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ENSURING MEDICARE BENEFICIARY ACCESS: A PATH TO TELEHEALTH PERMANENCY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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ENSURING MEDICARE BENEFICIARY ACCESS: A PATH TO TELEHEALTH PERMANENCY

TUESDAY, NOVEMBER 14, 2023

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:30 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Benjamin L. Cardin (chairman of the subcommittee) presiding.

Present: Senators Wyden, Whitehouse, Hassan, Cortez Masto, Daines, Thune, Young, Barrasso, Johnson, and Blackburn.

Also present: Democratic staff: Martha P. Cramer, Staff Director for the Subcommittee on Health Care of the Senate Committee on Finance, and Health Policy Advisor for Senator Cardin; Michelle Galdamez, Legislative Aide for Senator Cardin; and Matt Kearney, Legislative Correspondent for Senator Cardin. Republican staff: Grace Bruno, Health Policy Advisor for Senator Daines; and Matthew May, Legislative Aide for Senator Daines.

OPENING STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. SENATOR FROM MARYLAND, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator CARDIN. The Subcommittee on Health Care of the Senate Finance Committee will come to order.

The subcommittee today is holding a hearing on "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." I want to thank Senator Daines for his help in arranging for this hearing. The two of us have worked together in regards to the subcommittee's agenda during this year, and I want to particularly thank Chairman Wyden and Ranking Member Crapo for their support of our subcommittee and the work of our subcommittee.

Mr. Chairman, thank you for giving us the ability to establish an agenda. Our subcommittee has been busy during this year. We have had an active agenda dealing with health disparities, whether it is oral health or in rural communities or home health-care challenges. We have worked to try to put a spotlight on the disparities in our health-care system, and solutions that can help improve access to health care.

I particularly also want to thank Martha Kramer of my staff for work that she has done in putting together our agenda and our hearings, including this hearing on telehealth.

Let me just, by way of background, give you a little bit of my own personal experiences before the COVID pandemic, on the need

for telehealth. I think it was first brought to my attention when I was visiting Pocomoke City, MD. For those who do not know where Pocomoke City, MD is, Senator Daines, it is in a very rural part of our State.

I was visiting a veteran's health facility and witnessing a veteran getting ophthalmology care via telehealth through an ophthalmologist located in Baltimore, 150 miles from that clinic—and getting timely services. This individual would not have had services but for telehealth, because it would not have been possible to arrange the type of transportation to get to Baltimore.

So I saw firsthand what telehealth means as far as access to care—timely care and quality care. It is also less costly for the consumer, that is for sure. The consumer can get the care without having to change their work schedule and transportation schedules, et cetera. It is what the patient really wants, and it gives greater access to care than we would otherwise see.

Now, COVID put a real spotlight on telehealth. We saw a 63-fold increase in telehealth services in the Medicare population during COVID. I think we understand why, and Congress responded by removing some of the hurdles in telehealth.

Chairman Wyden, I particularly want to thank you and Senator Crapo for allowing us to establish a task force to deal with mental health issues. One of those task forces that dealt with mental health dealt with telehealth. Senator Thune and I cochaired that particular task force. So, many of our recommendations were incorporated in changes in the law, and that made it easier for telehealth services to be made available during the COVID pandemic.

Now, some of those provisions were made permanent. Others will expire. Several will expire at the end of 2024. We are talking about issues such as removing the restrictions on geography and who can receive telehealth services; the requirement for an in-person visit for certain telehealth services; the use of audio-only, which is an option that in many parts of our country is the only option available; and the qualifications for our qualified health centers and our rural health centers to be able to qualify as service providers for telehealth.

Those all will expire at the end of next year, and one of the reasons we are holding this hearing is to underscore the importance of permanency. Why? If you are investing in a health facility, you need to have the predictability to know that these services are going to be able to be continued well before the expiration date. And if you are a patient with a provider and you have a health plan, you need to know that health plan is not going to be disrupted because Congress is a little late in extending the programs. So, for all those reasons, it is important that we deal with the permanency of these provisions. That is the reason for this hearing.

There are a lot of misconceptions about telehealth that I think have been dispelled by so many studies that have been done. There have been studies done in regards to utilization and cost. It has certainly been very much manageable, much less than was anticipated when we acted in these areas.

So, there are a lot of areas where I hope we can dispel some of the concerns that have been expressed over the years. It is, I think, intuitive to us that if it is a choice between receiving no care or

receiving telehealth, that is not really a cost to our system. That is access to care, keeping people healthier, and doing what is necessary in order to make sure we have quality health care available to all.

With that, I will turn it over to my ranking member—who has been incredibly helpful in this year's agenda—Senator Daines.

OPENING STATEMENT OF HON. STEVE DAINES, A U.S. SENATOR FROM MONTANA

Senator DAINES. Mr. Chairman, thanks, and I want to thank you for your leadership with the subcommittee for this year. You know, it has been productive. We have had some very good hearings on relevant health policy issues. The chairman talked about a few, and I look forward to continuing to work together next year as well.

So I am glad we are turning our attention to the topic of telehealth, as we have had some crucial decisions and have some more coming at us to make when the Medicare pandemic-era waivers expire next year. For our conversation today, we are fortunate to be joined by a panel of some of the sharpest telehealth minds our country has to offer.

So I want to thank you all for bringing your experience, your expertise to our discussion, and for also making the trip to DC. I understand you have all traveled a ways to be here. I know that about Ms. Perisho, because she comes from my home State in Montana, and Whitefish is a ways away.

By the way, for those of you not familiar with Montana's geography, I appreciated the chairman's geography lesson today on Maryland. Let me put one out here on Montana. Whitefish is up in the very northwest corner of our State. It is the gateway to Glacier National Park. It is where my Montana-Norwegian ancestors actually built a hotel up there many, many years ago.

So I want to thank you, Ms. Perisho, for making the trip and being here to discuss this very important topic. I know you are a subject matter expert and passionate as well. We are glad you are here.

As we all know, the COVID–19 pandemic drastically changed our health-care sector in America, and our understanding of how we deliver health care. Telehealth, which was underused and understudied prior to 2020, suddenly became a crucial means of delivering health-care services to patients. Through a series of agency waivers and bipartisan legislation, the Medicare program pivoted over the last few years to allow for greater and more flexible telehealth access for beneficiaries.

Since implementing these flexibilities, we have seen the advantages that telehealth offers, and the expanded access it provides. In rural States like Montana and parts of Maryland, telehealth has completely changed the game in terms of health-care access.

At our rural health-care hearing earlier this year, I highlighted that two of our most challenging barriers to accessing care in rural States are distance and transportation. We might add weather at times in our Montana winters. With the ability to receive care virtually in the home, patients no longer have to travel multiple hours to see their providers, and the incorporation of audio-only tele-

health has increased access in areas without sufficient broadband infrastructure.

Telehealth also played a notable role in meeting the mental health needs of patients, arguably the mental health crisis we had during the pandemic, including in the Medicare population. Even after the height of COVID, CMS data reports that the share of Medicare services conducted via telehealth remains the highest for mental and behavioral health specialists.

Sadly, we are all aware of the mental health crisis in our country. Just last week in this committee, I joined my colleagues in marking up the BETTER Act, which contains significant proposals to expand access to mental health and substance use disorder services in our Federal health-care programs.

As the pandemic has demonstrated, telehealth can help us bolster mental health services and address some of the access gaps throughout the country. It is safe to say there is no going back now, as we have seen how transformative telehealth can be. We have proved the concept. The question is, how is Congress going to shape the future of telehealth when the Medicare waivers expire at the end of next year?

Policy decisions such as originating site eligibility, appropriate reimbursement, and in-person requirements will need to be addressed, and we are here to begin considering some of these policy questions. My colleagues in this committee and I have demonstrated our commitment to telehealth through various pieces of legislation which support and expand the flexibilities Medicare beneficiaries have relied on now the last few years.

My hope is that in today's conversation, we can help further inform the committee as we deliberate telehealth permanency.

Thanks again to our witnesses. We appreciate your continued work, your dedication, your expertise. We look forward to hearing from you. And most of all, thanks, Mr. Chairman.

[The prepared statement of Senator Daines appears in the appendix.]

Senator CARDIN. Thank you. Thank you, Senator Daines.

Now I will recognize the distinguished chairman of our committee, Senator Wyden.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you, Mr. Chairman. I want to thank you and Senator Daines. And I am going to be very brief and just make sure people understand that what Senator Cardin and Senator Daines are doing is so important.

If you look at the history of this committee, we have been intensively involved in Medicare, really looking at its origins and how it has evolved over the years. And one of the things I am proudest of is, we have helped shape the future of Medicare, particularly by using telemedicine.

And we did that, colleagues, starting—you cannot give enough credit to the late Orrin Hatch, our chairman—with our CHRONIC Care bill, because our CHRONIC Care bill was the first piece of legislation to say, look, Medicare is not just acute care, like you broke your ankle, for example, Part A of Medicare. Or if you had

a horrible case of the flu and then you went to the doctor, that was Part B.

By the time Chairman Hatch and I and many of our colleagues here got together, millions of seniors did not really use Medicare that way. They had two or more chronic conditions: cancer, diabetes, strokes, COPD. They needed a very different kind of health system. We pulled that together in the CHRONIC Care Act of 2018.

And at the center of the CHRONIC Care Act were our telemedicine provisions, and on a bipartisan basis, we did some awfully good work. I mean, we made it possible to expand access to innovative telehealth treatment options for life-altering conditions—for example, like telestroke and remote monitoring of diabetes.

That was CHRONIC Care 1.0, folks. And one of my proudest moments, I will tell my Republican colleagues, is I remember getting a call from Seema Verma, who was then the head of the Centers for Medicare and Medicaid Services, and she said, "We just love what you guys are doing in chronic care. I hope we can work together on it." And she pretty much used the telemedicine provisions that my two colleagues are talking about, that were in the CHRONIC Care Act, as the foundation for dealing with COVID, where we had so many folks at home.

So now we have a chance to build on that, and that is what is so exciting about what my colleagues are doing. I am not going to be able to stay, but I am going to give the panel a couple of questions first. I would really like to see us expand State/interstate licensure compacts, because if we look at what we did with CHRONIC Care 1.0, it was all about information technology and common sense, just common sense to expand these compacts in the digital age when people are so mobile.

And second, I am going to pose a question, particularly to you, Ms. Perisho, about the next innovative ideas for telehealth. Give us the next ideas, if you would, to pick up on telestroke and remote monitoring of diabetes, and help us fill these rungs with people who are going to be talking to Senators of both political parties about some of the exciting new technologies we can do when Senator Cardin and Senator Daines and all my colleagues here take us to CHRONIC Care 2.0. Because that is what I am committed to doing.

Thank you both, and I will look forward to following up with both of you.

Senator CARDIN. Well, thank you, Chairman Wyden. We appreciate your support and what you have done to advance access and quality to health care. So, thank you very much for your leadership.

I will now introduce our four witnesses, and I want to join with Senator Daines in thanking each of you for being here. We do have an expert panel that can really help us understand the current state of play of telehealth, but just as importantly, where the hurdles are for the expansion of this care—and where are we heading, and how can we make sure that our health policies allow for the most advanced forms of health care to be available to our constituents.

So I thank all four of you for being here. Your entire statements will be made part of our record. We will ask, after the introductions, that you proceed, in about 5 minutes, to summarize your comments, so that we have time for questions from members of the committee.

First—and the order I introduce you is the order that you will make your presentations. First, Nicki Perisho—who has already been mentioned by two colleagues—is the program director of the Northwest Regional Telehealth Resource Center based out of the University of Utah.

Ms. Perisho joined her team virtually from Whitefish, MT, and I now know where that is; thank you very much. She has worked in telehealth since 2010 and is considered a pioneer in the field, leading efforts toward telehealth growth, utilization, and sustainability for more than decade.

Dr. Eric Wallace is a professor of medicine in the Division of Nephrology at the University of Alabama at Birmingham. In 2015, he began using telehealth for the care of his patients on home dialysis, and for patients with the rare disease called Fabry disease.

In 2018, he was hired as the medical director of the UAB Health Systems Telehealth Program. In this role, he oversaw the rapid transition of health-care delivery to telehealth during the COVID–19 pandemic.

Dr. Chad Ellimoottil is the medical director of virtual care for the University of Michigan Medical Group, an associate professor of urology at the University of Michigan, and a telehealth policy researcher. In his role as medical director of virtual care, he leads the strategic planning and implementation of virtual-care services across all specialties, overseeing approximately 450,000 virtual encounters annually.

And then, Ateev Mehrotra is a professor in the Department of Health Care Policy at Harvard Medical School. His research focuses on delivery and innovation and their impacts on access, quality, and spending. These include innovations such as telemedicine, retail clinics, and e-visits.

He also is interested in the role of consumerism and whether price transparency and public reporting of quality can impact patient decision-making.

With that, we will start with Ms. Perisho.

STATEMENT OF NICKI PERISHO, BSN, R.N., PRINCIPAL INVESTIGATOR AND PROGRAM DIRECTOR, NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER, WHITEFISH, MT

Ms. PERISHO. Chairman Cardin, Ranking Member Daines, and members of the Senate Committee on Finance and Subcommittee on Health Care, I want to take time to thank you for this opportunity. I would also like to note that the views I am sharing are my own personal opinions and do not reflect on the Health Resource Services Administration, nor my employer the University of Utah, or the NRTRC.

I am really pleased that the subcommittee is exploring telehealth and what it means to potentially make it permanent or extend the waivers past 2024. I am very passionate about the right care, the right time, the right place for patients, and ways that work for

them, while at the same time providing appropriate payment to the providers, practitioners, and facilities providing those health-care services.

I am humbled to be with my panel today, but what is missing from the panel, in my opinion, is patient perspectives. So I will do my best to put the patient perspective into my testimony.

So first of all, I am a nurse. I grew up in a household with health-care professionals, and I am very passionate and believe it is your right to have access and to receive high-quality health care, regardless of the geographic location you reside in.

Thank you, Senator Daines, for leading in with a little background about Montana. That is where I live, and so finding high-quality health care is not always easy. It is not always safe; it is not always affordable. Montana is the fourth largest State by area. It is the eighth least populous State, and the third least densely populated State.

Our largest city within our borders is Billings, coming in with a population of about 118,000. I think that is about the number of protestors who are out in the Mall right now. So that is our biggest city in our State, and that city of Billings is about 450 miles from my hometown of Whitefish.

I have been involved in telehealth since 2010, and some people joke with me that that was before telehealth was cool, and I have to agree. I think one of my most memorable—what got me into telehealth and to be passionate and drive the wagon is, in 2010, we started a telestroke program.

We had funding through the USDA, the U.S. Department of Agriculture, and the Distance Learning and Telemedicine funding, to provide audio, video, and telehealth equipment to three Critical Access Hospitals in rural Montana. We had a team of neurologists that we worked with that were very passionate about telehealth as well, and I saw firsthand the benefits of stroke patients being administered tPA—which is the clot-busting drug for an ischemic stroke—for patients who otherwise would not have received this medication.

To this day, it has grown to 13 Critical Access Hospitals, and this summer they actually administered their hundredth dose of tPA. All of these Critical Access Hospitals had never given tPA before. So not only is that a cost saver for the health system, because a lot of these patients would have long-term modalities that would need therapies, but now a lot of them are able to live their lives as they were.

So, based on my experiences in working with telehealth, there are four key areas that I would like to see made permanent: eliminating the geographical requirements for origination sites; expanding to locations outside of the home; preserving audio-only telehealth visits; and expanding provider types for telehealth services, while ensuring payment parity.

It would be a disservice to limit the originating site to a patient's home or a clinical location. Public libraries, community centers, and fire stations, even a patient's parked vehicle—somewhere where they can access the Internet—have provided disadvantaged populations and practitioners access to telehealth. We call these

telehealth access points, and we are mapping them throughout the Nation.

Audio-only telehealth is important to increase accessed care to Medicare beneficiaries, because it does not require them to be proficient using a smart device, having a webcam, or even having an Internet connection. Broadband is not yet available to everyone, and it can be expensive in rural areas. If audio-only telehealth is not made possible, it is possible that some individuals might not be able to access health-care services. Expanding provider types—Federally Qualified Health Centers and RHCs—they provide primary care, behavioral health services, dental, and pharmacy services to underserved communities. It worked during COVID.

I also think that physical therapists, occupational therapists, and speech therapists should have permanent availability to see patients virtually—and payment parity. Practitioners are expected to bill for certain things, and if that service meets the definition of the code that they are billing for, they should be reimbursed at the same amount, regardless of whether or not the visit was in-person or via telehealth.

So, in closing, I really believe that telehealth plays a critical role in improving access to timely and regular health services with highly qualified practitioners, especially for patients with challenges that affect access and care coordination. So, thank you for your attention on this critical matter.

[The prepared statement of Ms. Perisho appears in the appendix.]

Senator CARDIN. Thank you for your testimony.

Dr. Wallace?

STATEMENT OF ERIC WALLACE, M.D., FASN, PROFESSOR OF MEDICINE, UAB EMEDICINE; MEDICAL DIRECTOR, CO-DIRECTOR OF HOME DIALYSIS, AND DIRECTOR OF THE RARE GENETIC KIDNEY DISEASE CLINIC, DIVISION OF NEPHROLOGY, DEPARTMENT OF MEDICINE, UNIVERSITY OF ALABAMA, BIRMINGHAM, AL

Dr. WALLACE. Chairman Cardin, Ranking Member Daines, and distinguished members of the Senate Finance Committee, thank you for the opportunity to testify on behalf of the University of Alabama at Birmingham, the American Medical Group Association, and the American Society of Nephrology.

I am the medical director of Telehealth for the University of Alabama at Birmingham. My role in telehealth started in 2013, when I recognized that my patients on home dialysis and with rare disease were spending hours driving to see me. I realized that their lives might be made better if we could deliver the same quality of care remotely. During the initial days of the COVID–19 pandemic, telehealth saved lives and provided a case study of just how important telehealth is in delivery of care.

In addition to the rapid transition to telehealth clinic visits, telehealth was critical to rural inpatient care. When patients with COVID–19 got stuck in hospitals unable to care for them and nowhere to transfer, telehealth enabled UAB to care for people who otherwise would have been left to die. Multiple times I was able to facilitate the transfer of a critically ill patient from one rural

hospital without telehealth to another rural hospital with telecritical care and telenephrology. Telehealth provided the resources needed to care for them in a way that was never before possible. The COVID–19 pandemic demonstrates that telehealth has the potential to transform a rural hospital bed from available but unusable to available and useful.

Congress played an important role in allowing for this complete and successful pivot to telehealth during the early days of the pandemic by providing targeted regulatory flexibility, but these flexibilities have not been made permanent. We have been to war with disease armed with telehealth, only to find we are battling new barriers and regulations, and nothing was permanent. Providers and clinics found it easier to give up on telehealth than to face an impossible onslaught of changing regulations, and as such, the utilization of telehealth decreased.

As we look to the future, how will telehealth play a major role in the success of any health-care system? Number one, telehealth is vital to the survival of rural health care by providing access to subspecialty support. Number two, telehealth is and will continue to play a large role in value-based care by reducing no-show rates and readmissions, and shifting more chronic disease management to the home. And three, alleviating nursing and provider staffing shortages by leveraging urban and national workforces.

It is important to note that telehealth means more to people than just health care. Since inception, UAB Telehealth has saved 28.5 million miles of driving for patients. This is the greenhouse emissions equivalent of having 2,600 passenger vehicles off the road for an entire year. Furthermore, Alabamians gained $16 million in work productivity by using telehealth.

Just as there was a need for telehealth before COVID–19, there is a need for telehealth now, and there will be a need for telehealth in the future. To allow this new area of medicine to continue to benefit patients, particularly those living in rural or urban areas with limited access to traditional sites of care, Congress must enact five policies.

Number one, the geographic restriction on telehealth should be permanently eliminated. Telehealth is for the urban and rural. Prior to COVID–19, patients had to do their telehealth in rural areas. I will never forget a patient of mine who was disabled. The patient lived no more than 2 miles from our clinic. But getting in and out of a vehicle and parking close to our clinic was enough to make any clinic visit a half-day event. He found an article that I was doing on telehealth, and he showed me that article, and he said, “Is this for me?” And I said “no,” because he lived in an urban area. Access to care problems are not geographically restricted; why should our regulations be?

Number two, the originating site requirement should be eliminated. Delivery of telehealth care within brick-and-mortar sites is a great way to care for patients who do not have access to technology. However, the home also has significant advantages in its ability to be scalable and reduce the need for health-care infrastructure.

Three, telehealth should be covered at parity with in-person visits. Telehealth visits continue to require staff, videoconferencing

platforms, and provider time. Telehealth does not equate to a fast visit.

Four, audio-only visits should continue to be covered. Some patients just cannot access video. Those are the same patients who need us the most. If audio-only goes away, these patients will be forced to choose between an in-person visit or nothing at all, and I fear they are going to choose the latter.

Five, prescribing of controlled substances that are not Schedule II, specifically suboxone and antiseizure medicines, should be allowed over telehealth.

In closing, permanent coverage of telehealth is critical to the survival of rural health, the future of our health-care system's ability to deliver equitable care regardless of geography, and is integral to our ability to deliver on the promise of value-based care.

Thank you for your time, and I look forward to your questions.

[The prepared statement of Dr. Wallace appears in the appendix.]

Senator CARDIN. Well, thank you for your testimony.

Dr. Ellimoottil?

STATEMENT OF CHAD ELLIMOOTTIL, M.D., MS, ASSOCIATE PROFESSOR AND MEDICAL DIRECTOR OF VIRTUAL CARE, UNIVERSITY OF MICHIGAN, ANN ARBOR, MI

Dr. ELLIMOOTTIL. Thank you. I would like to begin by expressing my gratitude to the members of the subcommittee for this opportunity to discuss the current and future state of telehealth in the United States.

Telehealth took off during the early stages of the pandemic, thanks to essential flexibilities such as removal of the geographic restrictions and coverage for audio-only telehealth. In a MedPAC survey, 90 percent of Medicare beneficiaries reported satisfaction with their telehealth visits.

Currently, telehealth accounts for about 10 percent of Medicare's office visits, a rate that has been stable since July 2021, and is anticipated to remain so until December 21, 2024. However, I am concerned about the potential decline in telehealth usage after that date, which could either occur rapidly or gradually.

Preventing both the fast and slow death of telehealth depends on the actions of Congress and CMS. The fast death of telehealth could occur if the originating site and geographic restrictions were reinstated. If that were to occur, there is no doubt that we would revert to the pre-pandemic levels of telehealth, where fewer than 1 percent of health-care providers and patients were utilizing telehealth services. The slow death of telehealth may occur when patients and providers become increasingly frustrated by regulations and unexpected bills, and ultimately stop using telehealth. Four key factors could contribute to this slow decline, if left unaddressed.

Factor number one is the lack of coverage alignment among payers. Medicare sets the standard, and many commercial payers follow. If Medicare continues to view expanded telehealth coverage as temporary, commercial payers will reduce or eliminate their coverage for telehealth services. This is already underway, and we are witnessing the development of a fragmented telehealth payment

system that creates confusion for both patients and providers. Imagine being a patient and not knowing whether your insurance will cover a video visit, a phone call, or neither. The path of least resistance for both patients and providers would be to schedule the next follow-up as an in-person visit, even if a video visit was clinically appropriate.

Number two is the loss of audio-only coverage. My personal research, along with that of others, has shown that there is an obvious digital divide. Recently, I experienced this myself in clinic when I attempted to conduct a video visit with a patient from rural Michigan who was experiencing connectivity issues. After about 5 minutes of troubleshooting, I resorted to picking up the phone and conveyed the exact same information about surgical options for his enlarged prostate over the phone. Such scenarios are quite common, particularly for Medicare beneficiaries residing in rural and underserved communities.

If audio-only visits become ineligible for billing in the future, health-care providers will simply not offer them, and as a result, Medicare beneficiaries will lose this option for remote care.

Factor number three is the loss of payment parity. The prevailing narrative suggests that the practice expenses related to telehealth visits are lower than those for in-person visits, thereby supporting the argument for payers to reduce reimbursement rates for telehealth visits.

While on the surface this narrative is quite convincing, the reality is that, unless your practice is entirely virtual, it is unlikely that your practice expenses have decreased. In a practice where 1 out of 10 office visits is virtual, health-care providers still incur the same costs for maintaining the physical office, equipment, and salaries of staff like clerks and nurses who schedule visits, collect records, and provide all of the care between visits. Practically speaking, these expenses do not decrease by 10 percent just because 10 percent of your visits are now virtual.

Number four is the implementation of guard rails that lack clinical evidence. While we all recognize the importance of preventing fraud and abuse, implementing guard rails like mandating periodic in-person visits for patients receiving telehealth services only creates barriers for health-care access.

In 2022, the Office of Inspector General evaluated 742,000 telehealth providers and found that only 0.2 percent displayed potentially fraudulent or abusive patterns. There is no need to impose in-person guard rails on the 99.8 percent of health-care providers who use telehealth without exhibiting any patterns of fraud and abuse.

Actions of Congress and CMS in these four key areas can help prevent the slow death of telehealth after December 31, 2024. I understand that there is appropriate concern, both within this committee and beyond, that permanent expansion of telehealth will result in excess health-care utilization and spending. Based on my research and my experience overseeing telehealth at the University of Michigan, I can confidently say that this is unlikely to happen. In my written testimony, you will find data that sheds light on what researchers have learned over the last 3 years.

While no single study or report can definitively capture the entire impact of telehealth on cost, quality, and access, I believe that most researchers will at least agree on these three points.

Point number one: telehealth expansion has not led to runaway health spending or utilization. Point number two is that telehealth does not compromise quality of care for patients. And point number three is that telehealth improves access to care.

In the end, making telehealth expansion permanent is about ensuring that Medicare beneficiaries have choices in their care. Whether it is in-person, via video, or through a phone call, I applaud this committee for its extensive efforts in making telehealth coverage permanent.

[The prepared statement of Dr. Ellimoottil appears in the appendix.]

Senator CARDIN. Thank you very much for your testimony.

Dr. Mehrotra?

STATEMENT OF ATEEV MEHROTRA, M.D., MPH, PROFESSOR OF HEALTH CARE POLICY, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL, BOSTON, MA

Dr. MEHROTRA. Thank you, Chairman Cardin, Ranking Member Daines, and other distinguished members of the subcommittee. I am honored to testify before you on a topic of such importance to Americans and their health.

I conduct research on telehealth because I hope we can address the common complaint that I hear from my patients, and what I am sure you hear from your constituents: that so many Americans have difficulty accessing care in a timely manner. In my testimony today, I wanted to touch upon how I think recent research can inform permanent telehealth policy.

At the start of the pandemic, some contemplated whether the unprecedented growth in telehealth was the beginning of a new normal. The reality has been more of a modest change. The number of telehealth visits in the Medicare program has fallen substantially, and now constitutes roughly 5 to 10 percent of visits. In surveys and interviews, both patients and physicians have greatly valued the availability of telehealth and want it to remaim an option, but they also remain uncertain about the quality of care provided.

Evidence is beginning to emerge on the impact of greater use of telehealth during the pandemic. In my own research, greater use of telehealth results in increased visits, roughly 2 percent more visits per person per year. The relative increase in visits was larger among lower-income, non-White patients, and was associated with small improvements in chronic disease medication adherence and fewer ED visits.

However, these changes were accompanied by a $248 or 1.6-percent increase in health-care spending per person per year. Our results are generally consistent with other recent work. Based on these findings, I recommend that Congress permanently eliminate geographic and site origination requirements, and allow video visits for all conditions.

While telehealth does not reduce health-care spending, the increase in spending is modest and there are some improvements in access and quality. Perhaps most importantly, patients and clini-

cians want telehealth to remain an option, and given the research, it is going to be hard to justify stopping coverage. Also, almost 4 years after the start of the pandemic, it is important to signal to clinicians that telehealth payments are here to stay, so that they can make the investments in telehealth with more certainty.

I recommend that telehealth visits be paid less than in-person visits. Payments for office visits are based on the time a clinician takes to provide care and the practice expense necessary to provide that visit. While they do require some overhead, telehealth visits do not require the same practice expenses, and physicians agree that these visits are less costly. Paying the same amount for telehealth visits will create distortions in the market. It will give virtual-only telehealth companies a competitive advantage. It will also incentivize clinicians to give up their practices. Roughly 5 percent of mental health specialists have given up their physical office and gone virtual-only. I think this is a problem, because patients want the option to see clinicians in person.

I want to end on a different issue that was raised by Senator Wyden, which is related to physician licensure. The pandemic prompted a temporary relaxation of State licensure requirements, and during the early parts of the pandemic, many Medicare beneficiaries continued to seek care from their out-of-State physicians.

Out-of-State telehealth use was greatest for some specific conditions such as cancer, among patients who live in areas right near a State border, and in more rural States such as Montana and South Dakota. Most of these temporary regulations have now expired, and patients are rightfully frustrated. Patients wonder why they must take a telehealth visit in their car, in a parking lot just across the State border, just to follow the rules.

This problem can be addressed in a straightforward way. Building off precedent in the Sports Medicine Licensure Clarity Act and the VA MISSION Act, the Congress can create a narrow exception. Under this exception, patients can get follow-up care from a physician in another State via telehealth if they have an established prior relationship with that physician. This is not a controversial idea. Key groups such as the American Medical Association and the Federation of State Medical Boards have supported the need for this type of narrow exception.

Again, I thank you for allowing me to appear before you today, and I look forward to your questions.

[The prepared statement of Dr. Mehrotra appears in the appendix.]

Senator CARDIN. Well, once again, let me thank all four of you for your testimonies and for your being here, and for the work you have done in this field.

I want to sort of harp on two points here first of all: one, the need for permanency of the provisions that are currently in law; and second, as just was pointed out, what additional improvements could we make that would make it easier for patients to access telehealth, or for providers to be able to provide telehealth?

I think you have made a very strong point in regards to convenience. I think you made a very strong point in regards to costs. Dr. Wallace, particularly, I think your point about the carbon footprint is a cost to carbon. So that is a cost issue. And loss of productivity,

I think we all could understand. You have to take a day off from work in order to see a doctor, particularly if you are in a rural community and you have to travel a long distance. I think we can all visualize how that additional cost is imbedded in a savings to telehealth.

And then last, if it is a choice between getting telehealth or no health care, no services at all, ultimately it is going to lead to a more difficult and costly intervention in health care. Unfortunately, our scorekeepers do not give us any credit for any one of those three. So that is where the struggle comes in.

The good news is that the cost issues have been manageable that we have gotten. So the dire projections have not come true. It has been certainly within the budgets that we have provided.

So I would like any one of the four of you who wish to respond. You mentioned the risk factor that if we do not file timely permanency or extensions, there is a fear that these services are going away. Therefore, it becomes self-fulfilling, because you do not schedule the next appointment because you do not know whether it is going to be covered or not, or you just do not set that up as your regimen.

So I would like you just to address for a few more minutes, if you might, the importance of giving predictability in this field. And although Congress thinks they can wait till December of next year, what are the consequences if we do not timely express this policy as a permanent policy?

Dr. WALLACE. Sure, I can certainly start. So I think that making telehealth permanent is very important. It is important for our health system. I was involved in our 3- to 5-year strategic plan for virtual care, and as we are thinking about the plan, it is really hard to understand whether or not telehealth investments should be made, because we do not know whether or not it is going to be covered after December 31, 2024.

The other thing is that, if we are going to wait, what will we be waiting for? I mean, there have been thousands of studies that have been completed since the beginning of 2020, and the message is quite clear, just like you mentioned, that there is no runaway health-care spending. Quality of care is not being compromised, and there is an improvement in access.

I do not think more studies are necessarily going to change that strong signal that is coming from everything that has been done. There was a recent review from AHRQ that confirmed the same thing too. So I think it helps us predict, and then it also sends a strong signal to the commercial market that telehealth is not just a temporary thing during the public health emergency, but instead it is actually a natural extension of health care.

Senator CARDIN. Dr. Mehrotra, you already mentioned the one point that Senator Wyden raised in regards to the regulatory framework. Are there other areas that we should be looking at to make it easier for providers to provide telehealth services or for patients to receive them, other than just the permanency of the current provisions?

Dr. MEHROTRA. I think there are a couple of other areas that have been areas of frustration for the clinical community. One was already touched upon, so I will just emphasize it right now, which

is the inability to prescribe certain medications for opioid use disorder.

We have, as all of us are aware in this room, a horrible opioid crisis. Many people are dying, and we have effective medications. But the uncertainty that currently remains right now about whether we can prescribe those medications via telemedicine, I think is another major issue.

I know there has been a lot of debate about that topic, but I think it is time for the DEA to move on this topic.

Senator CARDIN. Dr. Wallace, I see you are nodding your head. Anything further you want to add to that?

Dr. WALLACE. I cannot agree more, and it is not just Suboxone. I do not think anybody really agrees with the idea of opioids and benzodiazepines being prescribed over telehealth. But if you look at seizure medicines—so imagine yourself with a seizure disorder. We now take away your driver's license for 6 months because you are not supposed to drive when you have been diagnosed with a seizure disorder, and all of a sudden, we cannot prescribe you medicines over telehealth because you have to be seen in person. Almost all anti-seizure medications are controlled substances.

So things like this make no sense when you realize what we can do over telehealth, and for regulations' sake we will not be able to unless the controlled substances are allowed to be prescribed over telehealth.

Senator CARDIN. Thank you.

Senator Daines?

Senator DAINES. Thank you, Mr. Chairman.

Dr. Ellimoottil, you made the comment about strategic plans. It is awfully hard to make a strategic plan when the greatest threat is the uncertainty of Washington, DC. It becomes "plans" plural versus "plan." So, thank you for that push. We need to kind of fish or cut bait here, and that is why we are talking about permanency. We need to do it and hopefully make your strategic planning a little more efficient.

I want to go back to this workforce question. I was chatting with our witness, Ms. Perisho, earlier about the workforce shortage that we are seeing with nurses and health-care practitioners. Stress and burnout in fact amongst caregivers have intensified during the pandemic. The numbers we are seeing: an estimated 100,000 nurses left the profession in 2021. The Nation faces a projected shortage of up to 124,000 by 2034.

So our hospitals will need to make efforts to support, retain, recruit caregivers. But the bottom line is, they do not have enough caregivers today. There are not enough people in the pipeline to care for an aging population with more complex conditions.

Ms. Perisho, we chatted about that in my office earlier today. Given your experience with telehealth, particularly in rural and frontier areas, how can telehealth be leveraged to address the severe workforce shortage facing health care today?

