPM&R collaborated with more than a dozen specialty societies and the American Medical Association to send a message to the White House Coronavirus Task Force with the priorities we collectively agreed on (listed below). AAPM&R will continue our efforts toward advocating for PM&R-specific priorities.

Issue 1: Access to COVID19 Response Tools

Federal, state, and local governments must ensure the health care community has timely access to the basic tools needed to respond to the COVID-19 Pandemic, including those listed below. CMSS and its member societies recommends the federal government utilize every lever at its disposal to address these needs and that your Task Force urge state and local governments to do the same within their areas of jurisdiction.

- **Personal protective equipment** (masks, gloves, gowns, N95 etc.): The lack of PPE for health care providers is directly causing the spread of the novel coronavirus. PPE must be secured and distributed to frontline physicians and other clinicians. This issue needs to be of the highest priority for the manufacturers, distributors and the administration.
    - While the focus has appropriately been on front-line clinicians, our specialty societies want to elevate the need for PPE for other at-risk staff (e.g., radiology technologists, laboratory personnel).

- **COVID-19 testing:** The availability of testing must be ramped up immediately. It is critical that these tests be distributed and administered in an equitable manner.

- **Hospital capacity**: The nation is in desperate need for greater capacity, including ventilators, intensive care units, and hospital beds. Many hospitals will need to increase space with greater accommodation for patients needing isolation.

- **Monitor and ensure access to life-saving medications**: There is serious concern with access to needed medications including hydroxychloroquine for patients with rheumatoid arthritis and lupus as well as medications that will be needed to treat Covid-19, including diuretics and anticoagulants. There is also a critical need for blood.

- **Surge capacity for other needed services:** Beyond pandemic-related medical services, it will be critical to provide surge capacity for other services including mental health and substance use (e.g., crisis call center hubs, mobile crisis teams, and crisis receiving and stabilization facilities).

Issue 2: Expand Telehealth Coverage

Telehealth is a priority strategy for the screening and triaging of patients who believe they are infected with COVID-19. The administration should immediately support the health care system's ability to respond to the COVID-19 Pandemic by mandating important changes that would support telehealth:

- **Waive the requirement for a video element for telemedicine**: High percentages of Medicare beneficiaries fall in categories least likely to have access to video capabilities, including more rural areas, the elderly, and those with serious health conditions. These are many of the same patients who are more vulnerable to COVID-19 and would be at greater risk if forced to travel somewhere for a face-to-face visit should that even be an option.
    - Parity in payment and billing codes for telephone visits are urgently needed, especially for high-risk populations (e.g., mental health and substance use diagnoses).
    - Public and private payers should compensate for all telephone visits at the same level as face-to-face visits for the duration of the national emergency
        - Specifically, provide reimbursement for CPT codes 99441 – 99443 which are telephone evaluation and management services (E/M) provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. This would provide an option for patients and physicians that need to conduct a longer conversation of up to 30 minutes if necessary and also would not require that the discussion be patient-initiated.
- All types of telemedicine, including telehealth visits, virtual check-ins, phone consultations, and e-visits available to both new and established patients. Health and Human Services (HHS) has noted it will not conduct audits to ensure prior patient relationships for telehealth visits, however this flexibility was not extended to virtual check-ins or e-visits.

Address other key telehealth issues by:

- Including payment for telehealth under the Medicaid program.
- Requiring private health insurers (including ERISA plans) to adopt a similar policy to the Centers for Medicare and Medicaid Services for telehealth coverage.
- Relaxing restrictions around state licensing to allow telemedicine coverage for patients in other jurisdictions.
- Relaxing restrictions for in-person certification or recertification for patients at risk (e.g., hospice patients, supplemental oxygen).

<u>Issue 3: Address Other Policy Considerations</u>

Suspend MACRA Reporting Requirements and delay required reporting of the 2019 MIPS to the end of the year. At this moment in history, the nation's physicians should focus on being doctors and surgeons, not administrative reporting. While we appreciate that CMS has taken steps to extend MIPS reporting to April 30, 2020, we would recommend further extension to the end of 2020.

Direct financial assistance for practices: Treatments are delayed, patient volumes are dropping, staff are being laid off or getting sick, and other financial hits are impacting clinics, practices, and hospitals. Without direct financial assistance, many practices, particularly small- and medium-sized practices could go bankrupt. Like hospitals, practices are significant small business employers in their local communities. Please ensure that physician practices are recognized as small businesses with access to small business assistance and relief programs.

Waivers for regulatory and administrative requirements: Waivers are needed to remove barriers to providing care in inpatient, outpatient, and post-acute care settings (e.g., IRF 3-hour rule, prior authorization). In addition, practices and clinics do not have the bandwidth during the outbreak to make the significant changes necessary for required participation in alternative payment models (APMs) and deadlines for participation should be delayed.

Support Congressional funding for critical safety net programs. Programs that meet the needs of communities struggling with this pandemic include the Community Health Center Program, the Community Mental Health Program, the Teaching Health Center Graduate Medical Education Program, and the National Health Service Corps. The administration should support congressional efforts to reauthorize these programs as soon as possible.

Provide clear and timely clinical guidance: Physicians and other clinicians need evidence-base guidance on key issues, such as antimicrobial resistance, as well as the continuation of regular medication regimens, such as angiotensin-converting-enzyme inhibitors and angiotensin II receptor blockers for COVID-19 patients. The administration should make a public statement about both these issues to help address the current confusion among patients and their health professionals.