Ms. PERISHO. I think it is looking at hybrid solutions, and when I say "hybrid," I mean a mix of in-person care and virtual care.

Nursing specifically, virtual nursing has come about since the pandemic. There was a large shortage of nurses that you just mentioned during COVID–19, and innovative nursing programs have

come to fruition that really can support the nurses and the practitioners and take that level of stress off.

I think specialty care providing, allowing rural members to have access to specialty care via telehealth, is going to be cost-saving on the patient and also on the health-care side because there are going to be reduced readmissions. I really believe that by bringing in the virtual, you are going to improve the quality of life of the practitioners and the nurses too, which is going to decrease that burnout.

Senator DAINES. Thank you.

I liked a comment that you, Dr. Mehrotra, made in your testimony as we were listening. You made a recommendation that telehealth services should be paid less than in-person visits. I would like you to expand on that. That is an important question, certainly, for the committee. If you could expound on your view regarding pay parity, any concerns that lower reimbursement may discourage providers from offering telehealth services at all. You studied it. I would love your thoughts.

Dr. MEHROTRA. Yes, I think certainly paying less is going to decrease the use of telehealth and will obviously decrease the spending impact it is going to have. But I think that patients and physicians recognize the benefits of telehealth, they see its value, and I hope with that—I do not think it is going to eliminate its use. I think it will probably still be used in the manner it is being used right now, which is for patients who have difficulty accessing care, or as a quick substitute for a follow-up visit, so people do not have to drive 2 hours or so.

So I think it still has a valuable role, and I am not as concerned about that issue, that it is going to eliminate telehealth use.

Senator DAINES. But you still have a pretty strong view that there should not be pay parity? There should be a difference, lower——

Dr. MEHROTRA. I think there should be a pay difference. And it also allows for greater efficiency in the health-care system. We want to use our taxpayer dollars as effectively as possible.

Senator DAINES. I think we all agree that telehealth has expanded patient access. I think the data is about indisputable in that regard, to both patients and providers. These visits are important for ensuring patients get the care they need in a timely manner, without unnecessary barriers.

And I think the point was also put up today that—we talked about rural areas. We have rural challenges. But if you are in an urban area, it might take you a half-hour to drive three blocks, or it might take a half-hour to drive 20 miles in Montana.

But there has also been interest in ensuring this care is high-quality. But assessing telehealth quality can be challenging due to some of the data limitations.

Dr. Ellimoottil, I understand the University of Michigan Institute for Health Policy and Innovation did a study to assess quality of telehealth in Michigan by looking at rate of available emergency department visits and hospitalizations. Could you comment on this and other studies that have evaluated telehealth quality?

Dr. ELLIMOOTTIL. Certainly. Thank you, Senator. I think that is a great question. It is a hard question to answer because the asso-

ciation between telehealth and quality really depends on the condition. It depends on the type of telehealth and then depends on the quality measure. But I can certainly speak to that particular study.

When we looked at the use of telehealth among primary care practices in the State of Michigan, we found that there was no difference in the rate of hospitalizations and emergency room visits, and there was no increase and there was no decrease. I think similar findings have been found by MedPAC and the recent AHRQ review too.

So that is the association between telehealth and ER visits. But if you look at remote monitoring—we have a program at University of Michigan called Patient Monitoring at Home where we send patients home after a hospitalization for congestive heart failure, for example, with kits and monitoring.

What we found is that 70 percent of those patients had reduced hospitalizations after they were sent home or after they were started on the program. So it really does depend on the condition, the modality, and the quality measure that we are looking at. But across the board, I think that we do not see any decreases in quality, and then there are improvements in access.

Senator DAINES. Thank you.

Senator CARDIN. Senator Blackburn?

Senator BLACKBURN. Thank you, Mr. Chairman, and then thank you to you all for being here. I really appreciate it.

You know, when I was in the House, I worked on the telehealth issue. We had this legislation. We thought we were going to get it in the 21st Century Cures bill; we did not. So we moved it as a stand-alone, and of course once COVID hit, everyone said we need to have telehealth on the books. So it came in through the emergency health order. And being able to make these waivers, the COVID–19 waivers, permanent is something that I am hopeful we are going to be able to do.

What we have learned is that seniors, elderly, people with complex medical issues, people who have their primary source of care delivered at a great distance, they have really benefited from this. One of you mentioned in your statement the increase in access and the additional number of appointments that an individual would have.

So I am doing what I can, and I know that Senator Cardin and Senator Daines are doing what they can to work this issue through to the end of the year and make it permanent.

Dr. Wallace, I want to ask you about this: CMS has a rule that would require physicians to report their home address, and let me get you to weigh in quickly on that. And, Dr. Ellimoottil, I would like to hear from you on that also about the significant concerns that may come from that, if you feel like that is of a concern, having to have that. And then, if that requirement had been in place during COVID, what would it have done to access to care? So, Dr. Wallace, you go first.

Dr. WALLACE. Thank you, Senator, for the question. So our institution, when that rule was being evaluated—and it has recently been addressed in the new PFS rule.

However, operationally we would not be able to do it. We have 1,100 providers at UAB. We have residents, et cetera, and they are

providing health care in many locations. They could be in their office. So one of the questions that came up is, if they are not in the clinic but they are located in their physical office across campus, do we need to report that address? Is it the "home"?

So there are so many operational hurdles in doing that. It would be a major problem. The other thing was privacy of the physicians.

Senator BLACKBURN. Yes.

Dr. WALLACE. I think that many physicians would not actually do telehealth and would opt not to do telehealth if they had to report their address publicly.

Senator BLACKBURN. Well, and I would think that the consistency of your permanent business address should be sufficient.

Dr. WALLACE. I agree.

Senator BLACKBURN. Dr. Ellimoottil, go ahead.

Dr. ELLIMOOTTIL. Thanks. I will be quick, because I agree 100 percent with those comments, that privacy has been a major concern for us, as it was for the 100 organizations that sent a letter to CMS to try to avoid this situation. And then also, operationalizing it—we have 3,000-plus clinicians. We have providers who see patients in multiple different locations. We have providers who may travel, who may move or stay in temporary housing. So I think, all in all, it is very difficult to operationalize, and then the privacy concern is the other issue too.

But I agree with your point about the policy option there, which is where your patients are being seen in person, which is where your expenses are. So my understanding is, a lot of this has to do with payment adjustment. So it is where your patients are being seen in person that is likely the best address.

Senator BLACKBURN. Yes; okay.

Dr. Mehrotra, I want to come to you on digital health and chronic disease management. Some of the providers I have talked to in Tennessee have said that patient compliance is always a problem, and that patient compliance through COVID with diseases like diabetes was much better because people had that accountability of the telehealth, that they had to show up for that virtual appointment.

And when you look at diabetes—and it is $327 billion a year to treat this. Talk for a minute about the ability to use telehealth and digital health for coaching, for education, for pushing toward compliance.

Dr. MEHROTRA. Thank you, Senator Blackburn, and you are raising a really important point. I will say briefly that our research has highlighted that greater use of telehealth does improve that major issue that you described: compliance with people's medications.

It was also touched upon—remote patient monitoring—and I think that is really another very effective way in terms of helping patients, in terms of staying on their medications and getting the care that they need. So these are some examples of how this real innovation in digital health can improve chronic illness in the United States.

Senator BLACKBURN. I have run out of time, and I know there are others. I have a couple of other questions on that, but I will submit those. I feel like this is an area we can choose to put some emphasis on and expand. Thank you.

Thank you, Mr. Chairman.

Senator CARDIN. Thank you.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. Thank you, Mr. Chairman, and to the ranking member. Like my colleagues, I support telehealth services. I think they should be permanent, for the very reasons that you are all saying, and there are other barriers that we have to address.

Earlier this fall, I joined with Senators Warner and Thune in sending a letter to the DEA about using telehealth to prescribe controlled substances, just what you have been talking about, including medications for mental health and addiction treatment. We expressed our concern about the approach DEA proposed this spring, including the requirement that the patients see doctors in person to get the prescriptions. We also strongly encouraged the DEA to move forward with creating what they call a special registration pathway as an alternative to these restrictions.

My question for the panel is, one, in 2023, in the proposed rule, the DEA briefly discussed why they rejected the special registration idea, and they argued that the process would be too burdensome for both prospective telemedicine providers and patients.

I want to open that up to the panel, number one. Do you agree, or should we be looking at something to address these concerns?

Dr. MEHROTRA. Thank you, Senator. You are raising a key point, and we have written about this topic. But the reasoning that the DEA provided does not make any sense to me. I do not think that the risk—you know, asking a physician or any other clinician to go through that registration process seems very reasonable. If that is a mechanism by which that clinician can treat patients using telemedicine, I think it is a great option. So I disagree with the DEA on this.

Senator CORTEZ MASTO. Thank you, Doctor.

Dr. ELLIMOOTTIL. I agree. And if I could just make a quick comment on that. So, I think if the DEA process is not made burdensome, if they make it easy, I think that it will not be a problem. I think it is much more burdensome for us to operationalize the in-person requirement that the DEA was initially putting in that proposed rule.

When that proposed rule came out, we sent that out to all of our providers, just to give them a heads-up about what was coming down the line at the end of the public health emergency, and we had dozens of emails back from health-care providers about nuances to that rule that just were not written out.

And I think it is very difficult and hard for us to operationalize the in-person requirement. And in a lot of ways an in-person requirement is creating a clinical guideline, kind of out of thin air. I think that the registration process would be much better, and then I do understand the need for avoiding fraud and abuse. I think if we take a framework like the Office of Inspector General has, which is looking back and identifying patterns of fraud and abuse, I think we can handle this and be able to prescribe to Medicare patients in a very safe way.

Senator CORTEZ MASTO. Thank you. And that was my next question, because I know the requirement was an in-person visit, and

that was the way to try to protect against fraud and diversion in telehealth, including for prescribing of controlled substances.

But then my next question to you is, does that really address those issues, and if it does not, how do we address those? What are the recommendations to address the concerns that the DEA has with fraud and diversion? I am going to open it up to the panel. So I do not know if anybody wants to——

Dr. ELLIMOOTTIL. Certainly. And so I think for a lot of areas where we think fraud and abuse can run rampant, I think the perspective that we should have is, instead of creating guard rails prospectively, we should adopt a framework that the Office of Inspector General has outlined, in terms of identifying patterns of fraud and abuse, and sort of look retrospectively, investigate those issues, recreate the framework if necessary, once the investigation is done.

I think that will kind of lead to a much better sort of check on fraud than creating these prospective guard rails that lack clinical evidence.

Senator CORTEZ MASTO. Thank you.

Dr. Wallace?

Dr. WALLACE. Yes. I cannot agree more. Just because this is telehealth does not mean that it is different than in-person ways of monitoring fraud and abuse. So we already have a way to monitor fraud and abuse with opioid prescriptions for in-person. Those prescriptions are monitored by the PDMP. We have to check that routinely. We get a report once a year on our prescribing patterns. So the question for me is, why isn't the way that we currently monitor opioid prescriptions in-person, why is that not good enough for telehealth?

Senator CORTEZ MASTO. Yes.

And now I want to address the concerns with audio-only as well. I support audio-only, and I know there is also that concern with abuse as well. If we are really trying to open up this access at all of these levels and give the patients choices, we would want to include that, but guard against any type of fraud or abuse; correct?

Dr. WALLACE. Absolutely.

Senator CORTEZ MASTO. And is there a way to do it?

Dr. WALLACE. I think at the heart of this it is, what are we trying to achieve? Right now, we are trying to achieve a reduction in overdoses. Our State saw an 11-percent increase in overdoses. Why are we putting any barriers in front of the patient to get care for their addiction?

Senator CORTEZ MASTO. Thank you.

Thank you, Mr. Chairman.

Senator CARDIN. Well, thank you for your questions. I thought that was very helpful for the in-person visit issue, because that has been one of the major areas that we have been trying to clarify and make permanent. So, thank you for your questions on that.

So, let me get to one other area, and that is the audio-only versus the video and audio. I support that. Let me start off with where I am on it, because I know that there are communities and areas and households that do not have reliable video, so audio is going to be the only service that they are going to be able to get, if they are going to be able to use telehealth. But I just would like to get your view as to whether there is a difference in certain prac-

tices—where video becomes a more important ingredient for telehealth—that we should be aware of.

Our own experiences during COVID, all the Zooms that we were on or the videoconferencing we were on—a lot of us would have liked to have turned off our cameras, but we thought that we were obligated to keep our cameras on because of the interaction. Is there a difference in the quality of care because of the personal interaction of a video, where you do not have that on audio, and are certain practices more susceptible to that differential? Any stuff you can give us.

Ms. PERISHO. Thank you, Senator. I will take this one.

Senator CARDIN. Yes.

Ms. PERISHO. I think that there is, and I think it should be up to the practitioner to decide what is appropriate for audio-only versus video. I think it depends on if there is an established relationship with the provider and a patient first and foremost, and I will turn it over to my colleagues to answer.

Dr. WALLACE. Thank you, Senator. As far as the difference in quality, I agree it should be up to the physician to actually decide. One of the things that we need to understand is that we are still held to medical liability.

So, if we actually offer an audio-only phone call, and we cannot diagnose or help the patient over audio-only, and there is a poor outcome, we are held accountable. So providers who actually understand telehealth—which now after COVID I would say all providers do—have to make the decision, can I do this visit over audio-only or do I need video?

And if the answer is "no" to either of those, we actually can pivot and say this is something that needs to be handled in person.

Senator CARDIN. Let me challenge on this for one moment. If you are a provider and the option is audio-only or no service because the individual does not have reliable video, you may feel more comfortable with the video aspects, but you do not want to deny access to your patient.

So I guess my point is, I recognize there is a threshold, and you are responsible for that threshold. But is there a difference in the quality area between audio-only or visual?

Dr. WALLACE. I think it depends on what you are treating. I will give you an example of a clinic that I had last week. I take care of rare disease. Those patients travel hours to see me. So, in the middle, I tried for 5 minutes to get a patient on video.

If audio-only was not covered, I would have had to stop the video and say, "You are going to have to come in person." But now I have to schedule them for my next scheduled appointment, which may be 3 months away because there are no clinic slots. So what I was able to do is pivot to the audio-only.

Now in nephrology, we are largely lab-based. So I can still review all of the patient's labs. I can review all of the patient's imaging that they have had. So there are a lot of things that I can do that the patient was able to benefit from, even though they were not able to get on video.

Senator CARDIN. Of course, I could make a point here for wider broadband, affordable broadband in everyone's household. So that is another part of that, and as I understand it, in the infrastruc-

ture bill, there was a significant increase in the capacities in our country for video as well as audio.

So that may be a problem that we are solving, but as I said in the preliminary to my question, I support audio. I just really want to know if it is appropriate to do both audio-only or audio with video. Is there a difference in the quality or the comfort level from the patient's point of view or from the physician's point of view? Have there been any studies that would reflect whether we should be working a little bit harder to make sure there is greater access to broadband?

Dr. MEHROTRA. Maybe I will just jump in here. So first, I mean we have to recognize, if it is audio or nothing, audio is going to be better there. But I also have to acknowledge that audio visits—many clinicians are not sure about the quality that they are providing. They would prefer to do video. At least in some of the work we have done, they perceive that a video visit provides a bit better care. And I am worried about creating a two-tiered system in the future, where the rich get the video calls and the poor get the phone calls. So I do want to make sure that we are really pushing hard to make sure video visits for everybody are available.

And the reason I bring that up is because, while we have to acknowledge the barriers the patients face, also from our research we are seeing circumstances where it is driven by provider preference. Some providers are not providing. You have to offer the video visits, and you have to work with the patients to try to make sure you address those barriers.

I think that we need to really push on the provider community to make sure that they are offering video visits and working with patients to make sure they overcome those barriers, because I am worried a little bit about the default of going to phone calls when a video visit could have been better.

Senator CARDIN. Thank you.

Senator Cortez Masto, anything further?

Senator CORTEZ MASTO. I have one final question. And just to jump back to that, Dr. Mehrotra, is that why your recommendation is for telehealth services, that you would pay less for telehealth services than you would for in-person, is that right, to address some of that, or incentivize more of the in-person, to have the provider do the in-person when necessary? Or why would you make that recommendation, I guess?

Dr. MEHROTRA. Yes, my recommendation—thanks for raising that and clarifying that. It is a really key point. My recommendation was largely based on the way that the system is structured, less on incentives, but rather simply based on what we need to reimburse clinicians based on the cost to provide that care. And these visits are cheaper to provide, so we should reimburse appropriately.

Senator CORTEZ MASTO. Right. And then finally, can I just jump on a separate subject really quickly? So this Congress, Senator Daines and I led the Telehealth Expansion Act, and it is a bipartisan, bicameral bill that would make permanent a CARES Act provision that allows employers the flexibility to offer telehealth services below the deductible to employees with a Health Savings Account so that employers can offer telehealth services to employees regardless of the type of health plan they are enrolled in. To me,

this is common sense. This ensures that families in the private market or that are employed by large employers, that families could access vital telehealth services, including virtual primary care and behavioral health. We have not even talked about that. Behavioral health, mental health services are just as important.

So, Dr. Ellimoottil, I know this hearing is focused on the Medicare program, but can you speak to the importance of a bipartisan proposal like that, that lowers the access to care barriers for primary care, for telehealth services as well, and the benefits to patients, particularly in States like Nevada, where we have an urban core as well as large rural populations that literally cannot access some of these services?

Dr. ELLIMOOTTIL. Sure; thank you. So, I do think in general, any policy that expands access to telehealth is a good thing, and I am not very familiar with that particular policy. But I do think that it creates access, and that is important.

When we looked at the State of Michigan and found areas where there are provider shortages, we found that telehealth has, especially for mental health, actually allowed providers to provide care into the homes of these provider shortage areas.

So I think that I am supportive of any policy that is expanding telehealth.

Senator CORTEZ MASTO. Thank you.

Thank you, Mr. Chair.

Senator CARDIN. Senator Barrasso?

Senator BARRASSO. Thanks, Mr. Chairman.

Ms. Perisho, could you talk a little about telehealth? I mean, in Wyoming, like Montana, it is an important access point for care. It really does help our Medicare beneficiaries, for especially services.

I think that in 2021, the Department of Health and Human Services reported about 29 percent of Medicare telehealth services in Wyoming were provided by an out-of-State provider, which is of concern if there is some kind of a crisis where you actually need hands-on care right there.

HHS has stated that that high rate of outsourcing is likely reflecting a shortage of availability, especially since that is exactly right. I am concerned about relying too heavily on telehealth. It is important, it helps us, but are we worried about the issues? So, given the challenges you face in Montana, we face in Wyoming, how are you dealing with it from the standpoint of work shortages, workplace shortages?

Ms. PERISHO. You know, we get a lot of questions. We talked a little bit about the interstate licensing and cross-border licensing. I think that is one of the challenges: finding specialists licensed within that State.

In terms of workforce shortages, there are, since the pandemic, multiple providers that are providing only services via telehealth and are licensed in multiple States. And until we have sort of a solution to the cross-State licensure, I think that is the solution for now.

Senator BARRASSO. Yes.

I think, Dr. Mehrotra, in your opening statement you talked about how 5 percent of physicians have closed their physical doors

to become full-time telehealth providers. So, I do believe there is real value as well of having telehealth, but also the direct hands-on patient care component of it.

So you know, it is interesting, having practiced orthopedic surgery for 24 years. I feel I could go back and do the surgery. I am not sure I could do the computer work or the technical aspects of filling in all the spots. So the latest estimates are that doctors are now spending about 20 percent of their time inputting patient information into electronic medical records.

In our office, we did electronic medical records before it was a thing. We wanted to be on top of things. *The Economist* magazine, in their annual health barometer, said one of the greatest barriers they identified was that solutions are not always designed with the need of clinicians and patients in mind.

So I find it especially true with increasingly complex, fragmented systems required to provide telehealth. So, what existing telehealth services do you see more as barriers rather than solutions? Do you see those out there in some ways?

Dr. MEHROTRA. Senator, I think you are raising a real key issue here related to the administrative burden in the practicing of medicine. And I do think that we do have to be careful. One of the reasons that I have been enthusiastic about expanding geographic rules and conditions is because right now, there is a little bit too much thought process and administrative burden. Oh, does this telehealth visit get covered? Oh, that is mental health, but oh, maybe it is substance use.

You know, there are a lot of nuances there which do not translate well to clinical care. So I do think we need to be thinking about the administrative burden when we are thinking about telehealth policy. It is a key issue.

Senator BARRASSO. Yes, because if they are spending that much time saying, "How do I fill this out?", it is time when they are not in direct patient contact and doing what they want to do, if they are still trying to get home to be with family, friends, do other activities, and not feel overwhelmed or burned out, which is a key part of it. So thank you.

And, Dr. Wallace, if I could, you and I are both invested in improving patient care, improving outcomes. There are 60 of us in the Senate who have cosponsored the bipartisan CONNECT Act. Senator Schatz from Hawaii is the original sponsor. A number of us have cosponsored.

It addresses patient care outcomes. It allows for remote patient monitoring for people with chronic conditions. Remote patient monitoring, I think, is one of the most innovative and cost-effective solutions to chronic care management. It is trying to be used around the world where the technology is available.

So, as somebody who specializes in the treatment of chronic conditions, can you discuss how using remote patient monitoring for your Medicare patients would impact your ability to treat them?

Dr. WALLACE. Thank you, Senator. I 100-percent agree with you. So, the University of Alabama at Birmingham has a remote patient monitoring program that we started in 2018. What we did for Medicare beneficiaries, specifically our Accountable Care Organization, which has 17,000 beneficiaries, is we actually identified pa-

tients with heart failure, chronic kidney disease, diabetes, hypertension, and congestive heart failure. We subjected them to remote patient monitoring and ended up saving $1,300 per member per month using remote patient monitoring.

Senator BARRASSO. Per member per month?

Dr. WALLACE. Per member per month. The other thing is that, when you look at the number-one causes of end-stage renal disease in this country, they are hypertension and diabetes.

So, we have over 400,000 end-stage renal disease patients at a cost of $80,000 per patient per year. So with remote patient monitoring, if we are able to address hypertension—and in our program we were able to reduce the patient population's systolic blood pressure by 9 millimeters of mercury in the first 45 days. If we are able to address chronic kidney disease from hypertension and diabetes and get them under control, maybe we can reduce the amount of end-stage renal disease, which ultimately—even one patient off dialysis will pay for a whole lot of remote patient monitoring.

Senator BARRASSO. Well, if you had that kind of a decrease across the board of the systolic pressure, you do not know how many strokes you have prevented as well in the process, which is an additive effect.

Dr. WALLACE. Absolutely.

Senator BARRASSO. Thanks, Mr. Chairman.

Senator CARDIN. Thank you.

Senator Whitehouse?

Senator WHITEHOUSE. Mr. Chairman, I think it is very unfair that I have to follow an actual doctor in this conversation.

Senator CARDIN. Let the record reflect that *The Washingtonian* magazine a number of years ago listed the smartest member of the U.S. Senate as Sheldon Whitehouse. I rest my case.

Senator WHITEHOUSE. It is Barrasso. It was a misprint. [Laughter.]

I am glad you all are here, and I wanted to make one point and then ask a question.

I am a big advocate for moving away as fast as we can from fee-for-service, and moving toward value-based care. I am a particular fan of freestanding ACOs, because we had two very, very good ACOs operating in Rhode Island: Coastal Medical and Integra.

I think that when the incentives line up for doctors to provide the best care rather than the most care, then things like telehealth can actually happen fairly naturally. In fact, we have experience of ACOs being willing to install telehealth machinery in patient's houses because it works better, without having to get a special—you know, it's just part of the overhead essentially.

So I think this represents one of many areas in which, if we solve the fee-for-service billing nightmare and treadmill, a lot of good things will come. But I want to talk specifically about the TREATS Act and opioid and substance abuse treatment.

The TREATS Act is mine with Senator Murkowski, but I think there are six members of this committee who are cosponsors of it. And we have had, I think, 434 deaths from overdoses in Rhode Island, so it is really important to get the services out there that people need.

One of our service providers is an excellent group called CODAC—spelled with Cs, not Ks like the old camera company—run by a woman named Linda Hurley, who is very, very good. And there is a client of theirs, a patient of theirs, who works, and the time that she can get for her conversations with her treatment specialist are her lunch hours. Now, if she had to go someplace and sit in the waiting room and wait and fill out the clipboard form for the umpteenth time and then hope to be seen and all that, it would not happen. Her sobriety is supported by these regular conversations she has, and they happen because of telehealth. Otherwise, it would not work. She is a busy person. She has a busy schedule. Her employer is very strict about her being available when needed. So that is her window, and telehealth makes it happen for her and keeps her supported in her sobriety.

So, I guess I just wanted to ask Dr. Mehrotra a little bit about how you think telehealth is an advantage in dealing with the current opioid crisis and the terrible toll that it is taking.

Dr. MEHROTRA. Thank you for that point. I just wanted to emphasize the issue that we have an opioid crisis, and telehealth can be that mechanism to get that care for those patients where it is very difficult for them to get to their clinician—you told us about that story—but also where there is no one you can go to nearby, that you can drive to to get that care that you really, really need.

I also wanted to tie it back to what you were describing before, really briefly, which is that I have seen some really innovative——

Senator WHITEHOUSE. I might talk about rural Rhode Island, but I think Senator Thune might think that I was kidding.

Dr. MEHROTRA. There are some new payment models that are being used for opioid treatment programs, OTPs, as well as for opioid use disorder, where they are giving a monthly or weekly payment and saying, look, clinician, you provide the care as you need it, and let's not get into that administrative burden of this visit or that visit. So, I think it is a really exciting space for innovation, because we need it.

Senator WHITEHOUSE. Yes. So you are actually tying my two points together. The payment reform and available telehealth make a really good combination in terms of serving patients and reducing cost. You cannot do better than that. Thank you.

Senator CARDIN. Senator Young?

Senator YOUNG. Thank you, Mr. Chairman, and thank you to our witnesses for being here today.

I have to say, even prior to the pandemic, I was hearing from a lot of my constituents in Indiana—most of them rural, but a fair number within a suburban or urban context—about the benefits they were receiving from various telehealth options. And during the pandemic, of course, it was a real lifesaver for countless Americans.

Those flexibilities that made a number of the pandemic-era telehealth services possible—and still many of which continue today—have helped vulnerable seniors in my State. We still hear quite a bit about it from others who increasingly, it seems, are accessing care and benefiting from care in the safety and comfort and familiarity of their own homes.

So I am really excited about the possibilities and the future of telehealth services. I get frustrated at times about some of the friction points, usually governmental in nature, associated with a future deployment. So I will just—I have a series of discrete questions, beginning with Dr. Mehrotra.

Doctor, what data or evidence has CMS or others collected to determine what waiver should be made permanent, and is there any additional data that, in your mind, should be reviewed or collected as we think critically about creating an environment where telehealth can continue to be taken advantage of?

Dr. MEHROTRA. Well, Senator, thank you very much for that question. First, I do think that, currently, CMS has a process that is set up that can be improved to kind of determine—where groups will come to them, say for example physical therapy or others, about how we need to expand, what is the evidence base? And I think we can continue that.

But I think the larger point that I think your question raises, which is so critical, is this is a rapidly changing place, telehealth today versus 5 years ago versus 10 years ago. And we are going to need to be monitoring this extremely carefully, because new innovations like artificial intelligence and other things are coming down the pike.

So we need to be constantly monitoring this area, to understand how to best deploy telehealth.

Senator YOUNG. And do you feel like we have mechanisms in place to engage in that, sort of those iterative improvements, that constant monitoring, that will be helpful to innovation and deployment moving forward?

Dr. MEHROTRA. Yes, I do think that as much flexibility as can be provided to CMS and Medicare for that space is really critical, because there is going to be, and there also needs to be, investment from the agency in terms of determining how telehealth is going.

Senator YOUNG. If you look at current technology, current practices—I noted your discussions of what waivers should be made permanent. That is normally what we ask you. But are there any regulatory changes that you recommend that Congress and the administration not make permanent as it pertains to telehealth?

Dr. MEHROTRA. To me?

Senator YOUNG. Oh, yes. And then, Dr. Ellimoottil, we will go to you next.

Dr. MEHROTRA. One area I do not feel that we need to make permanent or make a move on right now is audio-only visits, where I feel like we can continue to push on the provider community to provide a video visit, because I feel like that is the real place where we need to improve care.

Senator YOUNG. Makes sense.

Yes, Doctor?

Dr. ELLIMOOTTIL. Thank you, Senator. That is a great question. I actually—I do disagree, and I do think that audio-only is necessary and should be included. I think the package of deregulation that occurred and the flexibilities that are currently available are good, and I do not think that there is any guard rail that is not in the current flexibilities that necessarily needs to be added in.

Senator YOUNG. Thank you. Disagreements are always interesting though, so I am going to ask you to explain that, please.

Dr. ELLIMOOTTIL. Yes. I mean, as we talked about earlier in the testimony, I actually call coverage of audio-only one of the four pillars that we need to prevent the slow death of telehealth over time, because audio-only coverage, audio visits occur when providers are connecting with patients and the patient cannot connect or does not have the ability to connect, and then you have to sort of flip that appointment to an audio-only visit.

So, when I am discussing kidney stone surgery with a patient, whether it is in-person, video, or audio, I am delivering the exact same care. So that is why I think it is an important element.

Senator YOUNG. Okay. Does anyone else want to address that question? Dr. Wallace?

Dr. WALLACE. I agree with Dr. Ellimoottil. Not only do we need audio-only coverage, we also need coverage of telehealth at parity. If telehealth is not covered at parity with in-person—the physicians have to keep the door open. So, in order to keep those doors open—if I am doing nine in-person visits and one telehealth for my patient population, which is largely rare disease—I need that to be covered on par with in-person, or what will happen is, you will just make a decision. The cost of nursing has gone up. The margins in health care have gone down, and what will happen is, you will be forced to make a decision, and the death of telehealth will ensue, as Dr. Ellimoottil has said.

Senator YOUNG. It seems to me that if you can discern, with a high degree of confidence or reliability, that telehealth services offer roughly the same outcomes, you offer the same compensation. If instead, your health outcomes are 75 percent—which they are not in every context, so I want to be very clear—but then you might think about an access to care versus a quality tradeoff. So it might get a little more complicated, but my instincts are, because you are a doctor and because what you said was intelligent, to agree with you. But I am out of time, so thank you, Mr. Chairman.

Senator CARDIN. Senator Thune?

Senator THUNE. Thank you, Mr. Chairman, and thanks to you and Senator Daines for holding this important hearing on telehealth. In South Dakota, we have long understood the value of telehealth, and the pandemic not only demonstrated the importance of telehealth, but also provided an opportunity to gather real data from its use. I think that helped to illuminate even more the potential way in which we can deliver, particularly mental health services, via technology. While we have extended the telehealth flexibilities in Medicare until December 2024, we need to work toward permanent telehealth policies in Medicare, such as those in bipartisan legislation that I have led with my colleagues, like the CONNECT for Health Act and the Telemental Health Care Access Act.

Dr. Mehrotra, telehealth has proven to be an essential tool for providing access to mental health care. Unfortunately, I am concerned that we enacted a policy in 2020 to require an in-person visit for telemental health visits in Medicare.

Telehealth offers an opportunity to increase access to mental health, but an in-person visit requirement seems arbitrary, and I think is going to make access even more inequitable. So last year,

Senator Cardin and I led a working group, as part of this committee's mental health-care initiative, to take a deeper look at how to improve telemental health care.

Our legislation proposed removing Medicare's in-person requirement for telemental health services. From your research on telehealth, can you tell us more about the challenges an in-person requirement would have for patients seeking mental health services, especially for those patients in rural areas?

Dr. MEHROTRA. Thank you, Senator. I think it is a really important issue. So, the one thing that we have done some work on is trying to understand how often does this in-person visit occur right now, before a first telemental health visit.

It is pretty rare; less than one out of five times in that 6 months in the current regs that we see a visit. I emphasize that point because it is going to be a big change in care if that in-person visit requirement goes into effect, and it is also clear to me that clinicians do not see that it is really critical.

And so, I think that kind of data helps support what I think a lot of us have spoken about, which is that this in-person visit requirement should be eliminated, because I do not think it is adding value in any way, and it is also deterring people from using telemental health to access communities where there are no mental health specialists for them to see locally.

Senator THUNE. Yes; thank you.

Ms. Perisho, first I am excited to hear about the work on telestroke. In 2017, Congress passed my legislation, the FAST Act, which eliminated the originating site restrictions for telehealth services to diagnose and treat stroke.

However, as you outline in your testimony, additional originating site and distant site restrictions still exist, preventing patients from accessing care. During the pandemic, Congress suspended Medicare's distant site requirements for Federally Qualified Health Centers and Rural Health Clinics.

In South Dakota, that enabled our health clinics to strengthen local access to care by building telehealth connectivity between remote, rural, and frontier sites. Could you discuss a little bit more the importance of allowing Federally Qualified Health Centers and Rural Health Clinics to serve as distant sites for telehealth?

Ms. PERISHO. Yes. Thank you for that question. I have stated in my testimony that FQHCs and RHCs should be distant site providers because a lot of times they are that first touch of the patient when they are having a health crisis, and they support so many facets of health care in terms of the primary care, behavioral health, dental, and so on and so forth. So I believe it is very important for FQHCs and RHCs in rural areas to be distant site providers.

Senator THUNE. Okay.

Let me just ask, come back to Dr. Mehrotra, and if I could get you to comment a little bit on your research and the evidence that we now have on the quality of care provided over telehealth. Can you summarize that maybe a little bit?

Dr. MEHROTRA. There has been a lot of research that has been done on this topic, Senator, and so I think it is a really key point. In my testimony, I touched upon some recent work that we have

done, which has found that the greater use of telehealth by a health system or a clinic is associated with some improvements in health. The one that I think is maybe particularly important is chronic illness medication adherence. Often our patients do not take their medications, and having that telehealth availability appears to have enough touch points to maybe increase their use of medications, which will have some long-term benefits. So I think it is a real key quality area.

Senator THUNE. And do you think with all the new data that we have, largely through the pandemic, we have more sort of real-life test cases for that broad adoption? And you have talked about—I think in your testimony too—that in the past, some patients have worried about the quality of those visits compared to in-person visits.

But with now just the amount, the volume if you will, of the data available, and an opportunity to analyze the impact of that, particularly during the pandemic, how do you see—I guess I want to ask—at least in the future, folks in government agencies that deal with these issues recognizing the value that telehealth delivers, and not just in making available mental health services, but also the quality of those services?

Dr. MEHROTRA. Yes, Senator. This was emphasized by other panelists, so I want to echo what they said, that in the pandemic, with the greater use of telehealth, we have seen little evidence or no evidence that it has hurt quality of care.

So I think it is a positive that we can go back to the American public and say, "Look, this expansion really did improve the health of Americans."

Senator THUNE. Okay; good.

Thank you, Mr. Chairman.

Senator CARDIN. I just really want to acknowledge one more time Senator Thune's leadership, us working together on a task force to look at mental health. We had telehealth, and I think we had the first recommendations out of any of the task forces to really expand telehealth for mental health services.

So, it was a pleasure to work with you, and a lot of our recommendations were implemented. I think the permanency of the provisions we have here today would further implement the recommendations from our task force.

This has been a great panel. Thank you all very much for your dedication to this field. I think your comments about this being a field where you are going to see—we have seen significant change over the last decade. We will see what happens in the next decade, because I think you will see this will be evolving, and your suggestions, I think, help us in trying to deal with this issue.

I want to keep the record open until the end of business on Friday. Next week we are in recess with the Thanksgiving week, so it is a little bit earlier deadline for our committee. But I would ask the cooperation of our members who have questions for the record to submit them by the end of this week. And if there are questions asked, if the panelists would respond promptly, we would certainly appreciate that.

And with that, with our thanks, the hearing will be adjourned.

[Whereupon, at 4:05 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. STEVE DAINES, A U.S. SENATOR FROM MONTANA

Thank you, Mr. Chairman. Before I begin, I want to thank you for your leadership in this subcommittee this year. It's been very productive—we've had some great hearings on relevant health policy issues, and I look forward to continuing to work together next year as well.

I'm glad we're turning our attention to the topic of telehealth, as we have some crucial decisions to make when the Medicare pandemic-era waivers expire next year.

For our conversation today, we are fortunate to be joined by a panel of some of the sharpest telehealth minds our country has to offer. Thank you all for bringing your experience and expertise to our discussion, and also for making the trip to DC. I understand you've all traveled a long way to be here—especially Ms. Perisho, from Whitefish, MT.

For those who are not familiar with Montana's geography, Whitefish is high up in the Northwest corner of the State—the gateway to Glacier National Park. Thank you, Ms. Perisho, for being here with us to discuss this very important topic.

As we all know, the COVID–19 pandemic drastically changed our health-care sector in America and our understanding of health-care delivery. Telehealth, which was underused and understudied prior to 2020, suddenly became a critical means of delivering health-care services to patients.

Through a series of agency waivers and bipartisan legislation, the Medicare program pivoted over the last few years to allow for greater and more flexible telehealth access for beneficiaries. Since implementing those flexibilities, we've seen the advantages telehealth offers and the expanded access it provides.

In rural States like Montana, telehealth has completely changed the game in terms of health-care access. At our rural health hearing earlier this year, I highlighted that two of the most challenging barriers to accessing care in rural States are distance and transportation.

With the ability to receive care virtually in the home, patients no longer have to travel multiple hours to see their providers, and the incorporation of audio-only telehealth has increased access in areas without sufficient broadband infrastructure.

Telehealth also played a notable role in meeting the mental health needs of patients during and after the pandemic, including in the Medicare population. Even after the height of COVID, CMS data report that the share of Medicare services conducted via telehealth remained the highest for mental and behavioral health specialists.

Sadly, we are all aware of the mental health crisis in our country. Just last week in this committee, I joined my colleagues in marking up the BETTER Act, which contains significant proposals to expand access to mental health and substance use disorder services in our Federal health-care programs. As the pandemic demonstrated, telehealth can help us bolster mental health services and address some of the access gaps throughout the country.

It's safe to say there is no going back now that we've seen how transformative telehealth can be. The question is how Congress will shape the future of telehealth when the Medicare waivers expire at the end of next year. Policy decisions such as

originating site eligibility, appropriate reimbursement, and in-person requirements will need to be addressed, and we are here to begin considering some of those policy questions.

My colleagues on this committee and I have demonstrated our commitment to telehealth through various pieces of legislation which support and expand upon the flexibilities Medicare beneficiaries have come to rely on over the past few years. My hope is that today's conversation helps to further inform the committee as we deliberate telehealth permanency.

Thank you again to our witnesses—we appreciate your continued work and dedication to this subject, and I look forward to hearing from you.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF CHAD ELLIMOOTTIL, M.D., MS, ASSOCIATE PROFESSOR AND MEDICAL DIRECTOR OF VIRTUAL CARE, UNIVERSITY OF MICHIGAN

I would like to begin by expressing my gratitude to the members of this subcommittee for this opportunity to discuss the current and future state of telehealth in the United States.

Telehealth took off during the early stages of the pandemic, thanks to essential flexibilities such as the removal of geographic restrictions and coverage for audio-only telehealth. In MedPAC's survey, 90 percent reported satisfaction with their telehealth visits.

Currently, telehealth accounts for 10 percent of office visits, a rate that has been stable since July 2021 and is anticipated to remain so until December 31, 2024. However, I am concerned about a potential decline in telehealth usage after that date, which could occur either rapidly or gradually. Preventing both the *fast and slow death* of telehealth depends on the actions of Congress and CMS.

The fast death of telehealth could happen if the originating site and geographic restrictions are reinstated. If that were to occur, there's no doubt that we could revert to the pre-pandemic levels of telehealth usage, where fewer than 1 percent of health-care providers and patients were utilizing telehealth services.

The slow death of telehealth may occur when patients and providers become increasingly frustrated by regulations and unexpected bills and ultimately stop using telehealth. Four key factors could contribute to this slow decline if left unaddressed:

1. **Lack of coverage alignment among payers**—Medicare sets the standard that many commercial payers follow. If Medicare continues to view expanded telehealth coverage as "temporary," commercial payers will reduce or eliminate their coverage for telehealth services. This is already underway, and we are witnessing the development of a fragmented telehealth payment system that creates confusion for both patients and providers. Imagine being a patient and not knowing whether your insurance will cover a video visit, a phone call, or neither. The path of least resistance for both patients and providers would be to schedule the next follow-up as an in-person visit, even if a video visit was clinically appropriate.
2. **Loss of audio-only coverage**—My personal research, along with that of others, has shown that there is an obvious digital divide. Recently, I experienced this myself in my clinic when I attempted to conduct a video visit with a patient from rural Michigan who was experiencing connectivity issues. After about 5 minutes of troubleshooting, I resorted to picking up the phone and conveyed the exact same information about surgical options for his enlarged prostate over the phone. Such scenarios are quite common, particularly for Medicare beneficiaries residing in rural and underserved communities. If audio-only visits become ineligible for billing in the future, health-care providers will not offer them and, as a result, Medicare beneficiaries will lose this option for remote care.
3. **Loss of payment parity**—The prevailing narrative suggests that the practice expenses related to telehealth visits are lower than those for in-person visits, thereby supporting the argument for payers to reduce reimbursement rates for telehealth visits. While on the surface this narrative is convincing, the reality is that unless your practice is entirely virtual, it's unlikely that your practice expenses have decreased. In a practice where only 1 out of 10 office visits is virtual, health-care providers still incur the same costs for

maintaining a physical office, equipment, and salaries of staff, such as clerks and nurses, who schedule visits, collect records, and provide care between visits. Practically speaking, these expenses don't decrease by 10 percent just because 10 percent of your visits are virtual.

4. **Implementation of guard rails that lack clinical evidence**—While we all recognize the importance of preventing fraud and abuse, implementing guard rails like mandating periodic in-person visits for patients receiving telehealth services only creates barriers to health-care access. In 2022, the Office of Inspector General evaluated 742,000 telehealth providers and found that only 0.2 percent displayed potentially fraudulent or abusive billing patterns. There isn't a need to impose in-person guard rails on the 99.8 percent of health-care providers who use telehealth without exhibiting any patterns of fraud and abuse.

Actions of Congress and CMS in these 4 key areas can help prevent the slow death of telehealth after December 31, 2024.

I understand that there is appropriate concern both within this committee and beyond that the permanent expansion of telehealth will result in excessive health-care utilization and spending. Based on my research and my experience overseeing telehealth at the University of Michigan, I can confidently state that this is unlikely.

In my written testimony, you will find data that sheds light on what researchers have learned over the last 3 years. While no single study or report can definitively capture the entire impact of telehealth on costs, quality, and access, I believe most researchers would at least agree on these three points:

1. Telehealth expansion has not led to runaway health-care spending or utilization.
2. Telehealth does not compromise quality of care for patients.
3. Telehealth improves access to care.

In the end, making telehealth expansion permanent is about ensuring that Medicare beneficiaries have choices in their care, whether it's in-person, via video, or through a phone call. I applaud this committee for its extensive efforts in making telehealth coverage permanent.

SUMMARY OF STUDIES ON THE IMPACT OF TELEHEALTH ON COST, QUALITY, AND ACCESS

Utilization and Costs

- From July 2021 through December 2022, the proportion of telehealth-based evaluation and management visits among Medicare FFS beneficiaries has consistently hovered around 11 percent. (Figure 1, Ellimoottil 2023)
- From March 2020 through December 2022, the combined total number of monthly in-person and telehealth office visits has not exceeded 2019 levels at any point. (Figure 1, Ellimoottil 2023)
- There were greater rates of same-specialty in-person follow-up in the 90 days after in-person office visits than after telehealth visits. (Gerhart 2023)
- The availability of telehealth has not led to additional primary care visits; instead, telehealth is serving as a substitute for specific in-person encounters, resulting in no overall increase in primary care utilization. (Dixit 2022)
- Patients who had visits for acute respiratory infections were more likely to seek follow-up care within 7 days after telemedicine visits (10 percent) compared to after in-person visits (6%). (Li 2021)
- Adjusted 30-day episode costs were lower for Medicare patients who had initial telehealth visits compared to in-person visits. These patients exhibited higher rates of 30-day return visits but lower rates of imaging and laboratory testing. Results are preliminary. (Ellimoottil 2023)
- Total cost of care per beneficiary increased in 2021 compared with 2019 across all regions evaluated but increased more in high-telehealth intensity regions. Conclusion: "Greater telehealth use was associated with slightly increased costs to the Medicare program." (MedPAC 2023)

Quality

- Hospitalization rates for conditions such as congestive heart failure and dehydration were lower in the second half of 2021. However, the rate of decrease in areas associated with high telehealth use was slower. Emergency department visit rates were not found to be associated with a region's telehealth

use. Conclusion: "Greater telehealth use was associated with little change in quality." (MedPAC 2023)
- Practices that have high levels of telehealth use had marginally higher overall hospital or emergency room visit rates than low telehealth practices. (Li 2022)
- AHRQ review of 165 studies reporting outcomes concludes: "Across a variety of conditions, telehealth produced similar clinical outcomes as compared with in-person care; differences in clinical outcomes, when seen, were generally small and not clinically meaningful when comparing in-person with telehealth care." (Hatef 2023)
- Beneficiaries were generally satisfied with the visits. Forty percent of telehealth users expressed their interest in continuing to use telehealth even after the pandemic ends. (MedPAC 2023)

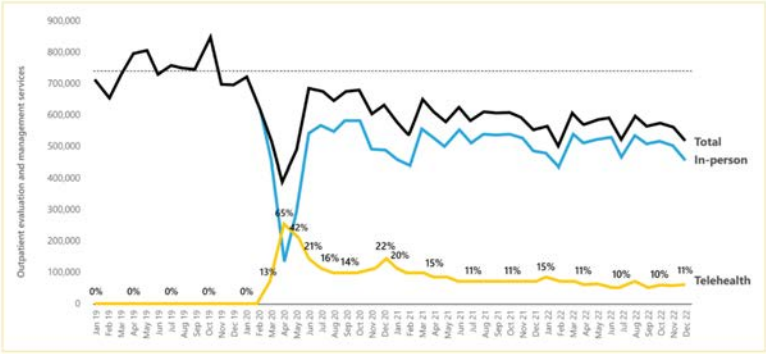
Access

- Total clinician encounters per beneficiary were lower in the second half of 2021 than in the second half of 2019, though the decline was slower, on average, among high-telehealth-intensity regions compared with low-telehealth-intensity regions. Conclusion: Greater telehealth use was associated with "slightly improved access to care for some beneficiaries." (MedPAC 2023)
- Patients who are older, are African-American, require an interpreter, use Medicaid, and live in areas with low broadband access are less likely to use video visits as compared to phone. (Chen 2022)
- Patients who had at least one telehealth visit for opioid use disorder were more likely to remain engaged in treatment for at least 90 days, compared to in-person treatment. Staying in treatment is key to reducing the risk for relapse and overdose. Among those who had at least one telehealth visit, those who were older (45–65+ years old), male, Black, or had housing instability were more likely to have only audio-only visits rather than video visits. (Frost 2022)
- Interviews with behavioral health providers revealed that they felt better equipped to meet their clients' diverse needs after receiving the flexibility to offer telehealth services when appropriate. Telehealth helped mitigate frequently cited barriers to accessing behavioral health care, such as the lack of transportation, missed work, and the need to arrange child care. (Beck 2021)
- Increase in overall and telehealth addiction treatment utilization after telehealth policies changed during the COVID–19 pandemic. There was no evidence that disparities were exacerbated. (Palzes 2023)
- Compared to patients with in-person visits, a higher percentage of patients with telemedicine visits gave higher satisfaction ratings for access (62.5 percent versus 75.8 percent, respectively) and care provider concern (84.2 percent versus 90.7 percent, respectively). Telemedicine visits consistently outperformed in-person visits over time in terms of access and care provider concern. (Patel 2023)

Summary

This list is not comprehensive; it simply represents a sample of the thousands of studies and reports conducted on telehealth since 2020. The impact of telehealth on costs, quality, and access depends on the condition, measure, and telehealth modality. The studies listed here specifically focus on video visits and do not cover other modalities, such as remote patient monitoring and telestroke. However, in general: (1) telehealth expansion has not resulted in runaway health-care spending or utilization; (2) telehealth does not compromise the quality of care; (3) telehealth improves access to care.

Figure 1: National Trends in In-Person and Telehealth Evaluation and Management Visits Among Medicare Fee-for-Service Beneficiaries, 2019-2022



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Li, K.Y., Ng, S., Zhu, Z., McCullough, J.S., Kocher, K.E., Ellimoottil, C. Association Between Primary Care Practice Telehealth Use and Acute Care Visits for Ambulatory Care-Sensitive Conditions During COVID–19. JAMA Netw Open. 2022 Mar 1;5(3):e225484.

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PREPARED STATEMENT OF ATEEV MEHROTRA, M.D., MPH, PROFESSOR OF HEALTH CARE POLICY, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

Next Steps in Telehealth Payment and Regulatory Policy

Thank you, Chairman Cardin, Ranking Member Daines, and distinguished members of the subcommittee; I am honored to have been invited to testify before you on a topic of such critical importance to Americans and their health.

My name is Dr. Ateev Mehrotra. I am a physician at the Beth Israel Deaconess Medical Center and a professor at Harvard Medical School. My research focuses on the impact of telehealth. Specifically, how does telehealth impact quality, spending, and people's ability to access care, particularly in rural communities? I have studied a wide range of clinical applications of telehealth, including stroke, mental illness, substance use disorders, contraception, and acute respiratory illness. I do this research because I hope telehealth can help address the common complaint I hear as a physician and what I am sure you hear from your constituents: that people across this Nation often have difficulty accessing timely care.

INTRODUCTION

The rapid adoption of telehealth early in the pandemic was dizzying, with telehealth visits accounting for 42 percent of Medicare outpatient visits in April–May 2020.[1] Clinical changes that I would have expected to take a decade occurred within weeks. Most Federal pandemic-era telehealth policies have remained temporary and have been extended numerous times by Congress. Implicit or explicit in the legislation authorizing these extensions is that more research is needed to dictate permanent regulations. As I describe below, some of that evidence is starting to emerge.

Some contemplated whether the unprecedented rates of telehealth use during the COVID–19 pandemic were the beginning of a new normal—one with telehealth as a core component of how patients receive care. The result has been more of a modest change in most clinical areas than a paradigm shift.[2] The number of telehealth visits per month in the United States continues to fall since its peak in April 2020 and today represents roughly 5 percent of all outpatient visits in Medicare.

In surveys and interviews, patients and physicians have greatly valued the availability of telehealth and want it to remain an option in the future.[3] However, both patients and physicians have questioned the quality of care in a telehealth visit, specifically due to the inability to conduct a full physical exam and key tests (*e.g.,* electrocardiograms).[4] Many patients prefer in-person visits.[5]

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[1] Gray, J., Tengu, D., and Mehrotra, A. 3 surprising trends in seniors' telemedicine use during the pandemic. STAT News. Aug. 30, 2021. *https://www.statnews.com/2021/08/30/three-surprising-trends-seniors-telemedicine-use-pandemic/*.

[2] One critical exception is treatment of mental illness where we have seen more sustained use of telemedicine.

[3] Mandated report: Telehealth in Medicare, Report to the Congress: Medicare and the Health Care Delivery System, June 2023. MedPAC, *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf.*

[4] SteelFisher, G.K., McMurtry, C.L., Caporello, H., Lubell, K.M., Koonin, L.M., Neri, A.J., Ben-Porath, E.N., Mehrotra, A., McGowan, E., Espino, L.C. and Barnett, M.L., 2023. Video Telemedicine Experiences in COVID–19 Were Positive, But Physicians and Patients Prefer In-Person Care for the Future: Study examines patient and physician opinion of telemedicine experiences during COVID–19. Health Affairs, 42(4), pp. 575–584.

[5] Predmore, Z.S., Roth, E., Breslau, J., Fischer, S.H. and Uscher-Pines, L., 2021. Assessment of patient preferences for telehealth in post-COVID–19 pandemic health care. JAMA Network Open, 4(12), pp. e2136405–e2136405. Sousa, J., Smith, A., Richard, J., Rabinowitz, M., Raja, P., Mehrotra, A., Busch, A.B., Huskamp, H.A. and Uscher-Pines, L., 2023. Choosing or Losing in Behavioral Health: A Study of Patients' Experiences Selecting Telehealth Versus In-Person Care: Study examines patient experiences selecting telehealth versus in-person care for behavioral health services. Health Affairs, 42(9), pp. 1275–1282.

My testimony will focus on the future of payment policy and regulations for telehealth. I began by describing three key principles that I believe should drive telehealth policy, and then I specifically discuss the following six issues related to payment and regulation:

1. Permanent expansion of telehealth coverage for all Medicare beneficiaries.
2. Whether telehealth visits should be paid at the same rate as in-person visits.
3. Role of audio-only telehealth visits.
4. In-person visit requirements.
5. Physician licensure in the context of out-of-State telehealth visits.
6. Telehealth payment models.

KEY PRINCIPLES OF TELEHEALTH POLICY

The first principle is that policymakers should formulate their telehealth policy decisions through the lens of *value*. In the case of telehealth, value is the dollars per improvement in care outcomes and access. Improvements in access could decrease travel time, disruption to lives, and the need for child care. Under the value framework, the questions are: what are the high-value applications of telehealth? And how can policies encourage higher-value applications of telehealth and discourage lower-value applications of telehealth?

Value is dictated by the condition treated (for example, common cold versus stroke) and the patient receiving care. Consider two patients with depression who can participate in a telehealth visit. One lives in rural Alaska with no access to local clinicians and substantial transportation barriers. Telehealth could be the only way he can access care and improve his condition. The second patient lives in Anchorage, her depression is well controlled, she sees her psychiatrist every month, and she is on the right medications. There is minimal value in an additional telehealth visit every 2 weeks for her depression.

Many of the policies that have been considered or implemented (for example, targeted expansions of telehealth by condition and limitations on which patients can receive telehealth) try to prioritize higher-value applications of telehealth while continuing to restrict applications with uncertain value. For example, implicit in Congress's expansion of telehealth for rural communities is that rural residents have more difficulty accessing care. Implicit in the expansion of telehealth for mental illness treatment is that mental illness is undertreated in the United States. The hope is that targeted expansions result in substantial quality improvements at a reasonable cost.

It is important to acknowledge that all such policies are inherently crude. There are patients in rural communities who are getting all the care they need without telehealth, and there are plenty of patients in urban areas who are not getting the care they need. Fundamentally, using billing rules and regulations in the fee-for-service system to determine when one form of telehealth is allowed and another is not allowed is a daunting task—clinicians and patients will quickly point out circumstances where the payment rules do not make sense. The growth of telehealth has accelerated the need to shift to other forms of payment.[6] This is a topic I touch upon below.

The second principle is that we should try to *avoid one-size-fits-all telehealth policies*—just as there can be no single coverage policy for all prescription drugs. In the same way different drugs yield different outcomes, telehealth's benefits will vary across clinical conditions, different forms of telehealth, and different providers. For example, telehealth for treating stroke could save lives, while telehealth visits for the common cold have little clinical benefit.

There are many different forms of telehealth. While much of the focus of debate on telehealth policy is on video visits, the pandemic has led to a surge in other forms of telehealth that have received less attention, such as asynchronous visits (eVisits), consultations between clinicians (eConsults), remote patient monitoring, and simple messages from patients asking for advice. Across over 300 health systems that use the Epic electronic health record, there has been a 57-percent increase during the pandemic in the number of messages patients submit daily via

[6] Adler-Milstein, J. and Mehrotra, A., 2021. Paying for digital health care—problems with the fee-for-service system. New England Journal of Medicine, 385(10), pp. 871–873.

patient portals asking for medical advice.[7] While I largely focus on video visits, I will touch upon payment policy for other forms of telehealth.

Another critical distinction in telehealth policy is the type of provider. While telehealth-only providers may improve access for Americans and have introduced many innovative models of care, they also raise new issues. They have lower overhead costs than "brick and mortar" providers because they do not have to pay for office space and equipment. Also, due to the pressures of venture capital funding, they have been pressured to grow as rapidly as possible. This pressure to grow rapidly may have been one driver of a recent scandal where a direct-to-consumer telehealth company was accused of overprescribing stimulant medications.[8] It is unclear whether telehealth-only providers should be regulated and reimbursed differently.

The third principle is that we want to *limit the administrative burden.* Administrative burden frustrates patients and clinicians and drives up spending. Already, clinicians sometimes struggle to correctly bill and document for telehealth visits.[9]

IMPACT OF TELEHEALTH ON SPENDING, QUALITY, AND ACCESS

Concern that telehealth will drive up health-care costs is a key impediment to its permanent expansion. Consistent with others, including the Congressional Budget Office,[10] I have expressed concern that greater telehealth use will increase spending. The concern is that in some circumstances, telehealth is *too convenient* and may encourage greater use of care such that telehealth visits may largely be additive to the health-care system. In other words, telehealth's ability to make care convenient and more accessible—the key to its enormous potential to improve the health of many patients—may also be its Achilles' heel.

After several years, evidence is beginning to emerge on the impact of greater use of telehealth. In our work, we took advantage of variations in uptake across large health systems to understand the impact of telehealth use. For various reasons, including the type of electronic health record, health system leadership, and local policy, some health systems adopted telehealth to a greater degree than others. We compared patients receiving care at health systems that used more telehealth during the COVID–19 pandemic to those that relied more on in-person services. The difference in telehealth use in 2020 was substantial—patients assigned to the highest telemedicine adoption health systems received 27 percent of their visits via telemedicine compared to 10 percent in the lowest telemedicine adoption. Though telemedicine use fell through December 2022, patients at high telemedicine health systems continued to receive more telemedicine through the end of 2022.

In 2021–2, we found a relative increase of 2.2 percent in visits per patient per year between patients in the highest and lowest telehealth use health systems. Most of these visits (83 percent) substituted for in-person visits. The relative increase in visits was larger among lower-income, non-White patients. Patients receiving care from higher telehealth health systems also had small improvements in chronic disease medication adherence and decreased ED visits. However, these changes accompanied a $248 (1.6-percent) increase in health-care spending per capita.

Our results showing increases in visits, small increases in spending, and modest improvements in quality are qualitatively consistent with other recent work. An analysis for the Medicare Payment Advisory Commission found that geographic areas with higher telehealth uptake through 2021 had a 3 percent relative increase in total clinical encounters and a spending increase of $165 per capita.[11] A 2021 study in Ontario found that greater physician telehealth uptake was associated with small decreases in ED visits.[12] Another analysis focused on telehealth for mental

[7] Holmgren, A.J., Downing, N.L., Tang, M., Sharp, C., Longhurst, C. and Huckman, R.S., 2022. Assessing the impact of the COVID–19 pandemic on clinician ambulatory electronic health record use. Journal of the American Medical Informatics Association, 29(3), pp. 453–460.

[8] Startup Cerebral Soared on Easy Adderall Prescriptions. That Was Its Undoing. Wall Street Journal. June 8, 2022.

[9] Wilcock, Andrew D., et al. "Legislation Increased Medicare Telestroke Billing, but Underbilling and Erroneous Billing Remain Common: Study examines Medicare telestroke billing." Health Affairs 41.3 (2022): 350–359.

[10] Lori Housman, Zoe Williams, and Philip Ellis, "Telemedicine," Congressional Budget Office, July 29, 2015, *https://www.cbo.gov/publication/50680.*

[11] Mandated report: Telehealth in Medicare, Report to the Congress: Medicare and the Health Care Delivery System, June 2023. MedPAC, *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf.*

[12] Kiran, T., Green, M.E., Strauss, R., Wu, C.F., Daneshvarfard, M., Kopp, A., Lapointe-Shaw, L., Latifovic, L., Frymire, E. and Glazier, R.H., 2023. Virtual care and emergency department

illness found that greater telehealth use was associated with more total visits (in-person plus telehealth) without substantial improvement in quality metrics.[13] Our results are also consistent with Congressional Budget Office modeling that telehealth expansions for mental illness will increase spending because of projected increases in total visits.[14]

Though we observe an increase in outpatient visit utilization, the increases that we and others have documented are relatively small. Several factors may explain this. Clinicians may have limited capacity to provide additional visits. Alternatively, there may have been limited demand from patients. As noted above, patients have worried that the quality of telehealth visits is lower than in-person visits.[15]

It is important to acknowledge the limitations of these studies. We use data through 2022, when there were still ongoing waves of COVID–19 illness, which may have impacted health care seeking behavior. One must be cautious in extrapolating results from the care patterns during the pandemic to those we will observe after the pandemic. The effects of telehealth on quality and spending could change as technology improves, health systems optimize telehealth services or patient demand changes. The results may not translate to virtual-only companies, and these broad-based evaluations do not capture the quality outcomes specific to a clinical area. Therefore, moving forward, it will be important to continue monitoring telehealth's impact on quality and spending in different clinical areas.

Policy Recommendation

Acknowledging these limitations, I recommend that Congress permanently eliminate site-location requirements and allow video visits for all conditions at any site to any Medicare beneficiary in the United States. My recommendation tries to balance the principles I described above. While telehealth does not reduce health-care spending, the increase in spending is modest, and the research has highlighted that greater telehealth can result in small improvements in access and quality. Perhaps most importantly, patients and clinicians want telehealth to remain an option, and policymakers will find it difficult to "take away" telehealth. Limiting telehealth expansions to some conditions or patients adds administrative burden (for example, navigating different modifier codes). Finally, almost 4 years after the pandemic's start, it is reasonable to signal to clinicians that telehealth payments are here to stay so they can make investments in telehealth with more certainty.

I would also permanently allow Federally Qualified Health Centers and Rural Health Clinics clinicians to provide telehealth visits beyond mental health visits as "distant" clinicians, enabling them to provide telemedicine care to patients in their homes. These clinics often treat patient populations with greater difficulties accessing care; therefore, their telehealth visits will likely be of higher value.

Invariably, areas will emerge where we observe overuse or low-value telehealth use. But those areas could be addressed on a case-by-case basis by Medicare. For example, Medicare could address concerns of fraud or overuse by requiring in-person visits if a physician wants to order specific high-cost tests.

Given the rapid pace of change in telehealth, I believe it is critical to give Medicare as much flexibility as possible in adapting telehealth policy. As noted above, I am both excited and concerned about the emergence of virtual-only companies. To better track the care they provide, Medicare should be able to require clinicians to report if they have any corporate affiliations and Medicare should have the ability to exclude specific companies they believe provide low-value care.

PAYMENT PARITY

Payments for office visits in the Medicare system are based on the time a physician or other clinician takes to provide care and the overhead to support the space,

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use during the COVID–19 pandemic among patients of family physicians in Ontario, Canada. JAMA Network Open, 6(4), pp. e239602–e239602.

[13] Wilcock, Andrew D., et al. "Use of Telemedicine and Quality of Care Among Medicare Enrollees With Serious Mental Illness." JAMA Health Forum. Vol. 4. No. 10. American Medical Association, 2023.

[14] Hall, C., Housman, L., Osgood, H. CBO Cost Estimate H.R. 5201 [Internet]. Washington, DC; 2020. *https://www.cbo.gov/system/files/2020-12/hr5201.pdf.*

[15] SteelFisher, G.K., McMurtry, C.L., Caporello, H., Lubell, K.M., Koonin, L.M., Neri, A.J., Ben-Porath, E.N., Mehrotra, A., McGowan, E., Espino, L.C. and Barnett, M.L., 2023. Video Telemedicine Experiences in COVID–19 Were Positive, but Physicians and Patients Prefer In-Person Care for the Future: Study examines patient and physician opinion of telemedicine experiences during COVID–19. Health Affairs, 42(4), pp. 575–584.

staff, and equipment necessary to provide that visit. For a common office visit (CPT 99213), the payment is roughly half for physician time and half for these practice expenses. While it does require some overhead, telehealth visits do not require the same practice expenses as in-person visits. Physicians also believe that telehealth visits cost less than in-person visits.[16]

Policy Recommendation

I recommend that telehealth visits be paid less than in-person visits. Some clinicians have objected. They argue that their practice expenses have remained the same because they provide both in-person and telehealth visits and therefore must maintain the same staff and resources. This argument does not convince me. I do not think Medicare should cross-subsidize in-person visits with telehealth visits because it will create distortions in the market. Paying the same amount for telehealth visits will give virtual-only companies a competitive advantage. It will also incentivize brick-and-mortar clinicians to give up their practice. We find that roughly 5 percent of mental health specialists have given up their physical office and gone "virtual only."

The correct difference in payment between a telehealth visit and an in-person visit is unclear. Currently, Medicare reimburses for a telehealth visit ~25 percent less than an in-person visit.[17] While this is a reasonable starting place, this difference may need to be adjusted as Medicare receives more data on the practice expenses necessary to provide telehealth visits.

AUDIO-ONLY TELEHEALTH VISITS

Another area of debate is the role of audio-only visits. Though it is unclear exactly what fraction of telehealth visits are audio-only,[18] it is clear that they are quite common. Audio-only visits may be particularly important for disadvantaged communities and safety-net clinics.[19] In a study on digital access, we found the proportion of patients with access to the necessary technology for a video visit was lower among those with a high school education or less, were Black or Hispanic, received Medicaid, or had a disability.[20] Many policymakers have mandated coverage of audio-only visits to ensure all people have access to telehealth. For example, Arkansas, Florida, Kentucky, Vermont, and Washington have all passed legislation ensuring access to audio-only care for all residents or those with Medicaid.[21] However, there are also concerns from physicians and policymakers that audio-only care may lead to inferior care. Though there is limited data on the quality of audio-only telehealth visits, in a survey of clinicians who treat substance use disorder, 70 percent perceived that their patients received higher-quality care via video than audio-only visits.[22]

One assumption is that clinicians turn to audio-only visits due to patient preference. However, growing evidence shows clinicians also turn to audio-only visits due to provider preference. Many clinicians do not offer video visits to all their pa-

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[16] Mandated report: Telehealth in Medicare, Report to the Congress: Medicare and the Health Care Delivery System, June 2023. MedPAC, *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf.*

[17] Mandated report: Telehealth in Medicare, Report to the Congress: Medicare and the Health Care Delivery System, June 2023. MedPAC, *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf.*

[18] Hailu, R., Uscher-Pines, L., Ganguli, I., Huskamp, H.A. and Mehrotra, A., 2022. Audio-only telemedicine visits: flaws in the underlying data make it hard to assess their use and impact. Health Affairs Forefront.

[19] Uscher-Pines, L., Sousa, J., Jones, M., Whaley, C., Perrone, C., McCullough, C. and Ober, A.J., 2021. Telehealth use among safety-net organizations in California during the COVID–19 pandemic. JAMA, 325(11), pp. 1106–1107.

[20] Roberts, E.T., Mehrotra, A. Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. JAMA Intern Med. Oct 1 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666.

[21] Michael Ollove, S. Telehealth may be here to stay. PBS News Hour. 2021; Health, Streeter D. Audio-Only Telemedicine Law Changes: Hospital Facility Fees Prohibited and Established Relationship Requirement Modified. Washington State Hospital Association. 2022, Bailey, V. Florida Senate Passes Bill Allowing Audio-Only Telehealth Use. mHealth Intelligence. 2022; Policy News, Kannensohn, K.J. Arizona Passes Broad Telehealth Law With Audio-Only Coverage. McGuireWoods. 2021.

[22] Uscher-Pines, L., Riedel, L.E., Mehrotra, A., Rose, S., Busch, A.B., Huskamp, H.A. Many Clinicians Implement Digital Equity Strategies To Treat Opioid Use Disorder. Health Aff (Millwood). Feb 2023;42(2):182–186. doi:10.1377/hlthaff.2022.00803.

tients, and they are less likely to be offered to historically marginalized groups.[23] There is substantial variation in video telemedicine use among Federally Qualified Health Centers. This difference appears to be driven by their information technology platforms and what investments were made in helping patients address barriers to obtaining video visits.[24]

Policy Recommendation

I recommend that Medicare pay for audio-only telehealth visits for a time-limited period, such as 2 years. Given the lower practice expenses, I believe an audio-only visit should be paid less than a video visit. While I recognize telephone calls may increase access for disadvantaged populations, I am concerned about a future with a two-tiered system where the poor and disadvantaged receive phone calls, and the wealthy have video visits. Though a phone call may be sufficient in many cases, I worry that on average phone calls may not lead to the same level of care. I also recommend Medicare require physicians providing an audio-only visit to attest that they offered the patient a video visit and that their clinic provides resources to patients who face barriers to video visits. I hope limiting payment for a short period and requiring this attestation will spur the necessary investments in support at clinics so that all Americans can receive a video visit. It will also create an opportunity for more research on what impact audio-only visits have on quality, spending, and access.

IN-PERSON VISITS BEFORE A TELEMENTAL HEALTH VISIT

At the end of 2020, Congress permanently expanded coverage of telemental health in Medicare but required that an individual have an in-person visit within 6 months before the first telemental health visit. Many mental health clinicians expressed concerns that there was no evidence of clinical benefit for this requirement, and it would create an unnecessary barrier to care. In December 2022, Congress passed legislation delaying the in-person requirement until January 2025.

To better understand what impact this rule may have on care in the future, we examined the care of Medicare fee-for-service beneficiaries. Of the more than 800,000 first telemental health visits in 2022, only 19 percent were preceded by an in-person visit with that clinician. Our results highlight that such a new requirement would require a substantial change in current practice. It could also imply that clinicians do not perceive in-person visits within 6 months as clinically necessary.

Policy Recommendation

I believe that Congress should remove the requirement for in-person visits requirements before mental health visits. While removing this requirement will likely increase spending on mental health, requiring in-person visits will decrease the ability of telehealth to expand access to mental health services for patients who live far from any mental health clinician and, therefore cannot have in-person care.

PHYSICIAN LICENSURE AND THE ROLE OF EXCEPTIONS

The COVID–19 pandemic prompted Federal and State Governments to relax licensure requirements temporarily to facilitate out-of-State physicians' care. During the early-pandemic period (through mid-2021), there was substantial use of out-of-State telehealth.[25] Among all Medicare beneficiaries with a telemedicine visit, 5 percent had an out-of-State telemedicine visit. In most cases, this was a continuation of an established relationship. Out-of-State telemedicine use was greatest for some conditions, such as cancer, among people who lived near a State border and in more

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[23] Ganguli, I., Orav, E.J., Hailu, R., Lii, J., Rosenthal, M.B., Ritchie, C.S. and Mehrotra, A., 2023. Patient Characteristics Associated With Being Offered or Choosing Telephone vs Video Virtual Visits Among Medicare Beneficiaries. JAMA Network Open, 6(3), pp. e235242–e235242.

[24] Uscher-Pines, L., Arora, N., Jones, M., Lee, A., Sousa, J.L., McCullough, C.M., Lee, S., Martineau, M., Predmore, Z., Whaley, C.M. and Ober, A.J., 2022. Experiences of Health Centers in Implementing Telehealth Visits for Underserved Patients During the COVID–19 Pandemic: Results from the Connected Care Accelerator Initiative. Rand Health Quarterly, 9(4).

[25] Andino, J.J., Zhu, Z., Surapaneni, M., Dunn, R.L. and Ellimoottil, C., 2022. Interstate Telehealth Use By Medicare Beneficiaries Before and After COVID–19 Licensure Waivers, 2017–20: Study examines interstate telehealth use by Medicare beneficiaries before and after COVID–19 led to relaxed licensure rules. Health Affairs, 41(6), pp. 838–845. Mehrotra, A., Huskamp, H.A., Nimgaonkar, A., Chaiyachati, K.H., Bressman, E. and Richman, B., 2022, September. Receipt of out-of-state telemedicine visits among medicare beneficiaries during the COVID–19 pandemic. In JAMA Health Forum (Vol. 3, No. 9, pp. e223013–e223013). American Medical Association.

rural States such as Montana and South Dakota. Most of these temporary regulations have now expired.

This return to pre-pandemic policy is not limited to video visits. Follow-up phone calls are also victims of this return to pre-pandemic licensure practice. Some lawyers have interpreted that a follow-up phone call constitutes the "practice of medicine" and must be limited to patients in a State where the physician is licensed. For example, the governing code in Texas defines practicing medicine as the "diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method" and notes that any "person who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this State . . . that would affect the diagnosis or treatment of the patient, is considered to be engaged in the practice of medicine."[26] Texas is not unique; similar definitions and rules exist in other States. Such rules can create issues for a patient seeking clinical advice from a physician in their home State while traveling to another State.

These geographic limitations of telehealth visits have created substantial frustration. Patients wonder why driving across a State border results in better care. For many video telehealth visits, patients sit in cars or coffee shops on smartphones, searching for good WiFi and sharing tips about the best parking lots just across the State border.[27] And many patients simply stopped following up with their out-of-State physicians.[28]

Unfortunately, reforms such as the Interstate Medical Licensure Compact, a process for making it easier for physicians to get a full license in multiple States, or the use of special telehealth licenses have had limited benefits. Expanding the use of licensure exceptions would be more helpful.[29] Many States have already incorporated exceptions to their licensure requirements. For example, Arizona allows a physician licensed in another State to provide telehealth to a patient in Arizona "[t]o provide after-care specifically related to a medical procedure that was delivered to a person in another State." Other key groups, such as the American Medical Association, support the need for greater use of exceptions for out-of-state telemedicine follow-up care. The Federation of State Medical Boards (FSMB) believes there is a need for exceptions that "permit the practice of medicine across State lines without the need for licensure in the jurisdictions where the patient is located. These exceptions to licensure are only permissible for established medical problems or ongoing workups and care plans."[30]

Using these exceptions is relatively simple for a physician. A physician only needs to be aware of the limitations of exceptions and that one cannot initiate a physician-patient relationship using an exception. From a patient perspective, such exceptions would allow most patients to use telehealth when needed. A student who is away for college can still see their psychiatrist in their home State. Patients traveling for work can keep in touch with their primary care physician regardless of where they are.

Policy Recommendation

I recommend Congress pass legislation implementing a narrow exception to State licensure allowing any physician to provide telehealth across State lines if they have an established prior relationship with that patient and are licensed in good standing in their home State. The advantage of Federal legislation is that it creates a clear set of rules nationwide. While many States have implemented similar exceptions, the language is not always consistent, and physicians have to carefully track the specific rules in the State where their patient is currently located. Creating this type of narrow exceptions for licensure is consistent with prior Federal licensure leg-

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[26] Occupations Code Chapter 151. General Provisions. *https://statutes.capitol.texas.gov/Docs/OC/htm/OC.151.htm.*

[27] Shachar, C., Richman, B.D. and Mehrotra, A., 2023. Providing Responsible Health Care for Out-of-State Patients. JAMA.

[28] Bressman, E., et al., Expiration of State Licensure Waivers and Out-of-State Telemedicine Relationships. JAMA Network Open, 2023, In press.

[29] Consensus Statement for Telehealth Licensure Reforms. Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics. *https://chlpi.org/wp-content/uploads/2023/11/Consensus-statement-Circulation-AMH_FINAL.pdf.*

[30] Federation of State Medical Boards, The Appropriate Use of Telemedicine Technologies in the Practice of Medicine. April 2022. *https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf.*

islation, such as the Sports Medicine Licensure Clarity Act[31] and the VA MISSION Act.[32]

PAYING FOR OTHER FORMS OF TELEHEALTH

As noted above, telehealth is not limited to video and audio-only visits. We are seeing rapid growth in other telehealth applications, such as remote patient monitoring.[33] In some cases, Medicare is paying for such care using monthly bundled payments instead of fee-for-service payments. The bundled payments include payments for data transfer costs and all communication between clinicians and patients in the month.

Similar payment innovation is needed for other forms of telehealth, such as portal messages.[34] The number of portal messages has surged during the pandemic, and clinicians, particularly primary care physicians, are frustrated because they spend substantial time at night answering these messages largely without reimbursement.[35] The fee-for-service system is poorly suited for frequent but short interactions, such as short phone calls or portal messages. When the units become smaller and smaller (*e.g.,* it may take a clinician only 2 minutes to respond to a portal message), the estimated $20 of administrative costs required to submit a bill for a single patient encounter may not be worth it.

Policy Recommendation

I encourage giving Medicare as much flexibility in creating payment models that use partial capitation or bundled payments to pay for telehealth applications such as portal messages. Such alternative payment models give clinicians the flexibility to use the full range of telemedicine tools (portal messages, video visits, eVisits, phone calls, eConsults, telemonitoring) best suited for an individual patient and clinical scenario and avoid the administrative burden of billing for each encounter.

SUMMARY OF POLICY RECOMMENDATIONS

To summarize, my policy recommendations are:

- Permanently eliminate site-location requirements and allow for video visits for all conditions for all Medicare beneficiaries.
- Pay for telehealth visits at a lower rate than in-person visits, avoiding telehealth parity.
- Pay for audio-only telehealth visits for only a time-limited period and require attestation from the clinician that they offered the patient a video visit.
- Remove in-person visit requirements before mental health visits.
- Introduce selective exceptions to State licensure that allow patients to get care from any clinician with whom they have an established relationship.
- Encourage innovation in payment models for telehealth that use bundled payments of partial capitation.

I acknowledge that the coverage decisions and payment choices I recommend are not perfect. They will deter some effective forms of telehealth and may add some administrative burden. Also, telehealth use is rapidly changing, and policy must adapt accordingly. However, I believe they represent the best way to encourage high-value applications of telehealth and encourage a necessary transformation of our health-care system.

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[31] Lennon, R.P., Day, P.G., Marfin, E.C., Onks, C.A., and Silvis, M.L., 2022. A general framework for exploring ethical and legal issues in sports medicine. The Journal of the American Board of Family Medicine, 35(6), pp. 1230–1238.

[32] Crowley, R., Atiq, O., Hilden, D., Cooney, T.G., and Health and Public Policy Committee of the American College of Physicians, 2021. Health Care for Our Nation's Veterans: A Policy Paper From the American College of Physicians. Annals of Internal Medicine, 174(11), pp. 1600–1602.

[33] Tang, M., Nakamoto, C.H., Stern, A.D. and Mehrotra, A., 2022. Trends in remote patient monitoring use in traditional Medicare. JAMA Internal Medicine, 182(9), pp. 1005–1006.

[34] Adler-Milstein, J. and Mehrotra, A., 2021. Paying for digital health care—problems with the fee-for-service system. New England Journal of Medicine, 385(10), pp. 871–873.

[35] As More Patients Email Doctors, Health Systems Start Charging Fees. KFF Health News. September 14, 2023. *https://kffhealthnews.org/news/article/email-doctor-visits-new-fees-copays/*.

Again, I thank Chairman Cardin, Ranking Member Daines, and members of the subcommittee for allowing me to appear before you today to discuss this critical topic in health care.

PREPARED STATEMENT OF NICKI PERISHO, BSN, R.N., PRINCIPAL INVESTIGATOR AND PROGRAM DIRECTOR, NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

Chairman Senator Cardin, Ranking Member Senator Daines, and members of the Senate Committee on Finance, Subcommittee on Health Care, thank you for the opportunity to testify at today's hearing: "Ensuring Medicare Beneficiary Access: A Path to Telehealth." The views I am sharing today are my personal opinions and are not the views of the Health Resource Services Administration (HRSA), my employer the University of Utah, or the Northwest Regional Telehealth Resource Center (NRTRC).

I believe it is crucial to emphasize the significance importance telehealth services are for Medicare beneficiaries. It is my belief that leniencies around eliminating the geographical restrictions for originating and distant site telehealth providers, audio-only telehealth visits, and allowable provider types and payment parity have had and why they should remain permanent in Medicare coverage.

I am pleased that the subcommittee is exploring telehealth that delivers the right care, in the right place, at the right time to patients in ways that work for them, while providing appropriate payment to the practitioners and facilities providing those health-care services. I am honored and humbled to testify alongside this seasoned panel of telehealth experts and want to note that in the absence of a patient witness, I will do my best to highlight the most important part of the equation, the benefits of telehealth for the patient.

I'd like to start with just a few facts about Montana, the fourth largest State by area, the eighth least populous State, and the third least densely populated State in the country.[1, 2] Low population density results in limited access to health care, most largely seen in specialty care, where providers are sparse. The population density by State underestimates the extremely rural nature of the Northwest region and Montana specifically.

The Native American/Alaskan Native populations living in the Northwest region make up a higher percentage than the total population in the rest of the Nation, with 6.3 percent of the Native American and Alaska Native population residing in Montana per the 2019 ACS 1-Year Estimates.[3]

	Montana
Total Population	1,068,778
Area (Sq. Mi.)	145,508
Rank of State by area	4th
Tribal lands (Sq. Mi.)	145,555
Number of Tribes	7
Population Density	7.35
Rural Percent of Population	44%
MUA/MUPs	51
HPSA/Primary Care	138
HPSA/Dental	123

[1] *https://www2.census.gov/geo/pdfs/reference/glossry2.pdf.*
[2] *https://www.census.gov/.*
[3] *https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2019/1-year.html.*

	Montana
HPSA/Mental Health	110

Historically, Americans residing in rural and frontier areas have faced disproportional challenges compared to their urban counterparts regarding access to clinical and behavioral health-care services. This disparity increased during the COVID–19 pandemic and stems from longstanding social inequities and systemic health conditions rural populations incur. Data indicates that rural communities experience higher blood pressure, obesity, diabetes, and higher incidence of tobacco consumption, putting individuals at higher risk of negative health outcomes from lack of access to quality, continuous disease management and mental health services. With the combination of increased comorbidities, decreased access to health care, and the decreased probability of health insurance coverage, rural community members are more likely to have a negative health outcome.[4] Research also reveals that rural and frontier residents are more likely than their urban counterparts to experience a higher incidence of suicide, unintentional injuries, and premature death. These residents also tend to be uninsured or underinsured, have lower incomes or live in poverty, lack social support, and are without a regular source of health care. Results from the CDC "Mortality in the United States" report found that Montana, Alaska, and Wyoming have the highest suicide rates in the Nation.[5]

I'd like to share why I am so passionate about telehealth. Following an internship at Craig Hospital, a neurorehabilitation and research hospital in Denver, CO, I began working as a critical care nurse in northwestern Montana; the patients I cared for included post-stroke patients. In 2010, the regional Montana hospital I was working for was awarded a Distance Learning and Telemedicine (DLT) grant through the United States Department of Agriculture (USDA). I was asked to lead the innovative telestroke program.

The telestroke program started by providing audio and video equipment to three critical access hospitals (CAHs) in northwest Montana, along with 24/7 neurologist coverage for patients suspected of suffering a stroke. Montana has 49 CAHs, and the majority of them are staffed with nurse practitioners, physician assistants, or family practice providers.[6] Rural patients who are suspected of suffering an acute ischemic stroke, an embolism, or a clot that stops the blood supply to brain tissue, might be candidates for tissue Plasminogen Activator (tPA)[7] which should be administered within 4½ hours of the onset of stroke symptoms. This is where the telestroke program becomes so valuable. A neurologist can assess the patient over video alongside a local practitioner and can decide whether or not to administer tPA. At that point, the patient is transferred via flight to a qualified stroke center in a larger city.

As part of the telestroke program, a vascular neurologist (who happened to have grown up in Montana and was at that time, the only vascular neurologist in the State) and the stroke nurse (me) would travel to the remote CAHs and provide education on the administration and monitoring of tPA. We formed a relationship and trust between the clinicians at the rural site and our telestroke team. During my time with this program, it grew to 13 CAHs in Montana and to offer specialties such as teleNeonatology, and telepediatrics. We also created originating sites in rural communities for patients to go to have a telehealth visit with their specialist in Kalispell. These types of visits allowed a patient to stay in their community, not travel long distances in in-clement weather, over mountain passes, alleviate risks of collisions with wildlife, preventing the removal of students from school, allowing parents to avoid taking time off from work. Monetarily, this allowed families to save money on gas, lodging, and food. The telestroke program is still in operation today, and the neurologists authorized their 100th dose of tPA via telehealth this past summer, potentially saving the lives of 100 patients. To note, those patients, most likely will not need long-term care or therapies, providing cost savings to the patient and the health-care system. I can honestly say this was made possible by access to telehealth, when this program started, not one of the CAHs had administered tPA.

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[4] *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/other-at-risk-populations/rural-communities.html.*

[5] *https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.*

[6] *https://mtpin.org/member-resources-facilities/montana-cahs/.*

[7] *https://www.ninds.nih.gov/about-ninds/impact/ninds-contributions-approved-therapies/tissue-plasminogen-activator-acute-ischemic-stroke-alteplase-activaser.*

Due to the success of this program, the hospital created a "Virtual Health Department," and I served as the virtual health manager, supporting the growth of telehealth in northwest Montana. I saw firsthand the benefits of telehealth. For instance, one cardiac specialist shared gratitude after "seeing" a congestive heart failure patient via telehealth and having the opportunity to look into the patient's kitchen where he recognized that the patient's diet was contributing to repeated trips to the ICU.

There have been frustrations. The city of Great Falls, population 60,400, did not have a nephrologist for patients with kidney diseases, but because the city was deemed urban, patients were not able to go to their local clinic as an originating spot to connect with a nephrologist via telehealth. So, patients had to drive at least 90 miles to Helena to see a nephrologist.

In my current role at the NRTRC, I provide technical assistance to practitioners wanting to implement, improve, or sustain telehealth services. I provide telehealth education to medical and nursing students. Based on my experiences, the four key areas I would like to see be made permanent are:

1. Eliminating the geographical requirements for originating site.
2. Preserving audio-only telehealth visits.
3. Expanding provider types for telehealth services.
4. Ensuring payment parity.

1. ELIMINATING THE GEOGRAPHICAL REQUIREMENTS FOR ORIGINATING SITE

The origination site is defined as the location where a patient is located when receiving health-care services by telehealth.[8] Before the pandemic, Medicare would reimburse for a telehealth visit if the patient was at an address that did not fall in a metropolitan statistical area; or, if the address was located in a metropolitan statistical area, the address must be in a rural area and be in a primary care or mental health geographic health professional shortage area (HPSA). In 2020, the Federal administration removed these restrictions, allowing patients to receive the care they needed, no matter where they were located, when they needed it, and health-care practitioners and facilities received payment equal to that of an in-person visit.

It would be a disservice to limit the originating site to a patient's home or a clinical location. Locations such as public libraries, community centers, fire stations, and even a patient's parked vehicle in a place where they can access the Internet have provided disadvantaged populations access to practitioners via telehealth. By adhering to the geographic limitations, we are contributing to the digital divide and health inequities. Many patients living in urban areas benefit from telehealth as well. Many caregivers don't have the ability to take their patients to an in-person doctor visit, which might delay preventive care or access to mental health services. Take the case of the wife of a man with frontotemporal dementia (FTD) who cannot attend in-person appointments because his particular manifestation of FTD does not allow him to be cared for by someone else, and his behavior is too disruptive in a waiting room. The man's wife commented, "Telehealth is literally a lifesaver for me."

My colleagues and I have been working to develop a resource that identifies Telehealth Access Points (TAPs, *https://findtelehealth.nrtrc.org/map*), which are dedicated public spaces where patients can access telehealth appointments. These spaces have a private space for a telehealth visit, an adequate Internet connection, along with a device with video, speaker, and microphone capabilities. It is imperative to ensure that all patients have access to telehealth, including those who may not have a private space or have limited broadband accessat home.

2. PRESERVING AUDIO-ONLY TELEHEALTH VISITS

Telehealth was a vital tool during the COVID–19 pandemic, ensuring continuity of care, reducing health-care disparities, and enhancing overall patient outcomes. Medicare's population of adults over age 60 account for 25 percent of physician office visits in the United States, and often have multiple morbidities and disabilities. Thirteen million older adults may have trouble accessing telemedical services that requires both audio and video; a disproportionate number of those are already disadvantaged in terms of accessing health care. Telephone visits may improve access

[8] *https://www.cms.gov/files/document/mln901705-telehealth-services.pdf.*

for the estimated 6.3 million older adults who are inexperienced with technology or have visual impairments.[9]

Audio-only telehealth is important to reduce barriers to Medicare beneficiaries' access to care because it does not require proficiency in using a smart device, having a webcam, or broadband connection. There are certain populations that are not quite comfortable with using the Internet and video technology.

Broadband is not yet ubiquitous and can be expensive in rural areas. Medicare rules should preserve an audio-only option for those patients who don't have other means to seek medical services. A health-care provider can provide qualified advice whether seeing the patient in person, via video, or listening over the phone. It is necessary for audio-only to be an option for those individuals who don't have connectivity or any other way to seek medical services. If audio-only telehealth is not made permanent, it is possible that certain individuals might not be able to access these services.

According to a study published in the *American Journal of Medical Services,* audio-only telehealth services provided similar benefits and were not inferior to video-based virtual visits. Many study participants shared that they would recommend an audio-only telehealth visit to others and that their medical concerns were addressed appropriately. Audio-only telehealth services promote health equity for people who are economically disadvantaged, live in rural areas, are racial or ethnic minorities, lack access to reliable broadband or Internet access, or do not have access to devices with video capabilities.[10]

I recommend that the same allowances for audio-only that are made for mental health visits are extended to clinical visits with provider discretion on whether an in-person, audio and video communication or audio-only communication is the best option for the health issue(s) and the patient. As a reminder, those allowances are when beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio-video interaction for the purposes of diagnosis, evaluation of treatment of a mental health disorder.

3. EXPANDING PROVIDER TYPES FOR TELEHEALTH SERVICES

Federally Qualified Health Centers (FQCHs) provide primary care, behavioral health services, dental, pharmacy, and a myriad of wraparound services to underserved communities. The use of telehealth during COVID was the first time that FQHCs were able to consistently bill for services that they provided using telehealth for Medicare beneficiaries. The conversation around telehealth expansion has long centered around increasing access for patients, which FQHCs were able to do through the COVID waivers. It's important that these COVID-driven changes be made permanent, and that we also continue to adopt virtual health technologies to assist with provider recruitment and retention and finding ways to optimize staffing and workflows. For years FQHCs in many States have been able to provide telehealth services for Medicaid beneficiaries, making the more stringent requirements for Medicare patients and reimbursement a source of health inequity.

Speech language pathologists, physical therapists, and occupational therapists were able to provide telehealth services during COVID and be reimbursed, demonstrating that those services could be provided safely and effectively and that a large amount of Medicare patients needed to use those services. To not have these services available could potentially hinder a patient's recovery from health-care episodes, such as stroke or post-orthopedic surgery or a pediatric patient born prematurely. During my time at the hospital, we would discharge pediatric patients after their neonatal intensive care with a prescription for speech therapy, even though there were no speech language pathologists within a 200-mile range.

4. PAYMENT PARITY

Providers who use their expertise and cognitive skills can attest that they do not give a lower quality of service for patients that they see via telehealth over those whom they see in-person, and this should be reflected in reimbursement so telehealth is not disincentivized. To note, the CMS Final Rule for CY 2024 Fee Schedule recognized that there are still practice expenses providers and clinics incur when the practitioner is in their home and have agreed to pay the non-facility rate, which is higher than the facility rate. Practitioners are expected to bill for certain things

[9] *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768772.*
[10] *https://pubmed.ncbi.nlm.nih.gov/35793732/.*

and if the service can meet the definition of the code they are billing for, they should be reimbursed the same amount regardless of whether or not the visit was in-person or via telehealth.

A common barrier to the adoption of telehealth has been State-specific laws and regulations governing reimbursement and professional licensing requirements. When the administration declared a Public Health Emergency (PHE) on March 13, 2020, and put waivers in place to remove regulations around telehealth, patients were seen virtually, keeping not only immunocompromised patients safe, but practitioners safe, and were paid for these services. The Office of Inspector General is monitoring potential fraud through use of telehealth *(https://oig.hhs.gov/reports-and-publications/featured-topics/telehealth/)*, and there have not been any announcements thereof.

It is important to acknowledge that delivery of telehealth includes myriad regulatory requirements, preferences, and challenges: and coordination of allowable services per Medicare, State Medicaid agencies, and other insurers, providers, locations, modalities, billing, payers, reimbursement, technology, provider preference, patient preference, to name a few. Now is the time to seize the opportunity to streamline and improve telehealth service delivery for everyone involved. The Office of Inspector General performed an audit of 440,003 Montana Medicaid telehealth paid claim lines totaling $43.2 million from March 1st through December 31, 2020, analyzing the procedure codes paid as telehealth and identifying which were allowable for billing as telehealth. The audit found that 99.9 percent of the lines reviewed were compliant with Federal and State requirements, and Medicaid providers generally complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during that period of the COVID–19 pandemic.[11]

In closing, telehealth plays a critical role in improving access to timely and regular health services with highly qualified health-care providers, especially for patients with challenges that affect access and care coordination. By addressing the outlined recommendations, Medicare beneficiaries will have consistent access to telehealth services, promoting their overall health and well-being. Making the telehealth leniencies discussed earlier a permanent fixture in Medicare coverage is a significant step toward improving the lives of American citizens.

Thank you for your attention to this critical matter. I appreciate the committee's dedication to enhancing health-care access for all Americans, and I am hopeful that you and your colleagues will continue to champion the cause of telehealth for Medicare beneficiaries.

PREPARED STATEMENT OF ERIC WALLACE, M.D., FASN, PROFESSOR OF MEDICINE, UAB EMEDICINE; MEDICAL DIRECTOR, CO-DIRECTOR OF HOME DIALYSIS, AND DIRECTOR OF THE RARE GENETIC KIDNEY DISEASE CLINIC, DIVISION OF NEPHROLOGY, DEPARTMENT OF MEDICINE, UNIVERSITY OF ALABAMA

The Importance of Permanency of Telehealth Payment Coverage

Chairman Cardin, Ranking Member Daines, and distinguished members of the Senate Finance Committee, thank you for the opportunity to testify on behalf of the University of Alabama at Birmingham and the American Medical Group Association. I am a professor of medicine in the Division of Nephrology at UAB, and I am the medical director of the UAB Health System telehealth program.

My role in telehealth started in 2013 when I recognized that one of my elderly dialysis patients was driving 2 hours twice monthly to get her dialysis care in Birmingham, AL. Furthermore, many of my patients with rare diseases, primarily with Fabry disease, an inherited disease which causes patients to suffer from severe pain, kidney failure, stroke, and heart failure, were also driving hours to see me. Their commutes and time spent in the waiting room were part of their disease burden. I believed that my patients' lives could be made just a little better if we could deliver the same quality care remotely. Furthermore, for every patient that could make the drive and wait for me, were there more patients that couldn't? **What if we could reach everyone?**

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[11] *https://oig.hhs.gov/oas/reports/region7/72103250.asp#:~:text=What%20OIG%20Found,with%20Federal%20and%20State%20requirements.*

UAB is home to UAB Hospital, the 8th largest hospital in the country, and performs over 1.7 million outpatient patient visits yearly. It is a world-class institution and ranks 11th in NIH research dollars awarded amongst public institutions. I am proud to call UAB not only my employer but also my home. But how can you have a world-class health-care institution in a State which ranks 46th in health-care outcomes? **What if we could remove even one barrier, such as geography, to improve access to care?**

So UAB, in collaboration with the Alabama Department of Public Health, worked for 2 years and developed a way through telehealth for me to see my dialysis and rare disease patients in a number of county health departments across the State. In 2015, we did the first fully comprehensive telehealth visit on a peritoneal dialysis patient.

There was a critical need for telehealth starting in 2020.

In March 2020, the President issued an emergency declaration for all States, given the magnitude of the COVID–19 public health emergency. UAB had already begun positioning ourselves for a rapid transition to telehealth delivery of care. Because of the groundwork laid years prior for Alabama patients to receive care over telehealth, by April of 2020, UAB transitioned over 74 percent of our outpatient clinic visits to telehealth. This allowed us to protect providers and our patients from the COVID–19 virus in the only way we knew how against an unknown pathogen at the time.

Furthermore, we watched telehealth transform rural hospitals. Prior to COVID–19, UAB was providing telehealth inpatient care, including telecritical care, telestroke, and telenephrology. When we started delivering telehealth services to Whitfield Regional Medical Center in Demopolis, AL, the average census of the hospital was around 20. In 2018, we started a telestroke, telecritical care, and telenephrology program at Whitfield, and the census started increasing; the average census is around 50 today. This is a significant benefit to the patient and their families. Equally important, keeping the care in the community helps our important rural health partners keep their doors open.

In many cases, telehealth provides better care than the previous in person alternative. Previously, if a dialysis patient arrived at Demopolis with life-threatening high potassium, they were given a medicine to remove the potassium through the stool. The patient would then be put in an ambulance and transported to the nearest dialysis-ready hospital, which would take at least 90 minutes. The ambulance had to wait at the hospital while the patient waited on a bed, and finally, around 8 to 12 hours later, the patient would be dialyzed. It was the best we could do at the time. But this was a disservice to the patient. An ambulance is used each time a patient is transferred to a larger center from Demopolis. Marengo County, AL, only has 3 ambulances, so if 2 patients were being transferred due to a lack of local services, that leaves only one ambulance to cover the whole county. With telehealth, we are able to do a nephrology consult on the patient in Demopolis; the rural hospital keeps the patient, and we are able to start dialysis within 1 hour of the patient's arrival, thus saving a transfer and time needed to treat the high potassium. Finally, UAB Hospital now has an open bed that can accept even sicker patients.

During COVID–19, there were times when Vanderbilt, Emory, Ochsner, and UAB were all full and could take no additional patients. Patients with COVID–19 needed high-risk ventilation and, at times, needed dialysis. I would be notified of these patients who otherwise would be left to die in a facility with no way to care for them. I notified one rural hospital without telehealth to transport their critically ill patient to one of our rural sites that had access to telenephrology and telecritical care. For the first time ever, patients were life-flighted into rural Demopolis, AL, which now had the resources to care for them. This demonstrates that telehealth has the potential to transform a rural hospital bed from available but unusable to available and useful. This is one of many examples of how telehealth is transforming care across the country.

The primary regulatory changes on both the Federal and State level that allowed for this complete and successful pivot to telehealth was:

1. The elimination of the geographic limitation;
2. The elimination of the originating site requirement;
3. The universal adoption of both private and public payers in parity for telehealth visits; and

4. And the allowance of audio-only visits and pay parity.

Unfortunately, these regulatory "flexibilities" are not permanent. They have been extended multiple times, with the current expiration being the end of 2024. At the end of the COVID–19 public health emergency, health-care providers that had successfully pivoted to telehealth, which was not an easy transition for most, were left with a seemingly endless barrage of new regulations regarding licensure, variations between private and public insurers, regulations in the prescribing of controlled substances, etc. Furthermore, the possibility that none of the previous "flexibilities" would be permanent added to provider frustration. We had been to war battling COVID–19 armed with telehealth only to find we were now battling new regulations. All of these regulatory hurdles increased to pre-pandemic levels. They left many providers confused and frustrated, **finding it easier to give up on telehealth rather than to face an impossible onslaught of regulations.** As a result, the utilization of telehealth began to decrease. But just as there was a need before COVID–19 for telehealth, there is a need for telehealth now, and there will be a need in the future. **Incorporating strategies, including telehealth, is the only way we will be able to organize our health care into meaningful systems to deliver equitable care across our vast geographic area in the United States.**

As we look to the future, how will telehealth play a major role in the success of any health care delivery system?

1. **Telehealth is vital to the survival of rural health care—**My father is now a retired physician. When he started his practice, it was not uncommon to be on call 7 days in a row every month, and that was if you were lucky enough to have 3 other providers to partner with. This type of call schedule is still common in rural areas. We are not training providers to be on call in this manner, making recruiting providers to rural practice difficult. Furthermore, the idea of practicing in a rural area without access to subspecialist help can be enough to decrease interest in establishing a practice in a rural area. The average age of providers in rural areas everywhere is increasing. Telehealth can help by providing call coverage and access to subspecialty support to rural providers, thus improving recruitment of primary care to these areas.
2. **Telehealth will play an ever-growing role in value-based care—**The applicability of telehealth strategies, including home-based telehealth visits and remote patient monitoring, has been proven specifically in high-risk patients. As the utilization of telehealth declines in the face of regulatory struggles, we may lose some of the momentum needed to truly realize the benefit that can be seen in value-based care approaches.
3. **Telehealth will continue to allow for the delivery of inpatient subspecialty services to urban and rural settings**—The inpatient delivery of subspecialty care is vital for both small urban and rural areas. These approaches allow for the distribution of a subspecialty workforce largely centered in large urban areas.
4. **Telehealth can alleviate nursing and provider staffing shortages by leveraging urban or national-based workforces.**

Telehealth has other advantages above and beyond what it provides for healthcare delivery. Since its inception, UAB telehealth has saved 28,500,000 miles of driving to and from doctor's visits. That is equivalent to the reduction in CO_2 emission of 2,619 passenger vehicles off the road for an entire year, saving patient's gas money, commute time, and time away from work and family. Alabama gained 16,1470,00 dollars in productivity by patients being able to work the times that otherwise would have been spent driving alone to doctor's appointments. We are one institution that uses telehealth, but multiply this by every institution, and you have improved CO_2 emissions and improved utilization of our fuel.

What do we need to do as a country to ensure that we continue to deliver telehealth now and ensure its survival to fully develop its potential within our national health-care delivery infrastructure and ensure its availability to scale up during times in the future, such as COVID–19?

1. **The elimination of the geographic restrictions needs to be permanent. Prior to COVID–19, patients had to do their telehealth in a medical facility in a rural area. The COVID–19 pandemic removed this restriction, which will expire at the end of 2024.** I'll never forget

a patient of mine who was unable to walk who lived in Birmingham. His father would take him to the clinic and was about to lose his job from driving his son to and from clinic visits. The patient lived no more than 2 miles from our clinic, but getting in and out of a vehicle and parking close to our clinic was enough to make any clinic visit a half-day event. He found out I was seeing patients through telehealth and brought me an article in which I had been featured. And he asked me, "Is this for me?" And the answer was "no" at the time because he lived in an urban area. Another example of the need for telehealth in urban areas relates to transplants. UAB is the only transplant center in the State, yet a patient in Mobile, AL, which is 4 hours away but urban, had to drive to a rural county to receive their transplant care. Why? Care for rare and ultrarare diseases can sometimes only be found multiple States away. We all would want our children to go to the "expert." Yet if the geographic restriction comes back, this would not be possible over telehealth for those living in urban centers. Access to care problems is not geographically restricted, so why should our regulations be?

2. **The elimination of the originating site requirement needs to remain permanent.** Delivery of telehealth care within brick-and-mortar sites is a great way to care for patients who do not have access to technology. However, the operational hurdles, including contracting for space in external sites and scheduling across systems and electronic medical records, are not such that it can be the sole manner to deliver telehealth services. The home is adequate and will continue to improve as a site of care as the accessibility to in-home diagnostics continues to improve.

3. **Coverage for telehealth needs to continue at parity for in-person visits and needs to be permanent.** The delivery of telehealth is not just a video visit with your provider. For these visits to be efficient, the same staff is needed to ensure the visit is a success. Someone has to schedule the visit; someone has to do med reconciliation and, in many cases, "room" the patient electronically. Furthermore, there are ongoing technology costs, including subscriptions to platforms, information technology support, etc. Should the reimbursement drop below parity, given the ongoing costs, providers will be unable to provide telehealth visits, which will be a great disservice to patients who now rely on technology as a lifeline to good care.

4. **Audio-only visits should continue to be covered.** Although video visits are a preferred method for delivering telehealth services, not all patients can access video visits. Suppose a provider attempts to get a patient on video due to technology access. In that case, the patient cannot get on video; this is documented, and care is rendered. That time should be reimbursed commensurate with the time-based codes for in-person visits. An hour's visit on the phone is still an hour of provider time. Furthermore, physicians trying to care for the most disparate of populations are going to be the hardest hit financially by regulations that reduce reimbursement for audio only telehealth. Unfortunately, the reality for some patients is audio only care versus no care at all.

5. **Controlled substances that are not Schedule 2 should be allowed to be prescribed over telehealth.** For many not in the medical field, controlled substances immediately conjure images of opioids and benzodiazepines. However, other medications are included, and some may not realize that antiseizure medications are in these categories. It does not make sense that a patient with epilepsy, whom we have restricted from driving, cannot get a prescription for their antiseizure medications over telehealth when appropriate. Furthermore, data has shown that suboxone, used to treat opioid addiction and prevent overdoses, can safely and effectively be prescribed for a limited quantity over telehealth, followed by quick in-person follow-up to ensure access to this drug. My colleagues who treat OUD at UAB were able to provide rapid access to addiction treatment and overdose prevention via telehealth during the pandemic. Now, regulatory barriers make it hard to get new patients, such as those recently released from rehab or jail, into addiction treatment using telehealth. Overdose deaths rose 11 percent in AL last year. We must extend the lifeline of telehealth to halt the overdose crisis.

6. **Direct supervision of residents should also remain possible via telehealth.**

In closing, we must maintain and support telehealth through permanent legislation as it is critical to the survival of rural health, the future of our health-care sys-

tem's ability to deliver equitable care regardless of geography, and is integral to our ability to deliver on the promise of value-based care. Just as important as its importance to the structure of health-care delivery is that behind each of these asks are human beings who have grown to rely on this technology as a lifeline to care. Thank you.

COMMUNICATIONS

AARP

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the Senate Committee on Finance's effort to examine Medicare beneficiary access to telehealth services.

Access to telehealth provides convenience, protects against exposure to infection, improves treatment adherence, enables chronic disease management, and promotes independence and autonomy for people with Medicare. Telehealth benefits can be particularly significant for older adults in rural areas or underserved communities by reducing or eliminating travel and wait times, distance and transportation barriers, and certain travel or transportation costs. These individuals face added barriers to care, including long distances and additional costs, when visiting providers and specialists. In some cases, a specialist or provider may be so far away that the distance is prohibitive, in which case the person may forgo care altogether. Overall, telehealth services are an important care-delivery tool and a valuable complement for in-person care.

Telehealth can also support America's more than 48 million family caregivers in their efforts to take care of their loved ones. Telehealth may offer working or long-distance family caregivers an alternative way to participate in their loved one's medical care. By reducing travel, wait times, and costs associated with in-person care, telehealth can also allow caregivers more time to tend to their own needs, which can alleviate some of the stress linked to balancing caregiving responsibilities with other obligations. Research has shown that use of telehealth services by family caregivers results in better physical and mental health, improved caregiving knowledge and skills, and higher satisfaction in their caregiving roles.

The COVID–19 pandemic forced Medicare to quickly adapt to an increased need for telehealth, often relying on waivers to allow for otherwise impermissible care. AARP believes Medicare beneficiaries should continue to be able to access care via telehealth beyond the current December 31, 2024, waiver expiration. However, we urge Congress to act deliberately and thoughtfully, rather than making all waivers and flexibilities permanent with one fell swoop. Just because a service or provider was permitted during the public health emergency does not mean it should automatically continue without examination. We now have 3 years of data on which to evaluate the quality, value, and utilization of telehealth services in Medicare. Decisions should be made for each service code, each provider type, each modality, and each reimbursement amount independently of their in-person counterpart, not writ large.

We know that older Americans use and have a favorable opinion of telehealth. According to recent AARP research, half of adults age 50-plus say they or a family member have used telehealth in the past 2 years. Yet a third of those who have experience with telehealth still expressed concern that the quality of care is not as good as with in-person care.[1] As the Committee and Congress work to address permanent access to telehealth in Medicare, we urge you to consider the perspective of people with Medicare.

Geographic and Originating Site Restrictions

AARP firmly believes that removing telehealth restrictions related to location and geography are fundamental and foundational to increasing access to care in the modern age. These restrictions prevent telehealth from being used by people, providers, and facilities in urban and suburban areas and prevent people with Medicare

[1] Keenan, Teresa A. *An Updated Look at Telehealth Use Among U.S. Adults 50-Plus.* Washington, DC: AARP Research, May 2022. *https://doi.org/10.26419/res.00535.001.*

from receiving care at home based on where they live. Similar restrictions placed on distant sites should be permanently removed as well, to allow patient engagement with Federally Qualified Health Centers and Rural Health Centers. Additionally, eliminating Medicare restrictions should be done in concert with reducing existing barriers to care elsewhere, such as through greater investment in broadband and workforce, to ensure the people and communities who have historically faced challenges accessing care and who can most benefit from telehealth have the opportunity to use it.

Telehealth Reimbursement

In general, payment for telehealth services should be sufficient to support telehealth use by providers and raise value for patients. Medicare and other payers should thoughtfully consider how to reimburse clinicians and other telehealth providers. This includes accounting for the cost of providing telehealth; the need to support patients' ongoing access to telehealth with compensation that fairly incentivizes its use; the need to avoid unnecessary additional costs; and the efficiencies telehealth may afford. Reimbursement for telehealth services should be independently calculated the same way as in-person services, taking into account the same relative value variables as in-person service codes. The cost of performing a telehealth service may not be the same as the cost of performing its in-person counterpart, thus it should not be reimbursed the same.

Quality and Program Integrity

AARP supports Congress removing statutory prohibitions to telehealth in Medicare and affirming the Centers for Medicare & Medicaid Services authority to implement telehealth coverage. But we believe that before CMS makes the expanded list of services and providers permanent, we must understand their impact on quality of care and outcomes, as well as on the program integrity and financial standing of Medicare. CMS has laid out a framework to do so through the Physician Fee Schedule regulatory process, and we urge both legislators and policymakers to not circumvent this and other processes intended to ensure quality and safety.

Relatedly, requiring a pre-existing relationship with a provider prior to a telehealth visit is an important patient safety standard. However, there are many instances in which the requirement becomes a barrier to care that can harm patients rather than protect them. Policy should be informed by clinical standards of care and determined for each service. Furthermore, many services, particularly mental health services, can be safely and effectively delivered via audio-only, rather than audio-video. Requiring a live video link can put an undue burden and create barriers to care for Medicare beneficiaries. Many people with Medicare do not have the technological capacity or understanding to operate a live video link. Others do have the know-how, but are stymied by a lack of broadband, bandwidth, and connectivity needed to maintain a stable video connection. Overall, we caution against making straight comparisons between in-person services and telehealth services, between different modalities, and between the providers delivering in-person versus the providers delivering care remotely. Ensuring high-quality, high-value care requires a more nuanced approach.

Conclusion

The recent Medicare telehealth waivers and flexibilities have clearly demonstrated the usefulness and promise of health care delivered via telehealth. People with Medicare risk losing the convenience and reliability of telehealth services when coverage ends in December 2024. We are grateful that you are working to address Medicare telehealth coverage well in advance of the looming deadline. Fortunately, there is much to build on already. For instance, we have endorsed S. 2016, the *CONNECT for Health Act.* We recommend Congress take up this and other legislation that will allow older Americans access to the array of tools and services available for delivering high-quality, high-value care.

Thank you for the opportunity to provide AARP's perspective on improving Medicare's coverage of telehealth services. We look forward to working with you to address this important issue and ensure continued convenient access to quality health care for older Americans.

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Dear Health Subcommittee Chair Cardin (D–MD), Health Subcommittee Ranking Member Daines (R–MT), and Members of the Senate Finance Health Subcommittee:

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide input to the Committee hearing on "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." We applaud your continued leadership and critical role in ensuring continued telehealth access post-COVID–19 public health emergency. We look forward to working with you to ensuring permanent access to telehealth.

The Alliance is dedicated to improving access to care through the reduction of policy, legal and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance also works in partnership with an Advisory Board of more than 50 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

The experience during COVID–19 has pushed forward a revolution in consumer attitudes toward virtual care. Polling data from the University of Michigan [1] showed that 64 percent of those surveyed in June 2020 were comfortable with using videoconferencing technology for any purpose, up from 53 percent in May 2019. A major study of more than 4 million primary care encounters from MedStar Health, Stanford Health Care, and Intermountain Health found that telehealth did not increase utilization, but rather served as a substitute for certain in-person encounters. In the same study, telehealth was mostly utilized for patients whose medical needs required multiple primary care visits during each year, suggesting that these telehealth encounters enabled follow-up for patients. A study from Epic Research,[2] also found similar results. A subsequent study [3] found that a significant share of physicians continue to heavily rely on telehealth services amid the general decline in telemedicine use post-COVID. Other studies [4] found similar results. *These findings show us that fears about overutilization of telehealth in Medicare are unfounded, as usage rates have declined to a small, steady proportion of visits. Patients and health care practitioners have adopted telehealth as needed, and are using it appropriately.* According to an Alliance-commissioned Medicare claims data analysis,[5] the average per service cost of an E&M telehealth visit to the Medicare program is less than in-person services by approximately 20%. The reason for this difference was that telehealth clinicians generally billed shorter visit codes than in-person providers.

Telehealth research continues to align in its findings and future telehealth research in the few years after the public health emergency will continue to demonstrate use for telehealth. Policymakers have more than enough data to see the benefits of telehealth and consider a permanent pathway to ensure that telehealth continues to be available and accessible for Medicare beneficiaries.

The Alliance will focus comments on (1) recommendations for a permanent telehealth expansion that Congress should consider—including steps to ensure equitable access; (2) other non-Medicare recommendations that we believe Congress should prioritize, and (3) while we generally do not believe additional telehealth guardrails are needed, we offer some options here that would be operationally feasible for health care organization to implement without significantly disrupting patient access to care.

Top Telehealth Priorities

The Alliance believes that Congress should expand access of Medicare telehealth by permanently lifting the barriers of 1834(m). It is important to note that the removal of these broad statutory restrictions does not mean the removal of guardrails on Medicare services. Even without specific restrictions on telehealth, the full array of payment, cost, quality, and fraud prevention powers afforded to the Centers for

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[1] *https://labblog.uofmhealth.org/rounds/telehealth-visits-skyrocket-for-older-adults-but-concerns-and-barriers-remain.*
[2] *https://epicresearch.org/articles/fewer-in-person-follow-ups-associated-with-telehealth-visits-than-office-visits.*
[3] *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806867.*
[4] *https://divisionofresearch.kaiserpermanente.org/telehealth-users/.*
[5] *https://connectwithcare.org/medicare-telehealth-analysis/.*

Medicare and Medicaid Services (CMS) would be available to ensure Medicare only paid for high-quality, clinically appropriate telehealth care.

Below, we outline several recommendations that Congress should consider to permanently expand telehealth to Medicare beneficiaries.

Core Statutory Challenges in Medicare

1. **Expand patient access to telehealth services by removing geographic and originating site limitations to enable patients to communicate remotely with their providers regardless of location.** The Alliance supports legislation to eliminate the originating site construct completely—rather than just adding the "home." Section 1834(m) of the Social Security Act has long been a barrier to expanding Medicare beneficiaries' access to telemedicine due to stringent originating site and geographic location restrictions. Evidence has shown that telemedicine is not only necessary in rural and underserved areas, but also in urban and suburban communities where mental health care may not be accessible, convenient, or affordable. Furthermore, Medicare/Medicaid populations traditionally face significant transportation barriers such as affordability and physical impairments, making it more difficult to get to an in-person location. While requiring specific sites of care for telehealth may have made sense when technology was new and unreliable, the commercial market today is effectively deploying telehealth nationwide. There is no reason for our most vulnerable populations to have less access to care. In addition to patients, providers also request this flexibility. An Alliance 2022 survey[6] found that 8 in 10 practitioners say that retaining telehealth for health care practitioners would make them, *personally,* more likely to continue working in a role with such flexibility.

2. **Remove distant site provider list restrictions** to allow all Medicare providers who deliver telehealth-appropriate services to provide those services to beneficiaries through telehealth when clinically appropriate and covered by Medicare—including physical therapists, occupational therapists, speech-language pathologists, social workers, and others. Additionally, direct CMS to work to ensure that in-person payment models, such as those in which a facility/provider organization bills on behalf of a care-team can be fully compatible with virtual care environment.

3. **Ensure Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics can furnish telehealth in Medicare** and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each. Current payment structures often do not capture the unique billing characteristics of telehealth and remote patient monitoring services and need to be updated to better align with the broader CMS payment environment.

4. **Allow the Centers for Medicare and Medicaid Services to cover audio-only telehealth services where necessary to bridge gaps in access to care.** Audio-only telehealth visits should continue to be an option for patients who lack access to the resources needed to participate in video-based telehealth. The digital divide is well documented and congressional plans are in place to help narrow its impact over the next 5 years. We collectively acknowledge that patients across a wide range of demographic groups do not have sufficient internet access, device access, or digital skills to connect with their clinicians over a stable video connection. In these instances, patients and providers should have the flexibility to choose when an audio-only telehealth visit is both clinically appropriate and preferred by the patient. This would be consistent with prior CMS language emphasizing the importance of patient choice. We anticipate that CMS would also maintain a list of services that were appropriate for audio-only care, as it has done for the past several years.

Additional Medicare Challenges

5. **Allow providers rendering telehealth services from their home to offer services without reporting their home address on their Medicare enrollment or billing paperwork.**[7] CMS allowance for practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment or billing paperwork will end on December 31, 2024.

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[6] *https://connectwithcare.org/alliance-news/patients-and-practitioners-agree-telehealth-is-important-for-patient-access-health-care-workforce/.*

[7] *https://connectwithcare.org/provider-location/.*

While these changes are within CMS's regulatory authority, we look forward to working with members of the Finance Committee to ensure CMS prioritizes the needs of telehealth providers in addition to patients.

6. **Drive better and more coordinated care for those with chronic disease through adequate reimbursement and flexibility supporting greater use of remote patient monitoring (RPM) technology.**[8] Remote patient monitoring has a huge potential to reduce Medicare expenditures through better health and avoided hospital admissions. Geographic variation results in lower Medicare payments for remote patient monitoring in rural areas, despite many costs being higher in these areas where connectivity is more difficult. While these changes are within CMS's regulatory authority, we request that members of the Finance Committee prioritize work to expand rural access to remote patient monitoring.
7. **Facilitate the removal of remaining telehealth restrictions on alternative payment models,** Accountable Care Organization's (ACO) telehealth flexibility is limited a narrow set of ACOs with downside risk and prospective assignment—even though other tools apply to all ACOs. Since all participants in the Medicare Shared Savings Program are being held accountable for quality, cost, and patient experience, all of them should have flexibility to use telehealth tools to deliver care. We recommend eliminating Sec. 1899. [42 U.S.C. 1395jjj] (I)(2) requirements limiting participation to a select set of ACOs. We believe CMS may already have the statutory authority to make these changes under 42 U.S.C. 1315a(d)(1) and 42 U.S.C. 1395jjj(f) if directing the use of authority instead would keep the score down.

Other Telehealth Challenges

1. **Encourage Additional Care Across State Lines**[9]—While we recognize that licensure is a state, not federal authority, we believe there is much that Congress can do to incentivize the adoption of licensure reciprocity among states. We strongly encourage Congress to support legislation and funding that helps patients receive access to care, even when that care is not available in their state. One option would be to provide incentives for states to adopt the Uniform Law Commission's Telehealth Act.[10] Simultaneously, there could be specific federal telehealth licensure carve outs similar to those successfully enacted by the Veterans Administration for VA patients, the Department of Defense for military spouses practicing medicine when deployed, and by Sports Medicine physicians to care for players even when they travel to another state. These telehealth licensure carve outs would allow for recognition of the providers home license when they virtually care for out of state patients under certain clinical scenarios such as organ donation, clinical trials, rare medical diseases, student health, and established patients. A multidisciplinary team of experts from leading national institutions developed a consensus statement[11] outlining these and other possible licensure solutions.
2. **Continue Oversight of the Drug Enforcement Administration (DEA)'s Regulations Restricting the Prescribing of Controlled Substances via Telemedicine**[12]—Special registration to prescribe controlled substances through telemedicine was originally called for in the Ryan Haight Act of 2008.[13] After 15 years of several congressional mandates to promulgate regulations related to a Special Registration for Telemedicine, the DEA has still not issued permanent policy. On October 6, 2023, the DEA extended temporary flexibility for telehealth prescribing through December 31, 2024. Its proposed rule, offered in the spring of 2023, would cut off access to care for millions of Americans and must not be finalized as proposed.
3. **Make Permanent the HDHP/HSA Telehealth Safe Harbor Created in Section 3701 of the CARES Act.**[14] This provision allows Americans with health savings account (HSA) eligible high deductible health plans (HDHP) to access telehealth services before their annual deductible was met, ensuring that employers and plans could support patients that were leveraging virtual

[8] *https://connectwithcare.org/remote-patient-monitoring/.*
[9] *https://connectwithcare.org/cross-state-licensure/.*
[10] *https://www.uniformlaws.org/committees/community-home?communitykey=2348c20a-b645-4302-aa5d-9ebf239055bf.*
[11] *https://chlpi.org/resources/consensus-statement-for-telehealth-licensure-reforms/.*
[12] *https://connectwithcare.org/dea-prescribing-of-controlled-substances/.*
[13] *https://www.congress.gov/110/plaws/publ425/PLAW-110publ425.pdf.*
[14] *https://connectwithcare.org/hdhp-telehealth/,*

care to access a range of critical health care services during the pandemic. This has provided important virtual care for 32 million individuals with these plans. As such, we strongly urge the Finance Committee to pass S. 1001—*the Telehealth Expansion Act of 2023* as introduced by Senators Daines and Cortez Masto.

4. **Allow Employers to Offer Telehealth Benefits for Seasonal and Part-time Workers.** Increasing access to some telehealth benefits for part-time employees, seasonal workers, interns, new employees in a waiting period can be a meaningful way to support workers—as long as this access supplements health insurance purchased by that individual or a family member. We urge Congress to find a way to continue expanded access that has been experienced by workers over the past several years.

Recommendations for Fraud, Waste and Abuse

The Alliance understands that with change sometimes comes risk, and that Congress holds ultimate authority for protecting the Medicare program. We understand and respect this responsibility. We also believe that, using the data we are collecting about the provision of telehealth services during the PHE, the Medicare program and the Office of the Inspector General at HHS will be able to target and differentiate nearly all fraudulent behavior. Congress must trust this capability and authority, rather than creating barriers to access between Medicare beneficiaries and critical health services.

The Alliance and its members strongly believe that *an in-person requirement is never the right guardrail for a telehealth service.* Requiring an in-person visit constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. It does not constrain those using telehealth for convenience. This creates a perversion of the Medicare payment system by reducing access for those who need it most, while allowing access for others. We cannot create a guardrail that is an access barrier between patients and their clinicians—it will lead to harm the most vulnerable and access-constrained Medicare beneficiaries.

We also believe it is important to note that nearly all of the fraud Congress may seek to prevent is fraud that mirrors activities currently occurring during in-person care. These concerns include fraudulent Medicare enrollment, false claims, fake patients, and durable medical equipment (DME) prescribing. All of these issues are problems for the Medicare program—and should be addressed as Medicare fraud problems. They are not new problems for telehealth services. Therefore, an in-person requirement would hinder legitimate telehealth providers while doing very little to stop fraudulent actors. Instead of creating barriers to services for Medicare beneficiaries, Congress must empower CMS to address fraudulent actors.

With the understanding the Congress may still want to pursue additional guardrails against fraud, waste, and abuse as part of telehealth legislation, we offer the following alternatives. Please note that many of these are simple regulatory changes, and could be issued as recommendations to CMS.

- **Develop restrictions to prevent the exploitation of telehealth services by soliciting telemarketers.** In combination with an enhanced Medicare provider enrollment process, we believe that a restriction on the solicitation would provide significant protection against durable medical equipment (DME) fraud actors exploiting telehealth services to drive improper DME sales. This restriction *would not apply* to patient outreach that: arises out of an established patient-provider relationship and is conducted for purposes of appropriate management of acute or chronic disease; arises out of a Medicare enrolled provider's referral to a new provider or supplier for appropriate items or services; or meets an otherwise applicable marketing exception under HIPAA or other federal or state consumer protection laws. We do not believe that this restriction would significantly hinder appropriate healthcare organization marketing or existing healthcare delivery models.
- **Strengthen the Medicare provider enrollment process for telehealth:**
  - Require new virtual-only providers to indicate their intent to bill only virtual services during the enrollment process. Subject these providers to enhanced scrutiny and/or audits.
  - Consider additional private-sector accountability tools for virtual-only providers, such as certifications. Such certifications could include education on billing and the avoidance of fraud and abuse in billing for telehealth services.

- To provide telehealth services to a Medicare beneficiary, all providers must indicate the intent to do so during enrollment. Phase in for currently enrolled providers. Establish clear billing guidelines for services arising out of telehealth service/CTBS.

- **In place of an in-person requirement prior to prescribing, consider alternate restrictions on DME.** While we recognize and support efforts to address DME fraud, including when it exploits virtual care tools, we believe there are better tools to address this concern:
  - Temporarily allow prescribing (for 2–3 years) with enhanced monitoring tools. At the end of this period leverage data collected to design any restrictions.
  - Enhanced monitoring tools should identify providers with unusual, high-volume DME prescribing patterns for audits or investigation. Initiate early communication with unusually high-volume providers that their volume is unusually high even before expending resources on an investigation.
  - Require that the prescribing of DME be tied to documented and auditable clinical criteria.
  - Require DME to be tied to a service code/submission (even if telehealth not billable)—making it easier for the Medicare program to track.

- **Strengthen existing HHS/OIG efforts to fight fraud and guide health care organizations.** The Office of the Inspector General at HHS has been effective in combating DME fraud that exploited virtual care tools. We should maintain and enhance that authority through additional resources. OIG must also issue telehealth compliance guidance, inviting input and opportunity to comment from the Alliance for Connected Care, the American Health Lawyers Association and other interested private sector groups before publication, to healthcare organizations to help prevent and mitigate unintentional mistakes related to Medicare telehealth billing.

The Alliance greatly appreciates the Senate Finance Committee's leadership in working to ensuring permanent access to telehealth. We look forward to working with you to develop and advance bipartisan legislation to enhance telehealth access for Medicare beneficiaries. If you have any questions or would like to hear from Alliance member experts on these topics, please do not hesitate to contact Chris Adamec at cadamec@connectwithcare.org.

Sincerely,

Krista Drobac
Executive Director

ALZHEIMER'S ASSOCIATION AND ALZHEIMER'S IMPACT MOVEMENT
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The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the United States Senate Committee on Finance, Health Subcommittee hearing on "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." The Association and AIM thank the Subcommittee for its continued leadership on issues important to the millions of people living with Alzheimer's and other dementia and their caregivers.

This statement highlights the importance of telehealth policies that continue to help people living with Alzheimer's and other dementia access timely and high-quality care, including efforts to expand capacity for health outcomes through Project ECHO, and the expansion of Medicare and Medicaid coverage of certain telehealth services. While greater coverage of telehealth services has allowed individuals living with Alzheimer's and other dementia to receive consistent care in numerous settings, we also encourage the Subcommittee to support innovative efforts to increase access to telehealth and telemedicine for Medicare beneficiaries for whom access to broadband or technology is problematic.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority.

Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Expansion of Telehealth Service Coverage

The Alzheimer's Association and AIM are grateful that the Centers for Medicare & Medicaid Services (CMS) permanently expanded Medicare and Medicaid coverage for many telehealth services important to persons living with dementia and caregivers. For example, CMS has permanently expanded coverage for numerous codes that are beneficial to people living with Alzheimer's and other dementia so that they can continue accessing care in settings that best serve their unique needs. In particular, the Alzheimer's Association and AIM supported CMS's decision to allow for telehealth coverage of care planning CPT code 99483. Care planning is critical for people with cognitive impairment under normal circumstances to help them manage comorbid conditions and make decisions about long-term care and support services, among others. Ensuring that a plan is established, documented, and updated is now more important than ever. Making this service available via telehealth will improve access to care planning for this vulnerable population. To that end, we also thank Congress for passing the bipartisan Improving HOPE for Alzheimer's Act (S. 880/H.R. 1873), which continues to educate clinicians on the importance and availability of this crucial Medicare care planning service.

Finally, we appreciate CMS's flexibility in allowing telehealth technology to be used in home health delivery. Thirty-two percent of individuals using home health services have Alzheimer's or other dementia. The ability to receive care in the home decreases visits to unfamiliar places that may cause agitation in people with dementia and can ease some burden on caregivers. This increased flexibility can reduce interruptions in access to this kind of quality care.

Expanding Capacity for Health Outcomes (Project ECHO)

First, we ask that the Subcommittee support the expansion of and continued investment in the use of technology-enabled collaborative learning and capacity-building models, often referred to as Project ECHO. These models use a hub-and-spoke approach by virtually linking expert specialist teams at a "hub" with the "spokes" of health providers in local communities to increase on-the-ground expertise. Using case-based learning, Project ECHO models can improve the capacity of providers, especially those in rural and underserved areas, on how to best meet the needs of people living with Alzheimer's and other dementia. In 2018, the Alzheimer's Association launched an Alzheimer's and Dementia Care Project ECHO Network—a highly successful telementoring program that has trained more than 330 health care professionals from 116 primary care practices and more than 250 professional care providers from 91 long-term care communities in a free continuing education series of interactive, case-based video conferencing sessions across the United States.

Project ECHO dementia models are helping primary care physicians in real-time understand how to use validated assessment tools appropriate for early and accurate diagnoses, educate families about the diagnosis and home management strategies, and help caregivers understand the behavioral changes associated with Alzheimer's. Participants express high levels of satisfaction with the program and the majority (95 percent) of primary care clinicians who join the Alzheimer's and Dementia Care ECHO program said the quality of care they provide improved as a result of their experience. Long-term and community-based care providers also benefit from Project ECHO dementia programs. Recent evaluations from the Alzheimer's Association demonstrate statistically meaningful increases in confidence in working with people living with dementia and overall disease knowledge post-ECHO completion and 92 percent of long-term care participants felt that the information gained through participation was valuable in their work.

In 2020, the Alzheimer's Association launched the Alzheimer's and Dementia Care ECHO Global Collaborative. We are engaging partners across the world using the ECHO model to increase equitable access to dementia detection and person-centered dementia care. This group meets quarterly and has identified three key working objectives: (1) increase the use of Project ECHO for Alzheimer's and other dementia care; (2) increase evidence around the efficacy of the ECHO model for dementia; and (3) increase and advance policy and funding support for ECHO programs focused on dementia. This robust network currently includes 18 partners spanning four continents, with nine additional organizations exploring the ECHO model for dementia.

One partner in the Alzheimer's and Dementia Care ECHO Global Collaborative is the Dementia ECHO Indian Country Program. The Indian Country Program is designed to support clinicians at the Indian Health Service and caregivers to strengthen the knowledge and care around dementia tribal patients. These ECHO programs are interactive online learning environments where clinicians and staff serving American Indian and Alaska Native patients connect with peers, engage in didactic presentations, collaborate on case consultations, and receive mentorship from clinical experts from across Indian Country. As a result, these ECHO programs enable primary care providers to better understand Alzheimer's and other forms of dementia, emphasize high-quality, person-centered care in community-based settings, and aim to improve health outcomes while reducing geographic barriers and the cost of care through a team-based approach.

Project ECHO was especially crucial during the COVID–19 pandemic, where the models played an important role in how health providers, public health officials, and scientists in real-time share best practices and information. For example, the Agency for Healthcare Research and Quality (AHRQ) established the AHRQ ECHO National Nursing Home COVID–19 Action Network of over 100 ECHO hubs to train nursing home staff on COVID testing, infection prevention, safety practices to protect residents and staff, quality improvement, and how to manage social isolation. The Network received nearly $237 million in federal funding during the pandemic, and, as a result, was able to reach nearly two-thirds of nursing homes in the United States. Investing in Project ECHO models is an innovative way to improve the capacity of a quality healthcare workforce to meet the needs of a growing aging population, including primary care physicians, specialists, and long-term care workers.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Subcommittee and its continued commitment to advancing legislation important to the millions of families affected by diseases such as Alzheimer's and other dementia. We look forward to working with the Subcommittee and other members of Congress in a bipartisan way to advance policies that would help this vulnerable population receive consistent, high-quality care through Medicare and Medicaid coverage of certain telehealth services and the continued expansion of Project ECHO models.

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Dear Chairman Cardin and Ranking Member Daines:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership to address issues impacting family physicians and their patients through today's hearing entitled "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency."

As the usual source of care for patients across the lifespan, family physicians are uniquely trained to practice across care settings and meet the needs of their communities, including offering care by their patient's preferred and most appropriate modality. This has more frequently included care delivered via telehealth, which has seen increased utilization as a result of the pandemic. Telehealth claims have jumped from 0.1% in 2019 to about 5% at the end of 2021.[1] According to a recent AAFP survey, 9 in 10 family physicians practice telehealth today.

The AAFP supports[2] expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes, and decrease costs when utilized as a component of, and coordinated with, longitudinal care.

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[1] Shaver, J. The State of Telehealth Before and After the COVID–19 Pandemic. Prim Care. 2022 Dec;49(4):517–530. doi: 10.1016/j.pop.2022.04.002. Epub 2022 Apr 25. PMID: 36357058; PMCID: PMC9035352.

[2] *https://www.aafp.org/about/policies/all/telehealth-telemedicine.html.*

Any permanent expansion of telehealth benefits should be structured to not only increase access to care but also promote high-quality, comprehensive, continuous care, as outlined in the joint principles[3] for telehealth policy put forward by the AAFP, the American Academy of Pediatrics and the American College of Physicians. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

As telemedicine services are expanded and utilized to achieve the desired aims, it is also imperative that outcomes are closely monitored to ensure disparities in care are not widened among vulnerable populations. Policies should acknowledge the geographical and socioeconomic disparities that exist and could be exacerbated by the improper adoption of telehealth if not explicitly addressed. Access to broadband is a social determinant of health. All patients and practices should have broadband access to support delivery of telehealth services in accordance with AAFP's policy on Health Care for All.[4] It is with these considerations in mind that the AAFP offers the following policy recommendations in response to today's hearing:

Promoting Patient-Physician Relationships

Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and underresourced communities and vulnerable populations. As discussed in the Academy's comments[5] on the CY24 Medicare Physician Fee Schedule proposed rule and our aforementioned joint principles, **the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship.**

Telehealth should also enable higher-quality, more personalized care by making care more convenient and accessible for patients. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the central value offered by a usual source of primary care, a continuous and comprehensive patient-physician relationship, increase fragmentation of care, and lead to the patient receiving suboptimal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care.

The AAFP strongly believes telehealth is most appropriate when provided by a patient's usual source of care. We have significant concerns about the rapid proliferation of direct-to-consumer (DTC) telehealth vendors and the resulting interference with the established patient-physician relationship. In the last several years we've seen new and different types of DTC telehealth vendors emerge, including many for-profit start-ups that market themselves in ways that lead a consumer to believe they are providing true, person-centered health care. The dangers of these types of companies extends beyond disrupting the established patient-physician relationship but can range from misusing patient data to making patients vulnerable to medical misinformation and can even lead to patient harm.

Studies have shown that DTC telehealth can lead to increased utilization and may ultimately increase overall health care spending. Meanwhile, in July 2022, the Office of the Inspector General (OIG) released a Special Fraud Alert[6] regarding fraud schemes where telemedicine companies offer kickbacks for prescribing medically unnecessary items and services for individuals with whom the clinician often does not have a relationship. As noted by the OIG, "These types of volume-based fees not only implicate and potentially violate the Federal and anti-kickback statute, but they also may corrupt medical decision-making, drive inappropriate utilization, and result in patient harm."

The AAFP remains concerned about the lack of regulation and transparency DTC telehealth companies are subject to and how that might impact patient care and outcomes. DTC telehealth cannot replace in-person care and is not an adequate replacement for a longitudinal patient-physician relationship, especially for patients with complex medical conditions.

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[3] *https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-Congress-TelehealthHELP-070120.pdf.*

[4] *https://www.aafp.org/about/policies/all/health-care-for-all.html.*

[5] *https://www.aafp.org/content/dam/AAFP/documents/advocacy/payment/medicare/LT-CMS-MedicarePhysicianFeeSchedule24ProposedRule-090623.pdf.*

[6] *https://oig.hhs.gov/documents/root/1045/sfa-telefraud.pdf.*

In light of these concerns, **the AAFP supports**[7] **the implementation of telehealth coverage guardrails to protect the quality and continuity of care delivered virtually, such as requiring an established patient relationship for some telehealth services.** Ensuring beneficiaries receive telehealth services from a clinician that knows them and can access their health record will help ensure patients receive appropriate care, including in-person services when needed.

A report[8] from the HHS Office of the Inspector General found that 84 percent of Medicare fee-for-service telehealth visits are already being provided by clinicians who have an established relationship with the beneficiary. Other studies indicate[9] patients prefer telehealth services provided by their usual source of care. Implementing additional guardrails would help ensure high-quality services are being delivered to beneficiaries without unduly restricting access to care, while also safeguarding program integrity.

Removal of Existing Medicare Restrictions

The Academy has advocated in support of permanently removing the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can continue to access care at home. The COVID–19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

Further, **the AAFP supports the removal of remaining telehealth restrictions on alternative payment models.** Currently, telehealth flexibility is limited to a narrow set of Accountable Care Organizations (ACOs) with downside risk and prospective assignment—even though other tools apply to all ACOs. Since all participants in the Medicare Shared Savings Program are being held accountable for quality, cost, and patient experience, they should all have the flexibility to use telehealth tools to deliver care.

Telehealth for Mental and Behavioral Health

The COVID–19 public health emergency (PHE) transformed access to mental and behavioral health care via telehealth, making it possible for many patients to be connected to appropriate clinicians and treatment that had otherwise been unavailable to them due to financial, geographic, coverage, or other barriers. **As PHE flexibilities end, we strongly urge that Congress implements policies to minimize disruptions in access to tele-mental and behavioral health care.**

The AAFP has consistently[10] advocated to Congress to permanently remove the in-person requirement for tele-mental health services for Medicare beneficiaries. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[11] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients. Arbitrarily requiring an in-person visit prior to coverage of telemental health services will unnecessarily restrict access to behavioral health care.

As acknowledged in the AAFP's recent comments[12] to the Drug Enforcement Administration (DEA), the in-person connection between a physician and patient can provide a valuable touchpoint for patients receiving Medications for opioid use disorder (MOUD) and other opioid use disorder (OUD) treatment services. However, existing shortages of clinicians prescribing buprenorphine for OUD, as well as numerous other barriers faced by patients with OUD, will prevent many patients from being able to obtain an in-person visit, particularly within the DEA's proposed 30-

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[7] *https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/vaccines/LT-HHS-PHEUnwinding-061722.pdf.*

[8] *https://oig.hhs.gov/oei/reports/OEI-02-20-00521.pdf.*

[9] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5704580/.*

[10] *https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/misc/LT-SenateFinCmte-BHI-111521.pdf.*

[11] Pew Trust. (2021, December 14). State Policy Changes Could Increase Access to Opioid Treatment via Telehealth | The Pew Charitable Trusts. *https://www.pewtrusts.org/en/research-andanalysis/issuebriefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth.*

[12] *https://www.aafp.org/content/dam/AAFP/documents/advocacy/health_it/telehealth/LT-DEA-TelehealthBuprenorphine-032923.pdf.*

day timeframe. **To that end, we strongly urge against requiring an in-person exam for prescribers of buprenorphine for treatment of OUD, given evidence in support of telehealth, limited access to OUD treatment prescribers, and relatively lower rates of buprenorphine diversion.**

While an in-person evaluation may be necessary for other primary care treatment (and as noted above, the AAFP encourages their requirement for certain other services), data shows that buprenorphine prescribing is particularly well-suited for virtual-only visits. Telehealth initiation of and continued treatment with buprenorphine has shown greater treatment retention, reduced illicit opioid use, improved access to treatment, greater patient satisfaction, and reduced healthcare costs.[13, 14, 15]

Nearly 160 million individuals live in a mental health professional shortage area, and many more have mental health professionals in their area that do not accept the patient's insurance or require unfeasible cost sharing.[16] Nearly 99 million individuals live in a primary care health professional shortage area and would be unable or challenged to receive MOUD without telehealth and audio-only visits.[17] This difficulty in access to care for patients is compounded by transportation, time, and childcare challenges, as well as trauma and stigmatization from past experiences with the health care system. All of which makes virtual visits critically important for initiating and maintaining OUD treatment.

Coverage of and Payment for Audio-Only Services

Telehealth can be a lifeline for many rural residents, who may encounter significant barriers such as distance, financial, insurance coverage, or lack of transportation to easily access in-person care. However, existing barriers continue to hinder the ability for individuals in rural communities to access quality telehealth services, as well. The lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits.[18]

In many instances, family physicians have reported that some of their patients, particularly seniors, are most comfortable with or can only access audio-only telehealth visits. One recent study of Federally Qualified Health Centers (FQHCs) found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[19] **Therefore, permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs.**

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Congress should implement policies that strengthen patients' relationships with their primary care physician, and physicians should not be paid less for

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[13] Vakkalanka, J.P., Lund, B.C., Ward, M.M. et al. Telehealth Utilization Is Associated with Lower Risk of Discontinuation of Buprenorphine: a Retrospective Cohort Study of US Veterans. J Gen Intern Med 37, 1610–1618 (2022). *https://doi.org/10.1007/s11606-021-06969-1.*

[14] Congressional Research Service, "Broadband Loan and Grant Programs in the USDA's Rural Utilities Service." March 22, 2019. Accessed online: *https://sgp.fas.org/crs/misc/RL33816.pdf.*

[15] "Ensuring the Growth of Telehealth During COVID–19 Does Not Exacerbate Disparities in Care," Health Affairs Blog, May 8, 2020. DOI: 10.1377/hblog20200505.591306.

[16] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022 available at *https://data.hrsa.gov/topics/healthworkforce/shortage-areas.*

[17] *Ibid.*

[18] Kelly A Hirko, Jean M Kerver, Sabrina Ford, Chelsea Szafranski, John Beckett, Chris Kitchen, Andrea L Wendling, Telehealth in response to the COVID–19 pandemic: Implications for rural health disparities, Journal of the American Medical Informatics Association, Volume 27, Issue 11, November 2020, Pages 1816–1818, *https://doi.org/10.1093/jamia/ocaa156.*

[19] Uscher-Pines, L., McCullough, C.M., Sousa, J.L., et al. Changes in In-Person, Audio-Only, and Video Visits in California's Federally Qualified Health Centers, 2019–2022. JAMA. 2023;329(14):1219–1221. doi:10.1001/jama.2023.1307.

providing patient-centered care. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

To that end, **the AAFP strongly urges Congress to pass the Protecting Rural Health Access Act (S. 1636/H.R. 3440), which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services.** The available data clearly indicates that coverage of and fair payment for audio-only services is essential to facilitating equitable access to care after the PHE-related telehealth flexibilities expire. This legislation would also permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home, which—as noted above—the AAFP has supported.

Thank you again for your continued bipartisan leadership to promote and protect access to high-quality care across modalities, and the AAFP looks forward to working with you and your colleagues to advance permanent solutions. Should you have any questions, please contact Anna Waldman, Associate of Legislative Affairs at awaldman@aafp.org.

Sincerely,

Tochi Iroku-Malize, M.D., MPH, MBA, FAAFP
Board Chair

Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits—that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. *For information about health care, health conditions and wellness, please visit the AAFP's consumer website,* www.familydoctor.org.

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On behalf of the American Council on Education and the higher education associations listed below, which represent approximately 4,300 public and private nonprofit colleges and universities, we thank you for the opportunity to share our views on telehealth in the higher education context as part of the record of the Subcommittee on Health Care hearing on November 14, 2023. This statement highlights the continuing importance and need for the interstate provision of telemental health services for students enrolled in an institution of higher education as a tool to help address the current student mental health crisis.

The mental health of college and university students continues to be an enormous challenge on campuses across the country, a problem that was only exacerbated by the COVID–19 pandemic. College students are reporting mental health challenges at a growing and alarming rate.[1] Nearly half of students have screened positive for depression, a significant jump from recent years and a level that disproportionately impacts marginalized communities.[2] Many traditional college-aged students arrive on campus already struggling with mental health challenges. A recent Centers for Disease Control and Prevention report found that more than 44 percent of high school students reported that they struggle with persistent feelings of sadness or hopelessness.[3]

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[1] *https://www.acenet.edu/Documents/What-Works-Mental-Health.pdf.*
[2] *https://healthymindsnetwork.org/wp-content/uploads/2023/03/HMS_national_print-6-1.pdf; https://healthymindsnetwork.org/wp-content/uploads/2019/04/HMS_national.pdf; https://www.sciencedirect.com/science/article/abs/pii/S0165032722002774?via%3Dihub.*
[3] *https://www.cdc.gov/mmwr/volumes/71/su/pdfs/su7103a1-a5-H.pdf,* pp. 16, 19.

While mental health concerns are impacting communities across the country,[4, 5] college students face a unique set of obstacles and challenges that can exacerbate their struggles. In addition to affecting their well-being, the rise in mental health issues among college students is impacting their success and completion. According to a recent national survey,[6] over half of current college students (55 percent) who have considered leaving college, often referred to as "stopping out," cite emotional stress as the primary driver. The same report also found students of color and students seeking associate degrees are disproportionally considering stopping out. In addition, nearly three in five students report experiencing food insecurity, housing insecurity, or homelessness, and many more report difficulty meeting other basic needs like childcare and transportation.[7] Basic needs insecurity is associated with higher levels of anxiety, stress, and depression.[8] Colleges and universities are diligently responding to meet the surging demand for mental health services, but many lack the resources to sufficiently do so. Over two out of five (44 percent) college students are struggling with clinically significant anxiety or depression, but less than half of these students had mental health counseling and/or therapy in the past year.[9]

To help address the college student mental health crisis and the expiration of COVID–19 era waivers, Congress should authorize the interstate provision of telehealth services for students enrolled in an institution of higher education in any U.S. jurisdiction if that healthcare provider is licensed to practice or provide such care in any one state or territory or through an interstate licensure compact.

During the pandemic, nearly every state instituted an emergency waiver to facilitate interstate care. Institutions relied on those waivers to use telehealth to continue to provide needed mental health services to students who were away from campus and unable to access campus counseling services. Unfortunately, these waivers are now expired, leaving many college students without access to medically necessary behavioral health care. Telehealth access to campus mental health services remains a critical need for students seeking treatment for depression, anxiety, and other mental health conditions.

Many students encounter disruption in behavioral health treatment when they leave campus during breaks, participate in remote educational programs, or need to find a new behavioral healthcare provider due to licensing restrictions preventing clinicians from practicing across state lines. These can also serve as barriers to students accessing care. While state-by-state compacts represent a positive development, they do not answer this national need.

Permitting colleges and universities to provide interstate telemental health services would address a unique challenge faced by students experiencing a behavioral health crisis and may also improve retention and graduation rates among affected students. Importantly, this flexibility would also help ensure continuity of care for students who have established therapeutic relationships with campus mental health providers or with healthcare providers in their home state during the course of their education.

We thank the Subcommittee for the opportunity to submit these comments and for considering our views.

Sincerely,

Ted Mitchell
President

On behalf of:

American Association of Community Colleges
American Association of State Colleges and Universities
American Council on Education
Association of American Universities
Association of Catholic Colleges and Universities
Association of Jesuit Colleges and Universities
Association of Public and Land-grant Universities
College and University Professional Association for Human Resources

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[4] *https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf.*
[5] *https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*
[6] *https://www.gallup.com/analytics/468986/state-of-higher-education.aspx.*
[7] *https://hope.temple.edu/sites/hope/files/media/document/HopeSurveyReport2021.pdf.*
[8] *https://pubmed.ncbi.nlm.nih.gov/35124789/.*
[9] *https://healthymindsnetwork.org/wp-content/uploads/2023/03/HMS_national_print-6-1.pdf.*

Council for Christian Colleges & Universities
National Association of College and University Business Officers
National Association of Independent Colleges and Universities
State Higher Education Executive Officers Association

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The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 230,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities. In so doing, growth, development, and overall functional abilities are enhanced, and the effects associated with illness, injuries, and disability are minimized.

Occupational Therapy via Telehealth History

The vast majority of occupational therapy professionals (OTPs) did not utilize telehealth to provide occupational therapy (OT) services before the COVID–19 pandemic since Congress had not previously established OTPs as Medicare telehealth providers. Significant innovation, however, was occurring at the Veterans Administration where OTPs were providing innovative OT services to patients, so the template for OT via telehealth was already developed. The number of OT telehealth encounters increased dramatically as Congress and CMS reacted quickly to enable Medicare beneficiaries to receive OT and other therapy services via telehealth once a Public Health Emergency (PHE) was declared.

Congressional action was essential to waive statutory restrictions on CMS that prevented OTPs as well as physical therapists (PTs) and speech language pathologists (SLPs) from providing services via telehealth in Medicare. CMS responded to Congressional waivers included in the CARES Act by issuing an emergency rule that added a series of therapy CPT® codes to the telehealth services list and another rule that included OTPs as eligible Medicare telehealth providers. This effectively enabled OTPs to provide services via telehealth to Part B Medicare beneficiaries during the COVID–19 emergency. Congress acted again in 2022 to extend these waivers through the end of 2024, and this allowed OT via telehealth to continue after the PHE expired on May 11, 2023. Further Congressional action, however, is necessary to allow such services to continue in Medicare on a permanent basis.

While Congressional language and intent was clear in the Omnibus Budget Act of 2023 that OTPs were to continue as telehealth providers at least until the end of 2024, CMS misinterpreted this provision as not applying to OT services provided via telehealth in certain facility-based settings including outpatient rehab facilities. This decision trickled out to these facilities in April 2023 with the PHE ending within a few weeks. After significant confusion imposed on facilities and engagement by multiple stakeholders including AOTA, CMS clarified that OTPs in all settings were covered by the Congressional waiver, and then extended this policy in its 2024 Fee Schedule. For this reason, AOTA urges Congress to proactively list OTPs along with PTs and SLPs as permanent Medicare telehealth providers as it did for all other Medicare telehealth providers in the past.

Legislation such as the CONNECT for Health Act of 2023 (S, 2016) would give CMS the authority to determine the telehealth status of OTPs and other therapists which is a step in the right direction; however, after the confusion related to OT in various settings, we urge Congress to make this determination by enacting the Expanded Telehealth Access Act (S. 2880/H.R. 3875). S. 2880 was introduced by Senators Steve Daines and Tina Smith to specifically enable OTPs, PTs, SLPs and audiologists to ***provide services via telehealth under Section 1834(m) of the Social Security Act on a permanent basis.***

Experience Demonstrates Effectiveness of OT Services via Telehealth

The rapid expansion of telehealth as a delivery mechanism for OT services during and after the PHE enabled occupational therapists and occupational therapy assistants to demonstrate the clear value of these services provided alone or in conjunction with in-person services. Telehealth has been especially beneficial for people in

rural and other underserved areas and to those for whom travel to receive services was already a barrier to access, including people with disabilities.

Virtual home safety evaluations have emerged as an additive OT telehealth benefit that cannot be duplicated in a facility/office setting. OTPs report that telehealth has enabled in-home "video tours" to identify home safety issues that would never be identified by the patient in a facility/office setting. This can be crucial in preventing falls, addressing functional decline, and avoiding costly emergency room visits and hospital admissions which can reduce the cost of care. **This service would end altogether if Congress does not allow OTPs to continue as Medicare telehealth providers after waivers end in 2024.**

The ability to provide OT services via telehealth has also enabled more patients to start care on the day ordered and to minimize cancellations, postponements, and schedule changes that are commonly connected to transportation, mobility, caregiver availability, weather, and other issues related to treatment in a clinical setting. This in turn has enabled some patients to complete treatment sooner and with fewer visits, which can reduce the cost of care.

In addition, telehealth has also made it much easier to connect with beneficiary caregivers who are often unable to take the time required to travel with the patient to in-person visits. This is especially important for some patients in the Medicare population who rely more heavily on a caregiver for assistance during appointments and for follow-up in the home.

Research Demonstrates Efficacy of OT Delivered via Telehealth

The AOTA Telehealth Position Paper [1] summarizes how occupational therapy practitioners use telehealth technologies as a method for service delivery for evaluation, intervention, consultation, monitoring, and supervision of students and other personnel. Further, it references the results of research on the use of telehealth in rehabilitation or habilitation, which includes occupational therapy.

There is a growing base of evidence demonstrating the efficacy of technologically mediated occupational therapy.[2] Ongoing research at University of Southern California Mrs. T. H. Chan Division of Occupational Science and Occupational Therapy Faculty Practice has shown that increased use of telehealth for pain-management patients decreased cancellations, increased access, and improved treatment effectiveness. Patient satisfaction with telehealth is also high. A more detailed list of their findings follows:

- Improved treatment effectiveness due to improved ability to assess and evaluate a person's home environment and contextual factors, rather than through verbal discussion or photos. This allows for more effective problem solving and identification of environmental barriers. This is especially clear in OT interventions for pain regarding body mechanics, ergonomics, physical activity routines, sleep positioning, falls prevention and recovery, and placement of durable medical equipment for optimal safety.
- Ability to access more people with chronic pain by eliminating the geographic barrier of having to drive to an in-person session. A recent evaluation of a telehealth group intervention for pain management, specifically for patients living in rural or remote areas, revealed that participants benefited from telehealth specialty pain management services.[3]
- Decreased cancellation rates due to pain flare ups or symptom exacerbations because patients do not have to commute to in-person sessions, but can participate from the comfort of their own home where they can access many of their pain management tools (*i.e.,* medication, heat/ice, self-massage units, lying down as needed, more control over ambient temperature).

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[1] American Occupational Therapy Association (2013). Telehealth. *American Journal of Occupational Therapy,* 67(6 Suppl.), S69–S90. *http://dx.doi.org/10.5014/ajot.2013.67S69.*

[2] Cason, J. (2009). A Pilot Telerehabilitation Program: Delivering Early Intervention Services to Rural Families. *International Journal of Telerehabilitation,* 2009;1(1):29–37. Hoffmann, T., Russell, T., Thompson, L., Vincent, A., Nelson, M. (2008). Using the Internet to assess activities of daily living and hand function in people with Parkinson's disease. *NeuroRehabilitation,* 23, 253–261. Ng, E.M., Polatajko, H.J., Marziali, E., Hunt, A., Dawson, D.R. (2013). Telerehabilitation for addressing executive dysfunction after traumatic brain injury. *Brain Inj.* 2013; 27(5):548–64.

[3] Scriven, H., Doherty, D.P., & Ward, E.C. (2019). Evaluation of a multisite telehealth group model for persistent pain management for rural/remote participants. *Rural & Remote Health,* 19(1).

- Improved continuity of care because patients who would travel long distances to come to the clinic may only be seen for treatment 1x/month, but with telehealth services, they can be seen weekly for improved accountability and to support long-term, sustainable behavior change.
- Improved patient satisfaction—patients are reporting improved participation and effectiveness of treatment because commuting to the clinic and driving can often be a trigger of pain or stress. By eliminating this factor, patients avoid starting treatment sessions in pain or fatigue and are able to participate more effectively during session.
- Reduced social isolation and occupational deprivation—due to compounding factors of managing a chronic condition and the long-term effects of pandemic-related restrictions, patients are reporting feelings of isolation and reduced functional participation in daily routines and meaningful activities. Experiencing occupational deprivation can have detrimental effects on health and wellness, self-efficacy, and identity.[4] With OT telehealth, patients can collaborate with their OT to identify strategies and opportunities to engage in occupations and social activities to combat isolation, occupational deprivation, and associated adverse health consequences.

Additional research has shown strong strength of evidence that motivational interviewing, fatigue management, and medication adherence performed via telehealth lead to positive outcomes.

Based on this research, both Medicare beneficiaries and the Medicare program would see great benefits in quality care, reduced costs, and reduced hospitalizations if occupational therapy is utilized fully. AOTA asserts that the same ethical and professional standards that apply to the traditional delivery of occupational therapy services also apply to the delivery of services received via telehealth. Occupational therapy interventions delivered via telehealth can assist patients to regain, develop, and build functional independence in everyday life activities to significantly enhance a Medicare beneficiary's quality of life. Telehealth may also address provider shortages and access problems, making necessary occupational therapy services available to underserved beneficiaries in remote, inaccessible, or rural settings and to beneficiaries with limited mobility outside their home. Further, occupational therapy is the chief profession with expertise in activities of daily living and community environments, which may be better observed and evaluated through telehealth services when the beneficiary is in their home environment.

Occupational Therapists Describe Benefits of OT via Telehealth

AOTA is confident that ongoing research and analysis by CMS and others into the use of telehealth to provide OT services will demonstrate what we are already hearing from OTPs throughout the country. Some examples of the use of telehealth to provide OT services follow:

- One particular patient was a woman with Parkinson's. She and her husband were sleeping on an air mattress in their den because she had a hip fracture and was not steady enough to climb the stairs to her bedroom. After her OT eval, she refused further in-person visits. I trialed telehealth visits with great success. I was able to have the husband aim the camera so that I was able to provide placement of recommended grab bars in the bathrooms, both upper and lower levels, as well as get a tour of the second level, something I had not been able to assess at the eval. I was able to help with technique and positioning for upper extremity exercises, and eventually, I was able to teach the husband how to assist the patient up/down the stairs, safely, as well as teach bed mobility so that the patient was able to sleep in her own bed upstairs versus an air mattress on the floor on the main level. She and her husband looked forward to my weekly visits and always updated me on the progress she had made. They were so grateful for the therapy I was able to provide remotely.
- Telehealth has been crucial for service to our CMS patients in our Post-ICU multidisciplinary clinic. Many of these patients would not be able to access the services for a variety of reasons if we cannot continue with telehealth.
- Telemedicine has been a very helpful but unexpected resource for service delivery. One of the primary barriers to clients participating in the 55+ Program in

[4] Whiteford, G. (2000). Occupational deprivation: global challenge in the new millennium. *British Journal of Occupational Therapy,* 63(5).

the past has been transportation. Many clients are fearful of driving, unable to drive due to other health conditions, or do not have access to a vehicle and alternative transportation is too expensive. Telemedicine has allowed these clients access to treatment now.

- Initially many of my older adult clients struggled and were fearful of technology and did not think they would be able to participate in online treatment. With coaching and assistance, many clients have overcome these barriers and now are using technology more to connect with family, friends, and other community resources. It has helped to decrease isolation for many both for treatment and in the community.
- I am an occupational therapist in an outpatient neurological clinic. The majority of my patient caseload includes adults and older adults with comorbidities and/or [who] are immuno-compromised. During the global pandemic, taking months off of therapy could have resulted in significant decrease in function for some of the patients I serve. Our clinic was on the edge of our seats while waiting to hear the CMS changes to allow occupational therapy providers to provide telehealth services. Once the change had been made, it opened up a new world of opportunity for us to serve these patients who so needed skilled therapy, but were unable to physically come into the clinic. As occupational therapists, we adapt. I am able to provide individualized, client-centered care through a new medium that was aligned with the patient's plan of care to reach their functional goals. Without the ability to provide the skilled services via telehealth, our clients would not have received the care they needed. Patients have been surprised with the effectiveness of telehealth therapy services. If CMS allows these changes to be permanent, we would be able to better serve those patients in effective ways through the use of this technology.

Global Telehealth Issues of Specific Concern to AOTA

While Congressional action is urgently needed now to allow occupational therapy professionals to provide services via telehealth on a permanent basis, AOTA also notes that for telehealth to move forward in any way, several other issues must also be addressed. **In order to maximize the benefit of telehealth services, the originating site for a telehealth visit must be the patient's home, especially for OT services as described above.** In addition, there is no justification for a payment differential for telehealth services, as practice expenses are unlikely to go down since practitioners need to maintain an office to perform both telehealth and in-person visits. Additionally, practice expense may increase as practitioners invest in HIPAA-compliant software and other technology to assist in telehealth visits. Also, Congress must allow some limited services to be provided via audio only, especially in the area of mental health and substance abuse, with self-care as an example of a code used by OT professionals.

Summary—Congressional Action Essential to Avoid Therapy Telehealth Cliff

In summary, OT interventions delivered via telehealth have enabled patients to develop, regain, and build functional independence in everyday life. Telehealth has also demonstrated advantages over in-person visits in some situations, especially for people in rural and underserved areas, and for the large number of seniors in all communities who face transportation and mobility issues, especially those with disabilities. Telehealth is also an ideal platform for conducting home safety evaluations as it provides a window into the person's home and often greater access to their caregiver.

As noted, Congressional action is essential to enable Medicare beneficiaries to continue to receive OT services via telehealth when appropriate. Passage of the Expanded Telehealth Access Act (S. 2880) would enable OT professionals as well as PTs, SLPs, and audiologists to ***provide services via telehealth under Section 1834(m) of the Social Security Act.*** Unless Congress acts, Medicare beneficiaries will face a telehealth "cliff" on December 31, 2024, whereby beneficiaries who are now accustomed to receiving some OT services via telehealth suddenly lose access to such services. We urge Congress to prevent this outcome.

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On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association submits the following comments in response to the Senate Finance Committee hearing "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience."The Economic Value of Physical Therapy in the United States,"[1] a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs. The committee should consider the insights provided in this report[2] to support access to, coverage of, and payment for physical therapist services, and to support policies that position physical therapists as entry-point providers to ensure beneficiaries have timely access to proven, cost-effective care.

As noted in APTA's recent economic report,[3] physical therapy can clearly decrease health care costs and reduce administrative burdens. As digital health technologies, including telehealth, expand into the health sector, physical therapists' and physical therapist assistants' access to these delivery tools should be considered in decisions regarding payment, coverage, broadband, and technology infrastructure policies. For example, the APTA report[4] demonstrates that physical therapy-based cancer telerehabilitation programs deliver a net cost benefit of approximately $4,000 per episode of care.

Expansion of Telehealth Under Medicare Due to the COVID–19 Pandemic

In response to the coronavirus public health emergency in 2020, Congress passed and the president signed into law legislation that authorized the Centers for Medicare & Medicaid Services to significantly expand Medicare's coverage of telehealth services during the PHE to protect the health and safety of Medicare patients. Under the authority of Section 1135 of the Social Security Act, CMS permitted virtually all medical providers, including physical therapists, to provide services via telehealth to Medicare beneficiaries. In late 2022, Congress approved legislation that extended Medicare's telehealth flexibilities for another two years. Therapy providers will be permitted to provide services to Medicare beneficiaries via telehealth until December 31, 2024. After that date, Medicare patients will lose telehealth as an option unless Congress acts.

The Role of Telehealth as an Option for the Delivery of Therapy Services

Physical therapists and physical therapist assistants use telehealth as a supplement to in-person services to treat a variety of conditions prevalent in the Medicare population, including but not limited to arthritis, multiple sclerosis, musculoskeletal conditions, Parkinson's disease, pelvic floor dysfunction, frailty, sarcopenia, and cognitive, neurological, and vestibular disorders. Physical therapists make determinations, in consultation with patients and caregivers, regarding the appropriate mix of in-person and telehealth services to meet the goals in the plan of care. The evaluation and treatment of a patient via the use of telehealth allows the physical therapist to interact with the patient within the real-life context of their home environment, which is not easily replicable in the clinic. Patient and caregiver self-efficacy

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[1] *https://www.valueofpt.com/.*
[2] *https://www.valueofpt.com/policy-and-payment/for-policymakers.*
[3] *https://www.valueofpt.com/globalassets/value-of-pt/economic_value_pt_u.s._report_from_apta-policy_paper-policymakers.pdf.*
[4] *https://www.valueofpt.com/.*

are inherent goals of care, and telehealth not only allows a physical therapist to maintain the continuity of care anticipated in the plan of care, but also allows for immediate and effective engagement when a specific challenge arises.

Skilled physical therapist interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Further, physical therapists already are experienced in modifying exercises for the patient to perform them safely at home, as a home exercise program is a common element of a treatment plan for patients who are treated in person. Physical therapy practitioners can use telehealth technologies to deliver the following services:

- Conduct evaluations or reevaluations, or provide quicker screening, assessment, and referrals that improve care coordination.
- Provide interventions via telehealth by interacting with the patient in real time to provide instruction in exercise and activity performance, observe return demonstration, offer instruction in modifications or progressions of a program, provide caregiver support, and promote self-efficacy.
- Give verbal and visual instructions and cues to modify how patients perform various activities. They also may suggest that the patient or caregiver modify the environment for safety reasons or to produce even more optimal outcomes.
- Conduct home safety evaluations and provide prehabilitation.
- Observe how patients interact with their environment and/or other caregivers, and to provide caregiver education.
- Determine the effectiveness of modifications to activities and strategies immediately rather than waiting for the next in-person visit.
- Reduce the number of in-clinic visits and still maintain important follow-up care. This might reduce travel time and/or burden for a patient, which, for some conditions, might result in faster healing. This also prevents any delays in modifying a program when it needs to be upgraded or downgraded.
- Co-treat with another clinician who is treating via real-time audio and visual technology.
- Consult directly with another PT or PTA for collaboration or to obtain specialty recommendations to incorporate into an existing plan of care.
- Conduct quick check-ins with established patients.

Policy Recommendation

APTA supports the ability of Medicare beneficiaries to maintain the option—when appropriate—to have therapy services provided via telehealth. The expansion of Medicare telehealth policies under the Section 1135 waivers, including permitting physical therapist services to be furnished via telehealth by PTs and PTAs, has provided greater options for patients to access care, especially in rural and underserved areas. APTA strongly urges Congress to enact legislation to maintain the current policy and add physical therapists and physical therapist assistants as permanently authorized telehealth providers under Medicare. Congress should enact the bipartisan Expanded Telehealth Access of Act of 2023 (H.R. 3875/S. 2880)[5] before the expiration of the current waiver on December 31, 2024.

We appreciate the opportunity to share our perspective on the role of telehealth in physical therapy and the need to continue to provide Medicare beneficiaries this option beyond the PHE by ensuring that PTs and PTAs become permanent authorized telehealth providers. Again, APTA strongly supports enactment of the Expanded Telehealth Access Act (H.R. 3875/S. 2880) to accomplish this goal. Should you have any questions, please contact APTA Congressional Affairs Specialist Steve Kline at stevekline@apta.org. Thank you for your time and consideration.

[5] *https://www.apta.org/advocacy/issues/telehealth/expanded-telehealth-access-act.*

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November 14, 2023

The Honorable Benjamin L. Cardin
Chairman
Senate Finance Committee Subcommittee on Health Care
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510–6200

The Honorable Steve Daines
Ranking Member
Senate Finance Committee Subcommittee on Health Care
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency.

Dear Chairman Cardin and Ranking Member Daines:

We applaud the Senate Finance Committee, Subcommittee on Health Care, for examining whether to make permanent the telehealth authorities that were critical for providing Medicare beneficiaries access to care during the COVID–19 public health emergency (PHE).

ASHP is the largest association of pharmacy professionals in the United States, representing over 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. We recommend that telehealth flexibilities be made permanent.

Telehealth authorities enabled ASHP's members to provide critical pharmacy services to Medicare beneficiaries throughout the COVID–19 public health emergency (PHE). Continuation of these authorities will expand access to care in rural and urban medically underserved areas, as well as provide critical care to those suffering from chronic conditions like substance use disorders (SUD). The success of telehealth services during the PHE has illustrated the value of telehealth long-term, particularly for patients with mobility issues.

Virtual Supervision: The Centers for Medicare and Medicaid Services (CMS) allowed virtual supervision during the PHE and has extended this authority through 2024, but has yet to make it permanent. Virtual supervision has allowed physicians and pharmacists to provide services from separate locations, as part of the same care team. This model increased patient access to care, particularly in rural and urban underserved areas, and also allowed for separation of providers during periods of high viral spread, which will continue to be an issue even in the post-PHE environment. These flexibilities were extended until the end of 2024. AHSP recommends that virtual supervision be extended permanently.

Initiation of Controlled Substance Prescribing: In 2021, more than 46 million U.S. patients met the criteria for substance use disorder.[1] During the PHE, the Drug Enforcement Administration (DEA) permitted DEA-registered clinicians to prescribe schedule II–V controlled substances, including buprenrophine for substance use disorder (SUD), to patients without an in-person medical evaluation, provided a telehealth visit is conducted and other conditions are met. This authority is set conclude on December 31, 2024 and DEA has indicated they are still considering potential limits on telehealth prescribing of controlled substances, including buprenorphine. Congress passed the Mainstreaming Addiction Treatment Act, because it recognized the need to expand access to medications for opioid use disorder (MOUDs). Continuation of the use of telehealth to prescribe medications for opioid used disorder, like buprenorphine, is another essential step to maintain and expand access to MOUDs. **ASHP recommends allowing the prescribing of schedule**

[1] Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States; 2023.

II–V controlled substances to patients via a telehealth visit be made permanent.

DEA Definition Undermines Delivery of Medication Management via Telehealth: The DEA defines telemedicine at 21 U.S.C. § 802(54) as follows: "The term 'practice of telemedicine' means, for purposes of this title, the practice of medicine in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient. . . ." This definition is based on outdated understanding of clinical and ambulatory pharmacy practice, and will significantly impede patient access to services. Eleven states now recognize pharmacists as prescribers of controlled substances, including buprenorphine.[2] Congress should not allow antiquated DEA rules to undermine patient access to pharmacist medication management services via telehealth. **ASHP recommends elimination of the pharmacist exclusion from the DEA's definition of "practice of telemedicine."**

Incident-to Billing of Evaluation and Management Services: To ensure the long-term success of telehealth, greater clarity is needed regarding billing codes. Currently, CMS has unnecessarily limited physicians' ability to bill fully for evaluation and management (E/M) services provided by a pharmacist on their care team, incident to the physician. According to a 2018 CMS clarification, incident-to services provided by a pharmacist[3] cannot be billed at anything beyond the lowest level of E/M codes, regardless of the complexity of care or the duration of the service (*e.g.,* 99211 in person or 99441 for telehealth). Use of the E/M codes for billing of telehealth services is also confusing and inconsistent. **In order for it to be financially feasible for care teams to use their pharmacists to provide medication and chronic disease services through telehealth, ASHP recommends that physicians be allowed to bill for E/M codes for established patients (99211–99215) and telehealth codes (telephonic equivalent to E/M codes) (99441–99443), including when provided by a pharmacist, if the incident-to requirements are met.**

Licensure: As recognized in the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, clarity regarding licensure around telehealth is critical to expanding access to beneficiary care for beneficiaries suffering from such conditions as mental health and SUD. To ensure access and continuity of care, states have been adopting a number of multi-jurisdictional flexibilities. These arrangements permit providers in another jurisdiction to use telehealth to treat a patient in another state. CMS needs to clearly indicate that telehealth services provided under these arrangements will be covered under Medicare and Medicaid. **ASHP recommends that these multi-jurisdictional licensure flexibilities be recognized by Medicare.**

ASHP thanks you for your work on telehealth. We look forward to continuing to work with you on this issue. If you have questions or if ASHP can assist in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

Tom Kraus
Vice President, Government Relations

Cc: The Honorable Finance Committee Chairman Ron Wyden and The Honorable Ranking Member Mike Crapo.

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[2] CA, ID, MA, MT, NV, NM, NC, OH, UT, TN, and WA.

[3] Note that as members of the healthcare team, clinical pharmacists practice under formally granted clinical privileges from the medical staff or credentialing system of the organization in which they practice or under written collaborative practice agreements (CPA) with individual physicians or medical groups. The Centers for Disease Control and Prevention has found "strong evidence that when pharmacists are part of the health care team, outcomes related to preventing or managing chronic diseases and adherence to medication improve." These outcomes include clinical and behavioral health indicators including lowering blood pressure, HbA1c, and LDL cholesterol levels *(CDC Advancing Team Based Care).*

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November 27, 2023

The Honorable Ron Wyden
Chair
Senate Committee on Finance
219 Dirksen Senate Office Building
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The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Statement for the Record, Hearing on *Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency*

Dear Chair Wyden and Ranking Member Crapo:

The American Urological Association (AUA) applauds the Senate Committee on Finance for holding the recent legislative hearing, *Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency.* We commend the Committee for examining policies to improve Medicare beneficiary access to care through telehealth.

The AUA is a globally engaged organization with more than 22,000 physicians, physician assistants, and advanced practice nursing members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 15,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research, and the formulation of health policy.

The AUA has prioritized telehealth since expanded access substantially benefits our members' patients and has formed a Urology Telehealth Task Force (UTTF) comprised of experts in this area. We have been actively engaged on telehealth policy and provided comments on the Centers for Medicare & Medicaid Services (CMS) regulations and draft legislation, including the *Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2023* (Pub. L. 117–328), on the topic. The AUA stands ready to work with you to develop permanent Medicare policies and appreciates your consideration of the following comments as you consider future legislation on this topic.

Lessons Learned

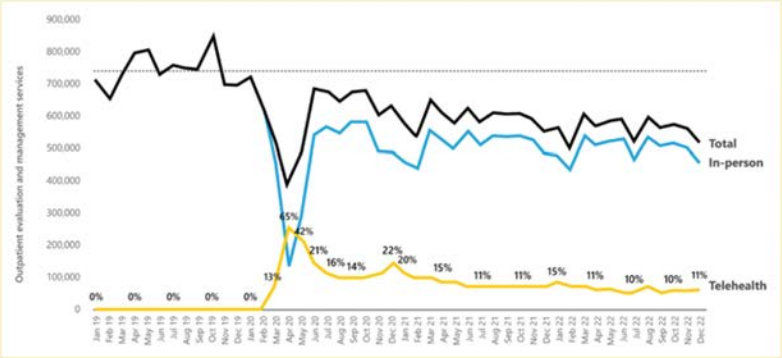
Since the beginning of the COVID–19 pandemic and the implementation of Medicare telehealth flexibilities, urologists have transformed their practices to deliver high-quality care to patients via telehealth. Data since the beginning of the COVID–19 pandemic has shown the impact of telehealth on cost, quality, and access to care and the results are clear—telehealth has not led to excessive healthcare utilization and spending, does not compromise quality of care for patients, and improves access to care for patients.

Utilization and Costs

From July 2021 through December 2022, the proportion of telehealth-based evaluation and management visits among Medicare fee-for-service beneficiaries maintained consistently around 11%, and from March 2020 through December 2022, the combined total number of monthly in-person and telehealth office visits did not exceed 2019 utilization levels at any point (Figure 1, Ellimoottil 2023).[1]

[1] Ellimoottil et al. Analysis of Medicare FFS data. 2023.

Figure 1: National Trends in In-Person and Telehealth Evaluation and Management Visits Among Medicare Fee-for-Service Beneficiaries, 2019-2022



Additionally, the availability of telehealth has not led to additional primary care visits, refuting the concern about unnecessary utilization.[2] On the contrary, it has promoted more timely access to healthcare services, especially for individuals in remote or underserved areas, thereby addressing disparities in healthcare access. This in turn has the potential to reduce our country's health care spending by minimizing costs for time, travel, and staff and allowing for timely care and optimized treatments and outcomes.

Quality

The Agency for Healthcare Research and Quality (AHRQ) conducted a systematic review of 165 studies reporting quality outcomes as it relates to telehealth visits. The review concluded, "Across a variety of conditions, telehealth produced similar clinical outcomes as compared with in-person care; differences in clinical outcomes, when seen, were generally small and not clinically meaningful when comparing in-person with telehealth care."[3] Therefore, the widespread satisfaction and maintained level of quality highlights the potential for sustained integration of telehealth services into the U.S. healthcare system.

Access

There is no doubt that telehealth has great potential to improve access to care and reduce health inequities and disparities, particularly for individuals living in rural and underserved areas who are required to travel significant distances to see specialists, like urologists. The Medicare Payment Advisory Commission's (MedPAC) 2023 report to Congress highlighted that greater telehealth use was associated with "slightly improved access to care for some beneficiaries."[4] Additionally, based on patient satisfaction ratings, telehealth visits consistently outperform in-person visits in terms of access and provider concern.[5] Results also show that individuals who are older, African-American, require an interpreter, use Medicaid, and live in areas with broadband challenges are less likely to use video visits as compared to phone calls.[6] This clearly highlights the need for coverage and payment for not only video telehealth services, but audio-only services as well.

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[2] Dixit, R.A., Ratwani, R.M., Bishop, J.A. et al. The impact of expanded telehealth availability on primary care utilization. npj Digit. Med. 5, 141 (2022). *https://doi.org/10.1038/s41746-022-00685-8.*

[3] *https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/use-telehealth-during-COVID-19-systematic-review.pdf.*

[4] *https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/.*

[5] Patel, K.B., Alishahi Tabriz, A., Turner, K., Gonzalez, B.D., Oswald, L.B., Jim, H.S.L., Nguyen, O.T., Hong, Y.R., Aldawoodi, N., Cao, B., Wang, X., Rollison, D.E., Robinson, E.J., Naso, C., Spiess, P.E. Telemedicine Adoption in an NCI-Designated Cancer Center During the COVID–19 Pandemic: A Report on Patient Experience of Care. J Natl Compr Canc Netw. 2023 May;21(5):496–502.e6. doi: 10.6004/jnccn.2023.7008. PMID: 37156477.

[6] Chen, J., Li, K.Y., Andino, J., Hill, C.E., Ng, S., Steppe, E., Ellimoottil, C. Predictors of Audio-Only Versus Video Telehealth Visits During the COVID–19 Pandemic. J Gen Intern Med.

Legislative Solutions

The AUA appreciates the action Congress has already taken to extend the waiver of the originating site and geographic restrictions and coverage of audio-only services through December 31, 2024, in the Consolidated Appropriations Act, 2023 (Pub. L. 117–328). However, more must be done to make these policies permanent to protect patient access to telehealth services.

The AUA supports the CONNECT for Health Act of 2023 that would permanently expand access to certain telehealth services ensuring that Medicare beneficiaries can continue to receive virtual care. Specifically, the bill would remove barriers to telehealth coverage in the following ways:

- Permanently removes geographic requirements for telehealth services.
- Expands originating sites to include the patient's home and other clinically appropriate sites.
- Expands the authority for practitioners eligible to furnish telehealth services.
- Improves Medicare's process to add telehealth services.
- Permanently allows Federally Qualified Health Centers and Rural Health Clinics to furnish telehealth services as distant site providers.
- Removes restrictions for facilities of the Indian Health Service and Native Hawaiian Health Care.
- Repeals the 6-month in-person visit requirement for telemental health services.
- Permanently allows for the waiver of telehealth restrictions during public health emergencies.
- Permanently allows for the use of telehealth in the recertification of a beneficiary for hospice.

The AUA urges the committee to support these provisions to ensure that telehealth continues to be accessible to Medicare beneficiaries. However, we believe Congress must do more to make telehealth policies permanent to ensure equitable access to telehealth services.

Payment Parity

While telehealth has consistently accounted for approximately 11% of office visits since July 2021, the AUA is concerned that there will be a decline in telehealth usage once telehealth flexibilities expire on December 31, 2024. Before reimbursement was established for telehealth during the COVID–19 public health emergency, few urologists equipped their practices with the platforms and infrastructure required to deliver virtual care. Telehealth platforms have their own associated costs, and urologists and their practices have limited reserve funds for technology that does not demonstrate a significant return on investment. Additionally, telemedicine requires many of the same overhead costs as in-person visits because the administrative requirements associated with the visit do not change and clinical space is still required for the treating physician, which preserves physician-patient privacy during the encounter, and practices cannot reduce the amount of clinical space available since virtual care supplements in-person care and is not a replacement.

The AUA believes that whether payment parity between in-person and virtual care is maintained will influence whether urologists and other physicians sustain their telehealth infrastructure and continue to offer virtual care to patients. We were grateful that CMS finalized policy to maintain payment parity for telehealth services delivered to patients in their homes in the Calendar Year 2024 Medicare Physician Fee Schedule. However, payment parity will only apply to the services delivered by urologists as long as the originating site requirement is waived. **Therefore, we urge Congress to permanently waive this requirement and support CMS' maintenance of payment parity for virtual care delivered to patients in their homes.** Anything less than payment parity will not be sustainable given the overhead associated with these visits and the return of more in-person care post-pandemic.

Audio-Only Coverage

Coverage of audio-only visits is a pressing health equity issue. Access to audio/visual telehealth technology varies widely by socioeconomic status and geographical location. AUA members' experience has demonstrated that patients living in poverty or in non-metropolitan areas are less likely to utilize audio/visual telehealth services. Additionally, many Medicare beneficiaries, particularly those who are older, may struggle to establish the simultaneous audio and visual connections required for

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2022 Apr;37(5):1138–1144. doi: 10.1007/s11606–021–07172–y. Epub 2021 Nov 17. PMID: 34791589; PMCID: PMC8597874.

telehealth services, either because they lack access to necessary connection or devices to facilitate simultaneous audio and visual connections, have difficulty navigating the appropriate devices, or refuse to appear on camera. **For these reasons, Congress must provide CMS with the authority to cover audio-only services permanently.** The AUA believes this policy supports health equity and will help reduce health disparities by ensuring Medicare beneficiaries retain broad access to appropriate services.

Implementation of Guardrails

The AUA recognizes members of Congress' concern with the threat of fraud and abuse as it relates to telehealth services; however, we are concerned that implementing guardrails of any kind will only create barriers to access to necessary healthcare services. The Office of Inspector General September 2022 report reviewed approximately 742,000 providers offering telehealth services and found that only 0.2 percent displayed potentially fraudulent billing patterns that warranted further scrutiny.[7] Therefore, despite the low incidence of fraudulent or abusive billing patterns among telehealth providers, the widespread imposition of guardrails may inadvertently hinder the broader adoption of telehealth, limiting its potential to enhance healthcare accessibility. **The AUA recommends that Congress refrain from implementing guardrails to ensure equitable healthcare access for all Americans.**

Thank you again for the opportunity to provide input and expertise. We welcome the opportunity to work with you to ensure permanent access to telehealth. Should you have any questions or require additional information, please direct your correspondence to Ray Wezik, Director of Policy and Advocacy at rwezik@auanet.org.

Sincerely,

Eugene Rhee, MD
Chair, Public Policy Council

Matthew Nielsen, MD
Chair, Science and Quality Council

ASSOCIATION FOR BEHAVIORAL HEALTH AND WELLNESS
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Dear Chairman Wyden and Ranking Member Crapo,

The Association for Behavioral Health and Wellness (ABHW) appreciates the Committee's support and leadership in addressing mental health (MH) and substance use disorder (SUD) issues. ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people, both in the public and private sectors, to treat MH, SUD, and other behaviors that impact health and wellness. The COVID–19 Public Health Emergency (PHE) resulted in a rise in mental health disorders. Telehealth has been a critical modality for those seeking mental health care, and utilization of tele-mental health services has remained high following the end of the PHE.[1]

We appreciate the opportunity to submit a statement for the record supporting the Committee's efforts to identify solutions and opportunities to ensure access to telehealth services. Our plans are invested in ensuring that their members have access to care. We are pleased to present our priorities for making permanent telehealth flexibilities after December 2024. ABHW supported the extension of current telehealth guidance and flexibilities in response to the PHE through December 2024. These long overdue changes to telehealth policies have allowed payers and providers to ensure patients can access necessary MH and SUD services long after the PHE has ended. We encourage the Committee to consider S. 2016/ H.R. 4189, the *Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT)*

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[7] *https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf.*

[1] KFF: Telehealth has Played an Outsized Role Meeting Mental Health Needs During the COVID–19 Pandemic, *https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/;* Healthcare Dive: Rise of Telehealth During Pandemic Boosted Mental Health Treatment Rates, *https://www.healthcaredive.com/news/telehealth-mental-health-JAMA-pandemic/639905/*.

for Health Act of 2023. This legislation makes these important Medicare flexibilities permanent and expands access to telehealth care.

As the Committee considers proposals to make these flexibilities permanent, ABHW urges the Committee and Congress to address telehealth policies as soon as possible instead of waiting until December 2024. Delaying action on these issues until later in the year will result in confusion as payers often make changes several months before the next plan year. Making the flexibilities permanent earlier will allow patients, payers, and providers to make informed decisions and plan for care.

To strengthen access to telehealth, ABHW recommends the following.

Repeal of the Medicare In-Person Requirements on Tele-Mental Health

ABHW encourages the Committee to repeal the Medicare in-person requirement on tele-mental health. Many individuals with mental health disorders may not be able to leave their homes at all or without significant assistance. Requiring that individuals must have an in-person visit with a provider within six months before receiving a tele-mental health service creates an unnecessary and stigmatizing burden to care. ABHW supports individuals having access to appropriate, quality care; however, this requirement is an additional difficulty to those seeking MH services that are not imposed on individuals seeking care for other medical conditions or SUDs. When making the telehealth flexibilities permanent, we urge the Committee to include language that removes the Medicare six-month in-person visit requirement for patients. ABHW recommends that the Committee work with the U.S. House of Representatives and consider H.R. 3432, the *Telemental Health Care Access Act of 2023.*

Interstate Licensure

During the COVID–19 pandemic, all 50 states used emergency authority to waive certain aspects of state licensure laws, thus providing widespread access to care. However, many states have rolled back these flexibilities. We encourage efforts to foster cross-state licensure reciprocity to support increased access to services. ABHW proposes that the Committee consider language for a national task force of federal and state leaders to examine interstate licensure and outline recommendations to increase access to behavioral health services.

Medication-Assisted Treatment In-Person Evaluation

Enhancing access to medication-assisted treatment (MAT) is more critical than ever, with increasing annual deaths from overdoses. The Centers for Disease Control and Prevention (CDC) estimates that there were nearly 112,000 deaths in the 12-month period ending in June 2023. The Kaiser Family Foundation reports that in 2020, 31% of these deaths were Black, Hispanic, or Asian individuals.

The Drug Enforcement Administration (DEA) in April 2023 released a pair of rules, one focusing on the telemedicine prescribing of controlled substances when the practitioner and the patient have not had a prior in-person medical evaluation; the second rule focused on the induction of buprenorphine via a telemedicine encounter. Both rules required that 30 days after a telehealth visit, an in-person visit was necessary. The DEA received 38,000 comments in response to these rules, with a significant majority expressing concern. Due to the overwhelming response to the regulations, the DEA extended the COVID–19 flexibilities until November 2023 and again extended the flexibilities until December 2024.

We encourage you to consider language, removing the in-person evaluation requirements for MAT. The in-person evaluation before prescribing controlled substances via telemedicine only results in reduced access to care. During the COVID–19 PHE, the DEA waived this requirement, enabling providers to safely prescribe controlled substances using telemedicine. A *Journal of Substance Abuse Treatment* study found that removing the in-person requirement significantly increased access to care and addressed health inequities in primary care programs providing buprenorphine treatment.

One way to address in-person requirements is through issuing guidance on a special registration. This registration would allow clinicians who want to prescribe a controlled substance via telemedicine without an in-person visit to register with the DEA. This guidance was required from the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018.* The DEA has recently signaled a willingness to consider a special registration for telemedicine, however, it has yet to issue one. The limited nature of the proposed rules and the uncertainty of issuing a special registration means that more work needs to be done to ensure continued telemedicine access to controlled medications.

Coverage of Audio-Only Telehealth Services

Audio-only telehealth services have proven their merit during the COVID–19 pandemic. ABHW supports the coverage of audio-only telehealth services when clinically appropriate and supported by evidence. We recommend its continued use while studies on its efficacy are ongoing. Additional consideration should also be given to areas with limited broadband, populations without telehealth-capable devices, or in necessary situations.

Telehealth Coverage in High Deductible Health Plans

As a part of the Coronavirus Aid Relief and Economic Security (CARES) Act, telehealth access was expanded to eligible Health Savings Account (HSA) plans as a pre-deductible benefit. In the face of rising symptoms of anxiety or depression, employers have worked to provide new and expanded behavioral health resources to their employees. In 2022, 75% of large employers offered access to lower- or no-cost mental health support through their tele-mental health provider, and 33% provided lower-cost counseling services at the worksite.[2] By expanding this HSA safe harbor, employers were able to continue to support individuals who were leveraging virtual care. We urge you to consider language such as H.R. 1843/ S. 1001, the *Telehealth Expansion Act of 2023,* which would permanently expand this exemption.

We look forward to working with the Committee and other stakeholders to identify solutions to ensuring access to telehealth after the current flexibilities end. ABHW urges the Committee to act soon so that patients, providers, and payers can predict what will occur in 2025. We thank you for the opportunity to submit ABHW's comments for the record. If you have any questions, please contact Maeghan Gilmore, Vice President of Government Affairs, at gilmore@abhw.org or 202–449–2278.

Sincerely,

Pamela Greenberg, MPP
President and CEO

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The Honorable Benjamin Cardin
Chair
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219 Dirksen Senate Office Building
Washington, DC 20510–6200

The Honorable Steven Daines
Ranking Member
Senate Finance Subcommittee on Health Care
219 Dirksen Senate Office Building
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Re: ATA Action Statement for the Record for Senate Finance Subcommittee Committee Hearing "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency"

On behalf of ATA Action, the American Telemedicine Associations affiliated trade association focused on advocacy, thank you for your continued support of telehealth and holding this critical hearing to examine a permanent pathway forward for the Medicare telehealth flexibilities to ensure patients continue to receive care where and when they need it beyond CY 2024.

Telehealth plays an essential role in our evolving healthcare system that has proven to expand access to care, reduce costs, assist with provider shortages, and overall help the health care system become more efficient and effective.[1] We appreciate that Congress understands the value of telehealth and is working in a bipartisan and

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[2] Business Group on Health, 2022 Large Employers' Health Care Strategy and Plan Design Survey: *https://www.businessgrouphealth.org/resources/2022-large-employers-health-care-strategy-and-plan-design-survey.*

[1] PRINT_ATA-TAW-Hill-Day-handout_9.11.23.pdf *(americantelemed.org), https://www.americantelemed.org/wp-content/uploads/2023/09/PRINT_ATA-TAW-Hill-Day-handout_9.11.23.pdf.*

bicameral way to ensure that telehealth services are allowed in the Medicare program after 2024.

Specifically, we urge Congress to make permanent the Medicare telehealth flexibilities implemented during the PHE, including:

- **Removal of Antiquated Geographic and Originating-Site Restrictions**
  Prior to the pandemic, a patient had to be in a designated rural area and in a healthcare clinic in order to have been able to receive reimbursable telehealth services under the Medicare program. During the PHE, the United States Department of Health and Human Services (HHS) waived these restrictions, thus allowing patients in any geographic area (not just rural) to receive telehealth services in any location, including in their homes. We urge Congress to permanently remove the Section 1834(m) geographic and originating-site restrictions to ensure that all patients can access care where and when they need it.
- **Ensure that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Continue to Furnish Telehealth Services**
  FQHCs and RHCs provide critical health care services for underserved communities and populations across the United States. During the pandemic, FQHCs and RHCs serve as distant sites and can be reimbursed for telehealth services. ATA Action urges Congress to ensure that the roughly 1,400 FQHCs and 4,300 RHCs can continue offering telehealth services permanently while receiving fair reimbursement.
- **Permanently Expand the List of Eligible Medicare Providers**
  During the pandemic, physician therapists, speech-language therapists, and occupational therapists were able to provide telehealth services and be reimbursed by Medicare. ATA Action is supportive of this flexibility and believes all practitioners should have the option to utilize virtual care when clinically appropriate and be reimbursed for the services rendered.
- **Maintain Audio-only Coverage**
  Congress and the Centers for Medicare and Medicaid Services (CMS) have expanded access to care since the pandemic, specifically for those lacking broadband or elderly individuals, by temporarily covering for audio-only services. ATA Action is modality, service, and provider neutral, meaning we believe any licensed provider should have the option to utilize different technologies to deliver care services so long as it meets the standard of care and is clinically appropriate. For this reason, we encourage Congress to ensure audio-only coverage is maintained permanently.
- **Repeal the Telemental Health In-person Requirement**
  ATA Action applauds Congress for expanding access and allowing telemental health services to be a permanent part of the Medicare program through its passage of the Consolidated Appropriations Act, 2021, Pub. L. 116–260. However, also included was an unnecessary and unexpected guardrail, an in-person requirement. This provision, which would go into effect after 2024, requires providers to see their patients in person no more than six months prior to conducting a telemental health visit. ATA Action strongly opposes statutory in-person requirements, as they create arbitrary and clinically unsupported barriers to accessing affordable, quality health care. Requirements such as these could negatively impact those in underserved communities and populations who may not be able to have an in person exam due to provider shortages, work, lack of childcare, and/or dearth of other resources.

  Over 160 million people in the US live in designated mental health professional shortage areas.[2] Many counties have no mental health professionals at all. We cannot ignore the importance of providing all Americans, regardless of whether they have seen a provider in person, with the opportunity to access life-saving health care. We strongly urge Congress to enact the Telemental Health Care Access Act (H.R. 3432),[3] which would remove the statutory telemental health in-person requirement, allowing patients to receive care where and when they need it, especially when they are most vulnerable. We thank Senators Cardin and Thune for their leadership on this legislation.

Fortunately, Congress agrees with the principles (above) in a bipartisan, bicameral fashion and have introduced numerous important pieces of legislation to make var-

[2] Shortage Areas (hrsa.gov), *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*
[3] *https://www.congress.gov/bill/118th-congress/house-bill/3432?q=%7B%22search%22%3A%5B%22HR+3432%22%5D%7D&s=6&r=1.*

ious flexibilities permanent. Our top priorities due to their comprehensive native and widespread support are the **CONNECT for Health Act** (H.R. 4189, S. 2016)[4, 5] and the **Telehealth Modernization Act** (re-introduction pending). We urge Congress to come together to pass permanency legislation well before the end of 2024.

While we recognize that this hearing is focused on Medicare flexibilities, we would also like to raise to policy flexibilities facing patients in commercial insurance plans which expire on or before the end of 2024.

- **Flexibility to offer telehealth pre-deductible in high deductible health plans (HDHPs):** In 2020, Congress enacted the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116–136) which included a provision that temporarily allowed employers to offer employees with high-deductible health plans (HDHPs) coupled with a health savings accounts (HSAs) to receive telehealth coverage without meeting their deductible while maintaining their eligibility for HSAs. Congress extended this provision in the omnibus at the end of 2022 extending it alongside the other Medicare flexibilities through CY 2024. We urge Congress to pass the Telehealth Expansion Act (S. 1001, H.R. 1843),[6, 7] which would permanently extend the exemption for telehealth services from certain high-deductible health plan rules. It is imperative that the 32 million Americans with HDHP–HSAs have the ability to continue using these using these lifesaving services. We thank Senators Daines and Cortez Masto for their leadership on this legislation.
- **Flexibility to offer telehealth benefits to workers that don't otherwise qualify for health care coverage:** In 2020, the United States Department of Health for Human Services (HHS), the Department of Labor and the Treasury Department jointly issued an FAQ in response to the COVID–19 pandemic. The FAQ specifically stated that the agencies would take a non-enforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan for the duration of the PHE. This flexibility expired on May 11, 2023 along with the public health emergency (PHE). Therefore, we urge Congress to action swiftly to either extend this flexibility for 3 years or pass the Telehealth Benefit Expansion for Workers Act of 2023 (H.R. 824)[8] which would amend the Public Health Service Act, the Employee Retirement Income and Security Act of 1974, and the Internal Revenue Code of 1986 to treat telehealth services as excepted benefits. Until Congress acts, millions of workers will lose access to critical health care services at the end of this plan year, if they haven't already. (See here for a stakeholder letter[9] signed by over 30 organization in support of this legislation).

Again, thank you for hosting this hearing to discuss telehealth permanency and preparing so far in advance of the CY 2024 expiration date. We look forward to working with the Senate Finance Committee members and Congress to ensure the appropriate telehealth policies are enacted that will provide certainty to beneficiaries and our nation's health care providers. If you have any questions, please reach out to Kyle Zebley (kzebley@ataaction.org).

Kind Regards,

Kyle Zebley
Executive Director

Re: ATA Action Recommendations on a DEA Special Registration Process

Thank you for DEA's efforts to hear stakeholder feedback by hosting public listening sessions to receive comments from healthcare practitioners, experts, advocates, pa-

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[4] *https://www.congress.gov/bill/118th-congress/house-bill/4189?q=%7B%22search%22%3A%5B%22HR+4189%22%5D%7D&s=5&r=1.*

[5] *https://www.congress.gov/bill/118th-congress/senate-bill/2016?q=%7B%22search%22%3A%5B%22S+2016%22%5D%7D&s=6&r=1.*

[6] *https://www.congress.gov/bill/118th-congress/senate-bill/1001/cosponsors?s=8&r=1&q=%7B%22search%22%3A%5B%22S+1001%22%5D%7D.*

[7] *https://www.congress.gov/bill/118th-congress/house-bill/1843?q=%7B%22search%22%3A%5B%22HR+1843%22%5D%7D&s=6&r=1.*

[8] *https://www.congress.gov/bill/118th-congress/house-bill/824/text?s=3&r=1&q=%7B%22search%22%3A%5B%22walberg%22%5D%7D.*

[9] *https://www.americantelemed.org/wp-content/uploads/2023/09/Support-for-Expanding-Access-to-Care-for-Employees-FINAL-9.15.pdf.*

tients, and other members of the public to inform DEA's regulations on prescribing controlled substances via telemedicine. We appreciate the opportunity to expand upon our comments[10, 11] to the March 2023 proposed rules[12, 13] to include recommendations around how to create a Special Registration process for telemedicine prescribing of controlled substances.

ATA Action, the American Telemedicine Association's affiliated trade association focused on advocacy, advances policy to ensure all individuals have permanent access to telehealth services across the care continuum. ATA Action supports the enactment of state and federal telehealth coverage and fair payment policies to secure telehealth access for all Americans, including those in rural and underserved communities. The ATA represents a broad coalition of health care providers, including those that exclusively practice telemedicine and those blending virtual and traditional in-person care. It is a guiding principle of the ATA that telehealth is health and health care practice should be regulated on a level playing field regardless of whether in-person or virtual, and regardless of type of virtual platform. ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system—by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs—if only allowed to flourish.

Research supports our statements about the importance of prescribing controlled substances via telehealth. A national study showed that utilizing telehealth for medications for opioid use disorder (MOUD) during the pandemic increased odds of treatment receipt and retention as well as decreased odds of overdose when compared to in-person care.[14] Dr. Shoff, a social science research analyst at the Centers for Medicare & Medicaid Services (CMS), worked on the study, and stated *"the findings showed that telehealth improved the receipt and retention of MOUD, suggesting that this method of healthcare delivery may address common barriers to OUD-related treatment such as transportation and perceived stigma associated with OUD."*[15] Results of a study in Southwestern Ohio showed that patients who received video-based telehealth services within 14 days of a substance use diagnosis did not drop out as frequently when compared to patients who received in-person services only.[16] Retention also has been shown to be higher in underserved communities when telehealth is used. Findings of a study conducted in Pennsylvania and New York that used a virtual-first telehealth OUD treatment platform indicated that regardless of race/ethnicity and geography, retention for buprenorphine use was high:[17] *"The limited number of buprenorphine prescribers also makes telemedicine a particularly attractive option for reaching patients in rural and other low treatment*

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[10] ATAAction. (2023, March 27). Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation (Docket No. DEA–407). *https://www.americantelemed.org/wp-content/uploads/2023/03/ATA-Action_DEA-telehealth-Docket-No.-DEA-407_March-2023.pdf.*

[11] ATAAction. (2023, March 27). Expansion of Induction of Buprenorphine via Telemedicine Encounter (Docket No. DEA–948). *https://www.americantelemed.org/wp-content/uploads/2023/03/ATA-Action_DEA-bup-via-telehealth-Docket-No.-DEA-948_March-2023.pdf.*

[12] DEA proposed rule "Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation" on March 1, 2023. *https://www.regulations.gov/document/DEA-2023-0029-0001.*

[13] DEA proposed rule "Expansion of Induction of Buprenorphine via Telemedicine Encounter" on March 1, 2023. *https://www.regulations.gov/document/DEA-2023-0028-0001.*

[14] Jones, C.M., Shoff, C., Hodges, K., Blanco, C., Losby, J.L., Ling, S.M., & Compton, W.M. (2022). Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID–19 Pandemic. JAMA Psychiatry. 79(10):981–992.

[15] National Institute on Drug Abuse (2022, August 21). Increased Use of Telehealth for OUD Services During COVID–19 Pandemic Associated with Reduced Risk of Overdose. *https://nida.nih.gov/news-events/news-releases/2022/08/increased-use-of-telehealth-for-opioid-use-disorder-services-during-covid-19-pandemic-associated-with-reduced-risk-of-overdose.*

[16] Gainer, D.M., Wong, C., Embree, J.A., Sardesh, N., Amin, A., & Lester, N. (2023, January 29). Effects of Telehealth on Dropout and Retention in Care among Treatment-Seeking Individuals with Substance Use Disorder: A Retrospective Cohort Study. Substance Use & Misuse. v 58(4), Pages 481–490. *https://www.tandfonline.com/doi/full/10.1080/10826084.2023.2167496.*

[17] Williams, A.R., Aronowitz, S.V., Rowe, C., Gallager, R., Behar, E., & Bisaga, A. (2023, March 24). Telehealth for opioid use disorder: retention as a function of demographics and rurality. The American Journal of Drug and Alcohol Abuse, v49(2), Pages 260–265. *https://www.tandfonline.com/doi/full/10.1080/00952990.2023.2180382?src=recsys.*

access areas."[18] Instead of embracing modern care that eases access to potentially life-saving treatment, in-person requirements do the opposite.

With Attention-Deficit/Hyperactivity Disorder (ADHD) on the rise, it is critical to look at the impacts of telehealth on prescribing practices. Researchers analyzed over 1 million initial patient visits from more than 200 large health systems for ADHD and anxiety to compare potential differences in prescribing practices for telehealth and in-person visits. The data were from January 1, 2020 through March 31, 2023. Eighty-four percent (84%) of the initial telehealth visit prescriptions were for stimulants, which was similar to 87% for patients seen in person.[19]

More than 150 million Americans reside in a federally designated mental health desert.[20] Thirty percent (30%) of patients lack local access to mental health care.[21] The issue is more pronounced within rural, low-income, and Black or Brown communities.[22] To compound the problem, our country has a mental health care provider shortage with more than 50% of counties in the country not having a psychiatrist.[23] The importance of telehealth laws for controlled substances goes beyond mental health. Cancer patients who are receiving palliative care may encounter significant challenges with attending outpatient appointments for reasons such as pain, shortness of breath, lack of energy, and the use of assistive devices.[24] These factors make in- person visits even more difficult for end-of-life cancer patients: *"the rapid adoption of telemedicine in response to the COVID–19 pandemic has proven to be highly beneficial for advanced cancer patients and caregivers."*[25]

We appreciate DEA's responsibility to write rules that provide effective controls against diversion and protect public health and safety, but the requirement that a patient see a clinician in-person is not an effective control against diversion and, instead, simply limits access to legitimate health care. ATA Action's comments to DEA's March 2023 proposed rules specifically detail why in-person mandates restrict access to care and how restricted access to telemedicine will increase patient harm and diversion risk. We appreciate DEA's efforts to review and incorporate stakeholder feedback on those comments, including considering the creation of a Special Registration process.

We maintain that in-person requirements are not a clinically appropriate or effective way to limit diversion and our first preference would be to permanently waive the in-person requirement as was done during the COVID–19 public health emergency. However, practitioners are willing to take extra steps to further demonstrate their legitimacy when practicing via telemedicine and make themselves available to DEA scrutiny in order to root out bad actors. Thus, we respond directly to DEA's questions regarding the creation of a Special Registration process for that purpose.

We recommend that DEA's approach to regulating the telemedicine prescribing of controlled substances balance the need to ensure patient access to care with the need to prevent diversion by considering the following two principles:

1. Clinical practice should not be limited by non-clinical decisionmakers.
2. Telehealth is not a type of care, but a modality of care. Rules should take into account the unique nature of the use of technology as a modality without arbitrarily restricting its use.
    a. Minimum expectation of clinical standards, best practices, and quality should not vary across modalities for the same service.

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[18] Lin, L.A., Fernandez, A.C., Bonar, E.E. Telehealth for Substance-Using Populations in the Age of Coronavirus Disease 2019: Recommendations to Enhance Adoption. JAMA Psychiatry. 2020 Dec 1;77(12):1209–1210.

[19] Bartelt, K., Barkley, E., Butler, S., & Sandberg, N. (2023, June 27). ADHD Medications Prescribed at Similar Rates During Telehealth and In-Person Visits. Epic Research. *https://epicresearchblob.blob.core.windows.net/cms-uploads/pdfs/adhd-medications-prescribed-at-similar-rates-during-telehealth-and-in-person-visits.pdf.*

[20] DEA Telehealth Proposal Brings Risks, Not Patient Protections. Health Affairs Forefront, March 23, 2023. *https://www.healthaffairs.org/content/forefront/dea-telehealth-proposal-brings-risks-not-patient-protections.*

[21] *Ibid.*

[22] *Ibid.*

[23] *Ibid.*

[24] Aldana, G.L., Onyinyechi, V.E., & Reddy, A. (2023). Best Practices for Providing Patient-Centered Tele-Palliative Care to Cancer Patients. Cancers, 15(6), 1809. *https://doi.org/10.3390/cancers15061809.*

[25] *Ibid.*

b. However, differences in operations by modality should be taken into account—just as there are advantages and disadvantages to receiving a service in a hospital versus a doctor's office, there are advantages and disadvantages to receiving a service remotely.
c. Advantages of receiving a service remotely include more standardized care across a national practice which may result in higher quality, more convenience and accessibility for both the patient and the provider, and potentially reduced infrastructure costs. Increased access to care is critical given current provider shortages and geographic maldistribution of providers.
d. The countering disadvantage to increased access to care via the use of technology is the increased reach that bad actors may have using technology, which speaks to DEA's concerns of diversion and overprescribing.
e. We must ensure that DEA has the tools it needs to prevent diversion without limiting the ability of legitimate prescribers to practice.

Therefore, to create a Special Registration process for telemedicine providers seeking to prescribe controlled substances via telemedicine as a part of their clinical practice, we make the **attached recommendations.** These recommendations seek to strike the balance between ensuring legitimate prescribers can practice, thereby expanding access to needed health care services using the telehealth modality, with preventing diversion. Our recommendations are also designed to fit into DEA's current infrastructure without creating undue burdens for providers.

Lastly, we urge DEA to consider realistic timelines when implementing these new processes. We appreciate the ability for stakeholders to comment on proposed rules and the allowance of adequate time for DEA to consider such comments. We also emphasize that following a final rule, DEA should allow adequate time for the healthcare industry to accommodate new clinical and administrative procedures and update systems—such as electronic health records, pharmacy management systems, and license verification systems—to promote compliance.

We are pleased to share these recommendations with the DEA. We also look forward to commenting once again on any new or modified proposed rules that DEA puts forth to address telemedicine prescribing post-pandemic. Please do not hesitate to contact us at any time with questions or for further discussion.

Sincerely,
Kyle Zebley
Executive Director

ATA Action's Recommendations to DEA for a Special Registration Process for Telemedicine Prescribing of Controlled Substances Without a Prior In-Person Visit

September 2023

1. The Special Registration process should work in conjunction with the existing registration process.

Anyone prescribing, dispensing, or administering a controlled substance must register with the DEA under the Controlled Substances Act using form 224 or form 224a for renewals. Form 224 registration is available to practitioners (MD, DO, DDS, DMD, DVM, DPM), "mid-level practitioners" (NP, PA, OD, RPh, and other entities as recognized by their state),[26] pharmacies, hospitals, clinics, and military practitioners. Currently, DEA requires registration in each state where the practitioner practices.

Special registration should be an optional supplemental form associated with the existing registration process and should result in a modifier on a practitioner's DEA number, such as a "T" at the end, to indicate that the provider has a special telemedicine registration. Providers should use the modified DEA number when issuing a prescription via telemedicine. Thus, a provider will have the same registration number whether they prescribe in person or via telemedicine, but will be able to indicate *both* that they have gone through the special registration process and that the specific prescription was issued via telemedicine when the DEA number on the prescription includes the modifier. We encourage DEA to ensure that this type of information can be transmitted in e-prescribing platforms.

[26] Mid-Level Practitioners Authorization by State. (n.d.). *https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf.*

2. Telemedicine providers should *not* be required to maintain local addresses in every state where they practice.

The value of telemedicine by nature is only fully captured through the ability to practice across state lines. Improving access to care in remote areas or areas lacking specific services or providers will only occur when technology is able to be used to bridge gaps in geography. The Special Registration process should help realize the potential of telehealth to address health access issues while maintaining appropriate oversight of providers.

Providers are already required to obtain state licenses and authority in the states where they practice. Thus, many telehealth providers hold multiple state licenses. However, the most significant limiting factor to a multi-state practice, and the most counter-intuitive, is the requirement to have a physical location in every state where you practice. Having a physical address in each state defeats the purpose of serving patients remotely. Medical boards do not require physicians to have an in-state brick-and-mortar address in order to obtain a medical license, and DEA should follow that same approach for applicants with multistate telemedicine footprints.

In order to obtain a DEA registration, DEA requires applicable state controlled substances licenses and registrations. During the COVID–19 public health emergency, the requirement to have state authority from each state where you practice was waived and prescribers could operate nationwide using one DEA from one state registration. If DEA deems it necessary to maintain the pre-pandemic requirement that applicable controlled substances authority or registration be obtained in every state where the provider practices, the Special Registration process should allow for such authority to be obtained without the need for a physical address in each state. For prescribers who are not dispensing, administering, or otherwise handling or storing a controlled substance in a state, a physical address in that state should not be necessary. Practitioners should follow all applicable state laws in states where they practice, but it is not necessary for a telemedicine provider to maintain a physical presence in a state where they practice. The Special Registration process for telemedicine prescribing should recognize and account for that.

3. Special Registration should include the elements DEA needs to monitor for illegitimate practitioners and illegal prescribing practices.

- Personal/business information
  - *Address, phone, and email:* This is collected in the standard registration process. Practitioners should be able to list the site where they practice in person, the site where they conduct their telehealth practice, or the location of their practice group office. The purpose of this is not to have a physical location in each state, but for the practitioner to be easily contacted by authorities as needed. Thus, the location must include a phone number and email address at which the practitioner can be directly reached. It may be a corporate headquarters if the corporate headquarters has the ability to directly reach the individual practitioner within a reasonable timeframe. Practitioners should NOT be required to publicly list their home address or phone number, even if it is the location where they practice most often. Limiting the physical locations will have the added benefit of making it easier for DEA to monitor an ever-more diverse and mobile prescriber workforce.
  - *Provider identification number:* Prescribers should register for telemedicine as individuals using their NPI number.
- State authority
  - *State practice licenses:* Consistent with DEA registration, practitioners should provide valid and active State medical or other clinical licenses to practice, including supervisory agreement or other authorities, as required by the state. Practitioners should provide this information for every state where they have authority to practice.
  - *State controlled substances registration:* Should be provided as applicable, but there should not be a requirement that providers maintain a physical presence in each state (see recommendation #2).
  - *States of practice:* In addition to and consistent with state license and controlled substances authority provided, providers could indicate the states in which they intend to practice. This would need to be easily updatable without re-registration as providers obtain authority to expand into new states.

- *Proof of malpractice insurance:* Practitioners could provide proof of malpractice insurance.

- Background check
  - Clinicians currently undergo a standard federal FBI background check as a part of the process to obtain their clinical licenses. If DEA also requires a background check, it should utilize a streamlined process to obtain the necessary information with limited burden on the provider. The DEA should either access the existing federal background check information or request a copy from the practitioner.

- Attestations—we recommend that the DEA include a list of required practices that an applicant should attest to adhering to, potentially including:
  - *Description of practice and clinical protocols:* Similar to the information that practitioners provide when applying for malpractice insurance, DEA could require a brief description of a practitioner's practice, including patient population served and internal and external clinical and quality assurance protocols in place.
  - *Prescription drug monitoring programs:* Practitioners should attest that they will utilize the prescription drug monitoring program as required by state law.
  - *Diversion control protocol:* Similar to provider responsibility under HIPAA around maintaining privacy of protected health information, practitioners could attest to having practices in place to prevent diversion. Such practices could include the assignment of a clinical or non-clinical Diversion Prevention Officer (similar to a HIPAA Privacy Officer) who is responsible for training staff on identifying and preventing inappropriate practices and periodically reporting any violations to DEA using existing suspicious activity reporting processes. The attestation could include the question "does your medical practice have an internal reporting and investigation process for activity suspicious for diversion or inappropriate prescribing?".
  - *Patient identification verification protocol:* Practitioners could attest to utilizing protocols that ensure patient identity is verified before prescriptions are issued.
  - *Emergency protocols:* Practices could attest to protocols and procedures they have in place to address medical emergencies during the course of practice.

- Training requirement
  - *For all registrants:* Starting July 2023, all new and renewed DEA registrants must complete an 8-hour training course on addiction medicine, per Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines.[27] Special Registration could reiterate the required proof of this training.
  - *Special Registration training:* DEA could add a one-hour training requirement in order to obtain Special Registration. This training should not be specific to addiction services, but should be related to preventing diversion of all controlled substances and any unique considerations related to the practice of telemedicine. For example, Washington state now requires healthcare professionals offering telemedicine services to complete telemedicine training, which can either be approved publicly available training or training developed internally by the practice that meets certain guidelines.[28] Mechanics of the training could also be pulled from current HIPAA training requirements.

DEA asks what data is already reported to federal and state authorities, insurance companies, and other third parties. Practitioners report prescribing information to state PDMPs as required by state law or policy. When practitioners contract with insurance companies, they are often required to report licensing and other informa-

[27] Substance Abuse and Mental Health Services Administration. Training Requirements (MATE Act) Resources. *https://www.samhsa.gov/medications-substance-use-disorders/training-requirements-mate-act-resources.*

[28] Washington State Hospital Association. (n.d.). Washington State Telehealth Training Information. *https://www.wsha.org/policy-advocacy/issues/telemedicine/washington-state-telemedicine-collaborative/telemedicine-training/*.

tion. It would not be feasible for either practitioners to report, or for the DEA to receive, data on every prescription at the patient level as a national system for reporting such information does not exist and would trigger significant patient health information privacy and security concerns. It would also be administratively burdensome to create a system redundant to the PDMP.

Potentially feasible actions to provide DEA with more visibility into the prescribing and dispensing landscape and more tools to pursue bad actors could include:

- Requiring that prescribers retain records and share with DEA upon request.
    - Requested information could include aggregated, non-patient-specific, data around prescribing trends over a set time period.
- Requiring that practices proactively report suspicious activity, including based upon their protocols attested to above.
    - In one example, a telehealth provider had a sophisticated system for tracking and verifying patient identity and was able to identify a "patient" illegally submitting identification for multiple identities. Catching such an actor would be more difficult in a brick-and-mortar setting without the use of technological tracking. The suspicious activity was voluntarily reported to the local DEA, but there was not a streamlined mechanism to easily share such information with the DEA.

When reviewing prescribing patterns, it is important for DEA to consider the population that the telemedicine prescriber serves; telemedicine prescribers are often specialized into a treatment area and patients with specific conditions seek them out, so trends may vary from a provider who sees every type of patient in a geographic area. Put more directly, the mere fact that a specialized telehealth practitioner has a high volume of prescriptions of a specific medication should not, on its own, trigger suspicion.

4. Special Registration should not be limited to any specific specialty or treatment condition. Schedule II prescribing could involve additional oversight but should not have additional restrictions.

A wide range of disciplines, including family medicine, internal medicine, pediatrics, child and adolescent psychiatry, endocrinology, emergency medicine, and substance use disorder care rely on appropriately prescribing controlled substances and, therefore, should not be excluded from the Special Registration process.

ATA Action believes that telehealth is health and that clinical judgment should be left to the clinician. There are not distinctions for prescribing of controlled substances for different conditions or treatments for in-person providers, nor should there be for telemedicine providers. It would also further restrict access to certain medications if providers had to obtain another separate registration to prescribe them.

However, we understand that schedule II medications are classified as more dangerous than schedule III–V medications and recognize DEA's interest in particularly limiting diversion of those medications. Therefore, we recommend the same general Special Registration process for schedule II–V medications, but with some additional information required, on the same form, of registrants who indicate interest in prescribing schedule II medications. We would envision the process mirroring DEA's current form which distinguishes between narcotics and non-narcotics. The additional information required could be drawn from the suggestions in recommendation #3, should not be overly burdensome, and should maintain clinicians' ability to practice good clinical judgment.

5. Dispensers (pharmacies and pharmacists) should be able to identify legitimate prescribers who have a current Special Registration.

Traditional practice of pharmacy often relied on pharmacist-prescriber relationships in local areas. Especially in the fallout of the opioid epidemic, pharmacists have been trained to be suspicious of any "red flags" in prescribing patterns and are thus suspicious of prescribers they are not familiar with or not in their geographic area. This has resulted in denials to dispense legitimate prescriptions simply because they were issued via telemedicine, which has negatively impacted patient care. The Special Registration process should be used to help dispensers identify legitimate telemedicine prescribers and have confidence in the legitimacy of prescriptions issued by a prescriber with a Special Registration, even if from a remote location.

We note that the March 2023 DEA proposed rules contemplated requiring the prescriber to include a notation on the face of the prescription that the prescription has been issued via a telemedicine encounter, which we refer to as a telemedicine "stamp." Clinically, a valid prescription is a valid prescription and the fact that one was issued via telemedicine makes it no less so. If the stamp simply indicates that the prescription was done via telemedicine, we anticipate that dispensers would simply see it as an additional "red flag," which would result in further denials to dispense legitimate prescriptions.

If DEA chooses to maintain this prescription "stamp," we recommend utilizing it to help dispensers identify prescribers who have undergone the Special Registration process to prescribe controlled substance via telemedicine, thereby giving the dispenser confidence that the telemedicine prescription is indeed valid. We recommend that DEA should make clear that the addition of the "T" modifier to the registration number should explicitly indicate to the pharmacist that the geographic red flag should not be considered. If possible, we recommend that DEA create some manner of safe harbor for pharmacists who ignore the geography red flag based on the prescriber's verified Special Registration status. Pharmacists still have the corresponding responsibility to ensure that they fill legitimate prescriptions, but geography should not be a "red flag" in that process when a prescription is sent by a telehealth provider that has gone through the Special Registration process.

6. The location of the patient should not require any registration unless otherwise required because controlled substances are dispensed or administered at that site.

Patients should be able to receive telemedicine services from their home or any other location, to include clinics, residential treatment facilities, halfway houses, jails, juvenile detention centers, prisons, group homes, rehabilitation centers, schools, qualified hospice programs, and assisted living facilities. Those locations where the patient is during the visit should not be required to have any controlled substances authority. The prescriber prescribing the controlled substance (and the dispenser dispensing it) should hold the controlled substances authority, not the location of the patient when they see the prescriber remotely.

7. The Special Registration process should not place any arbitrary limits on a clinician's ability to practice within the scope of their authority.

- Prescribers should NOT be limited to treating an arbitrary number of patients.
- Prescribers should NOT be limited to issuing prescriptions for an arbitrary time period.
- DEA should not arbitrarily limit which clinician types have which authorities or privileges—that is governed by state clinical practice laws and boards.
- Prescriptions should NOT be limited to FDA-approved indications. It is legal and common for clinicians to use their clinical judgment to prescribe medications "off-label."

CADENCE
295 Lafayette St., 7th Floor
New York, NY 10012

Dear Health Subcommittee Chair Cardin (D–MD), Health Subcommittee Ranking Member Daines (R–MT), and Members of the Senate Finance Health Subcommittee:

Cadence appreciates the opportunity to provide input to the Committee hearing on "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." Our expertise is in the better management of chronic disease through remote physiologic monitoring (RPM), which our data show improves health outcomes while lowering the cost to the federal government of providing care for Medicare beneficiaries. We provide RPM services to over 10,000 patients nationwide. In partnership with some of the most innovative health systems in the country, Cadence offers chronic disease management tools and services that give patients—including those in rural and underserved areas—24/7 access to our clinical team through cutting-edge technology.

In less than 2 years, we have deployed in 17 states and are providing life-changing care to seniors suffering from heart failure, hypertension, and type 2 diabetes. Cadence data show an approximate **50% decrease in patients' total cost of care** ($4,100 in savings per patient per year), inclusive of the incremental costs associated with remote monitoring, and an **18% reduction in the number of**

emergency department visits for patients after 6 months in the program. As part of our monitoring, 84% of Cadence patients take vitals and transmit them to the Cadence platform at least 16 days per month. With Cadence clinical staff closely monitoring that data and responding to any anomalies, patients report feeling safer and more connected to their providers. The adoption of RPM is also freeing up ordering clinicians to see more patients through the improved management of those with chronic conditions, increasing access to care in communities suffering from shortages of clinical staff.

Testimony presented by Dr. Chad Ellimootil, Dr. Eric Wallace, and Dr. Ateev Mehrotra on November 14th highlighted RPM's efficacy in treating and managing chronic illness as well as in reducing hospitalizations. As Dr. Wallace noted, "RPM pays for itself." We wish to build on this testimony by requesting that the Committee remove roadblocks to the adoption and scaling of this innovative technology. **Building on this hearing, we request that the Committee:**

(1) Continue to highlight RPM's potential for improving patient care and reducing Medicare expenditures and work with the Centers for Medicare and Medicaid Services (CMS) to support appropriate reimbursement and data collection on the efficacy of RPM.

(2) Consider addressing geographic disparities in Medicare payment that prevent providers like Cadence from further expanding services to rural beneficiaries, leaving potential savings from improved management of these individuals on the table. Consistent RPM reimbursement must cover the costs of providing those services, and currently does not meet that threshold in many rural areas.

For more detail on Cadence's services, clinical outcomes, and cost savings for Medicare, please review our comments on the Calendar Year 2024 Physician Fee Schedule Proposed Rule, attached for your reference.

RFI RESPONSE

1. Incorporating RPM in primary care reduces Medicare expenditures.

Cadence's experience treating and managing thousands of Medicare beneficiaries alongside primary care providers has made clear that RPM is key to the future of primary care. Ninety-five percent of the providers who order our RPM services are primary care providers who want to improve how they manage their patients' chronic conditions outside of the office visit. Patients in the Cadence program are highly engaged and report vitals daily, leading to a 51% decrease in patients' total cost of care, inclusive of the incremental costs associated with RPM services.[1] The program also results in significant improvements in medication adherence: Our data show a 5x increase in the percentage of congestive heart failure patients on all four pillars of Guideline Directed Medical Therapy, the "cornerstone of pharmacological therapy for patients with heart failure."[2]

As part of future deliberations on telehealth, chronic disease, or rural health, we request that the Committee consider how innovative models, like Cadence, can continue to help reduce health care spending through primary care services empowered with digital health management tools. This effort should be coupled with data collection on the efficacy and cost savings of RPM.

2. Medicare does not appropriately reimburse Rural RPM services, despite the cost savings RPM demonstrates.

We encourage the Committee to consider the geographic disparity in reimbursement for RPM, which disincentivizes the adoption of RPM in rural communities. Cadence is at the forefront of providing remote monitoring to these communities, as approximately one-third of our patients live in rural and underserved areas.

While costs for in-person care are primarily related to workforce costs and often vary geographically, the costs of furnishing digital health services tend to be more consistent and independent of the service location. Cadence and many other digital health providers deliver RPM solutions to patients using the same model of care and clinical workforce regardless of where patients live, meaning that identical services

[1] Calculated as average reduction in total cost of care between patients enrolled in Cadence versus eligible but never enrolled and patients enrolled in Cadence versus ordered but never enrolled in Cadence. Based on ACO data using patients enrolled in Cadence in 2022, inclusive of over 9,000 eligible patients with congestive heart failure, hypertension or type 2 diabetes.

[2] Jay Patel, et al., *Guideline-Directed Medical Therapy for the Treatment of Heart Failure with Reduced Ejection Fraction* (2023), *https://pubmed.ncbi.nlm.nih.gov/37254024/*.

(including providing medical devices, educating the patient on the devices, monitoring physiologic data on an ongoing basis, and delivering treatment management services) are reimbursed at different rates under CMS' formula. For example, RPM reimbursement for data collection (CPT code 99454) in all of Missouri is 61% of what it is in San Jose, California, even though the costs associated with this service are largely the same regardless of where it is utilized.

CMS' own data shows that RPM reimbursement is lowest in states where the prevalence of chronic disease is well above the national average:

RPM reimbursement is lowest in states where the prevalence of heart failure, hypertension, and diabetes is well above the national average

RPM reimbursement is 16% less in AL versus WA, despite significantly higher chronic disease prevalence in AL

	Prevalence of Chronic Disease [1]			RPM Reimbursement [2]				Monthly Per Patient Reimbursement
	HF	*HTN*	*Diabetes*	*99453*	*99454*	*99457*	*99458*	*Ex. Claim with single units of 99454, 99457, and 99458(i.e., one month of RPM services)*
Washington [3]	−2%	−12%	−5%	+11%	+11%	+7%	+6%	***+8%*** | $149.87
National Average	14%	57%	27%	$19.32	$50.15	$48.80	$39.65	$138.60
Alabama	+2%	+9%	+3%	−13%	−12%	−7%	−6%	−9% | $126.34

[1] CMS Chronic Conditions Public Use Database. ''Chronic Conditions Prevalence. State/County 2018.'' *https://cms-oeda.maps.arcgis.com/apps/MapSeries/index.html?appid=062934f815eb412182b3d324054ea6f0.*
[2] Reimbursement represents Payment Amounts per the 2023 CMS Physician Fee Schedule in Place of Service 11 (Non-facility).
[3] Reimbursement represents the average of the two representative localities: Washington—Seattle (King Cnty) & Washington—Rest of State.

Unfortunately, current RPM reimbursement is inadequate in many rural and exurban areas relative to the resources required to create and maintain an effective program that conforms to CMS' requirements. High quality RPM is labor-intensive and requires technical expertise. Costs associated with devices and our technology platform include:

- *Cellular and Wi-Fi-enabled medical devices.* We source and program each device to upload patient readings automatically to the Cadence platform. Additional costs associated with devices include shipping fees; ongoing cellular fees per device; in certain instances, cellular or Wi-Fi signal boosters to enable connectivity and avoid data collection disruptions for patients located in rural areas with poor internet or cellular connections; and replacement parts or devices.
- *Continuous patient support.* We staff clinical team members 24 hours a day, 7 days a week, and 365 days a year to address patient and device issues. Labor-intensive and costly around-the-clock service is necessary to ensure timely care for patients with chronic and acute conditions and avoid unnecessary trips to the emergency room. Patients have access to Cadence 24/7 via text message, phone, and email.
- *Technology platform maintenance.* We sync patient vitals from our software to the electronic medical record to ensure this information is captured in the patient's chart. We also staff a team to improve electronic medical record integrations, which are far from standardized in the United States today, and employ full-time software engineers who design and engineer improvements, address software issues, and ensure the security of patient information.

Given these concerns, we request that the Committee consider legislation that would implement a payment adjustment in Medicare by setting a de facto floor for payment related to RPM. We believe that the logical approach to determining this floor would be by benchmarking it to the average payment rate for all geographies, without the rural payment adjustment included. We recognize this is a significant request, and are happy to meet with you and present a more comprehensive look at our cost data justifying this recommendation.

Thank you for your consideration of these recommendations. We welcome the opportunity to engage with you in greater depth on the feedback presented above. Please feel free to contact me directly at meryl@cadencerpm.com.

Sincerely,

Meryl Holt
Head of Legal

September 11, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on the CY 2024 Physician Fee Schedule Proposed Rule (CMS–1784–P)

Dear Administrator Brooks-LaSure:

Cadence appreciates the opportunity to submit comments in response to the Calendar Year 2024 Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Proposed Rule. As a provider of remote physiologic monitoring (RPM) services to over 10,000 patients across 13 states, we offer general feedback regarding the development of payment policies for RPM services and responses to specific issues relevant to our program.

Cadence applauds CMS for its leadership in improving outcomes and increasing access to life-saving care by introducing coverage for RPM codes in 2019. The use of these RPM services advances CMS policy priorities, including improving quality and patient outcomes while reducing program expenditures. RPM also enables more robust primary care by supporting the ongoing connection between patient and provider.

As patients and providers continue to experience the benefits of RPM, we urge CMS to refine its RPM policies to meet the practical realities and costs of delivering these invaluable services. We encourage CMS to pursue the growth of demonstrably high-value, evidence-driven RPM programs. In partnership with over 400 primary care providers and cardiologists across the United States, our data shows significantly improved patient outcomes and engagement and reduced costs to Medicare:

- *Improved Patient Outcomes*
  - 18% reduction in the number of emergency department visits for patients after 6 months of participation in the Cadence program, compared to those who had not enrolled.
  - 5x increase in the percentage of congestive heart failure patients on all four pillars of Guideline Directed Medical Therapy (GDMT).[1] For a 70-year-old patient with heart failure with reduced ejection fraction, achievement of all four pillars of GDMT provides an additional 5.2 years of life, on average.
  - 55% increase in the percentage of hypertension patients with well-controlled blood pressure.[2]
  - 43% of type 2 diabetes patients achieved their blood glucose goal.[3]
- *Reduced Costs*
  - 51% decrease in patients' total cost of care, inclusive of the incremental costs associated with RPM services.[4]
  - 63% reduction in the number of ambulance rides for patients in the program.[5]

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[1] David I. Feldman et al., *A Nationwide Telehealth Heart Failure Program: Can Remote Patient Monitoring and Guideline Directed Treatment Protocols Help Bridge the Gaps in Heart Failure Management,* 29 J. of Cardiac Failure 4 (April 2023), *https://www.onlinejcf.com/article/S1071-9164(22)00760-6/fulltext.*

[2] "Well controlled" is defined as less than 140/90 mmHg.

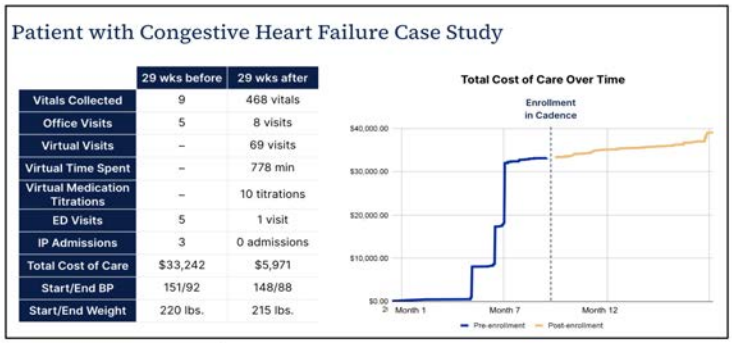
[3] "Blood glucose goal" is defined as less than 154 mg/dL (Hemoglobin A1C < ~7).

[4] Calculated as average reduction in total cost of care between patients enrolled in Cadence versus eligible but never enrolled and patients enrolled in Cadence versus ordered but never enrolled in Cadence. Based on ACO data using patients enrolled in Cadence in 2022 inclusive of over 9,000 eligible patients with congestive heart failure, hypertension or type 2 diabetes.

[5] Results based on a difference-in-differences analysis using ACO data using patients enrolled in Cadence in 2022 inclusive of over 9,000 eligible patients with congestive heart failure, hypertension or type 2 diabetes.

- *Increased Patient Access to Healthcare*
  - More than 4 million vitals transmitted from home by over 10,000 patients in the last 12 months.
  - Over 48,000 alerts resolved for all patients.
  - Over 66,000 remote visits with Cadence clinical staff.
  - 84% of patients engage with their devices at least 16 days each month.[6]
  - 80% of patients remain actively engaged after six months in the program.[7]

The patient case study below exemplifies the dramatic increase in patient access, improved outcomes, and decreased costs. Cadence enables this level of care for tens of thousands of patients across the United States daily. CMS should encourage the continued growth of RPM to meet the needs of the millions of beneficiaries who are currently not receiving these services.



I. Cadence's overarching priorities in the Proposed Rule.

- **RPM supports highly coordinated primary care and should be valued accordingly.** There is no debate that access to high-quality primary care produces better health outcomes and equity for communities.[8] Over 95% of the thousands of patients enrolled in Cadence's RPM program had an order placed by their primary care physician. Yet, RPM reimbursement has not received the attention and focus within primary care initiatives that we believe is appropriate.
- **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) should receive RPM reimbursement commensurate with rates for similar services under the Physician Fee Schedule.** We appreciate that CMS is proposing to institute separate payment for RPM services in these settings and capture the increased costs associated with care management services, but the proposed reimbursement under HCPCS G0511 is insufficient. The payment methodology for the RPM components does not fully reflect the costs of providing RPM services in the RHC and FQHC settings and will exacerbate disparities in access between those who rely on these providers and other Medicare beneficiaries.
- **CMS should reimburse under 99454 for monitoring associated with each device utilized in the delivery of RPM services.** It is often clinically reasonable and necessary to collect data from two or more separate medical devices to manage certain conditions and/or combinations of conditions. Existing reimbursement practically limits high-cost, high-need patients to monitoring via a single device, decreasing access to effective care and diminishing the potential for cost savings to Medicare.
- **We appreciate CMS' clarification with respect to data collection requirements for 99453 and 99454, and wish to emphasize that 16 days of data should *not* be required to bill treatment management services**

[6] Data based on the last 12 months of enrolled patients.
[7] "Actively engaged" is defined as transmitting at least one vital per month. Data based on the last 12 months of enrolled patients.
[8] CMS, *CMS Announces Multi-State Initiative to Strengthen Primary Care,* June 8, 2023, Press Release, *https://www.cms.gov/newsroom/press-releases/cms-announces-multi-state-initiative-strengthen-primary-care.*

codes 99457 and 99458. Neither CMS nor the American Medical Association have endorsed this position previously and there is no medical literature or other clinical reasoning that supports this change. Such a requirement would be unnecessarily burdensome and likely limit patient access to care since all treatment management services would be uncompensated if a patient failed to submit 16 days of data.

A. *RPM supports highly coordinated primary care and should be valued accordingly.*

1. We urge CMS to focus on improving reimbursement for RPM, just as it has for other primary care services.

Our experience treating and managing thousands of Medicare beneficiaries alongside primary care providers has made clear that RPM is key to the future of primary care. 95% of the physicians who order our RPM services are primary care providers who want to improve how they manage their patients' chronic conditions outside of the office visit. RPM should therefore be an integral part of CMS' ongoing push to support and enhance primary care services for Medicare beneficiaries.

CMS has already acknowledged the complexity of ongoing primary care in other contexts outside of RPM services, such as through the creation of a separate add-on payment, G2211, designed to capture resource costs associated with evaluation and management visits for primary care and longitudinal care of complex patients. The Proposed Rule also recommends a 3% increase in payment rates for family practice. Additionally, CMS is launching its Making Care Primary Model to increase access to high-quality primary care services.[9] The rationale underpinning these policy decisions should extend to improving reimbursement for RPM and supporting its integration into other primary care services.

2. RPM reimbursement continues to decline.

Cadence acknowledges and supports CMS' move to recognize RPM as a primary care service for the purposes of ACO attribution in the Proposed Rule.[10] However, we are concerned that CMS has not devoted adequate attention to reconciling the investment required to deliver meaningful RPM services with the associated payment rates.

Reimbursement for the RPM codes tied to recurring services has declined significantly since 2020, as illustrated in the table below, despite the increasing costs of devices and labor required to deliver RPM. While we understand there are a number of factors driving these payment decreases, some outside of CMS' control, we want to emphasize the patient access implications of such significant decreases in a short period of time for a demonstrably high-value service.

	2020		**2024 (Proposed)**		**% Difference 2020–2024 (Proposed)**	
	Non-Facility	**Facility**	**Non-Facility**	**Facility**	**Non-Facility**	**Facility**
99453	$18.77	N/A	$19.65	N/A	4.7%	N/A
99454	$62.44	N/A	$46.83	N/A	**−25.0%**	N/A
99457	$51.61	$32.84	$48.14	$ 29.15	**−6.7%**	**−11.2%**
99458	$42.23	$32.84	$38.64	$29.15	**−8.5%**	**−11.2%**

As we noted in last year's comment letter,[11] CMS should take steps to ensure that the Physician Fee Schedule pays for the clinical team's work involved in maintaining longitudinal relationships, providing personalized care, and coordinating across

[9] CMS, *CMS Announces Multi-State Initiative to Strengthen Primary Care,* June 8, 2023, Press Release, *https://www.cms.gov/newsroom/press-releases/cms-announces-multi-state-initiative-strengthen-primary-care.*

[10] 88 FR 52262, 52450 ("We propose to revise the definition of primary care services used for assignment in the Shared Savings Program regulations to include the following additions: . . . (2) Remote Physiologic Monitoring CPT codes 99457 and 99458").

[11] Cadence, Comment Letter regarding CY 2023 Physician Fee Schedule Proposed Rule, August 25, 2022, *https://www.regulations.gov/comment/CMS-2022-0113-15536.*

the care team via RPM. These are high-impact services for both patient outcomes and costs that should be valued accordingly.

3. Reimbursement should reflect the resource intensity of high-quality RPM services.

Cadence's positive clinical and cost-saving results are due to a nurse practitioner-led clinical team, state-of-the-art technology platform, and connected medical devices that monitor patient vitals such as blood pressure, heart rate, blood glucose level, and weight. Today, Cadence serves patients suffering from hypertension, congestive heart failure, and type 2 diabetes, which collectively afflict approximately 65% of Medicare beneficiaries.[12] Our health system partners, which include leading academic medical centers and the largest health systems in the United States, selected Cadence after unsuccessful efforts to build in-house RPM programs due to complexity and costs.

Once a practitioner determines the need for RPM, the Cadence care team educates and instructs the patient on the use of medical devices, creates a tailored care plan, and begins automatically recording patient vitals on our technology platform via device transmission. Our clinical staff reviews these readings before performing regularly scheduled and as-needed visits to ensure the patient is progressing toward their care plan goals. Our staff uses guideline-directed care protocols to respond to alerts, titrate medications, order labs, and escalate patients to the appropriate care setting. Detailed clinical protocols and highly trained nurse practitioners are critical to deliver the highest quality care and to avoid overwhelming primary care providers who already lack the time to appropriately manage patients with chronic disease.[13]

A tremendous commitment of resources is required to create and maintain an RPM program that is effective and engaging for patients and providers, and that conforms to CMS' requirements. High quality RPM is labor-intensive and requires technical expertise. Our work does not stop when we hand a device to a patient. Costs associated with devices and our technology platform include:

- *Cellular and Wi-Fi-enabled medical devices.* We source and program each device to upload patient readings automatically to the Cadence platform. Additional costs associated with devices include shipping fees; ongoing cellular fees per device; in certain instances, cellular or Wi-Fi signal boosters to enable connectivity and avoid data collection disruptions for patients located in rural areas with poor internet or cellular connections; and replacement parts or devices. We are aware CMS has resisted payment for cellular and Wi-Fi fees in the past; we strongly urge CMS to reconsider this position given such fees are a cost allocated to each patient's device and are more appropriately characterized as a direct practice expense.[14]
- *Continuous patient support.* We staff clinical team members 24 hours a day, 7 days a week, and 365 days a year to address patient and device issues. Labor-intensive and costly around-the-clock service is necessary to ensure timely care for patients with chronic and acute conditions and avoid unnecessary trips to the emergency room. Patients have access to Cadence 24/7 via text message, phone, and email.
- *Technology platform maintenance.* We sync patient vitals from our software to the electronic medical record to ensure this information is captured in the patient's chart. We also staff a team to improve electronic medical record integra-

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[12] CMS, *Multiple Chronic Conditions, Prevalence State/County Level: All Beneficiaries by Age, 2018, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/mcc_main.*

[13] *See* Devon McPhee, *Primary Care Doctors Would Need More than 24 Hours/Day to Provide Recommended Care,* UChicago Medicine, August 3, 2022, *https://www.uchicagomedicine.org/forefront/research-and-discoveries-articles/primary-care-doctors-would-need-more-than-24-hours-per-day-to-provide-recommended-care.*

[14] *See* 83 FR 59452, 59575 ("We disagree with the commenters and we continue to believe that the monthly cellular and licensing service fee constitutes a form of indirect PE. We believe that licensing and data costs are administrative costs that are not unique to individual procedures, in the same fashion that we do not assign separate direct PE for higher electricity costs to diagnostic imaging procedures as compared to cognitive evaluation procedures. We continue to believe that these data costs are appropriately captured via the indirect PE methodology as opposed to being included as a separate direct PE input. We also note that other services that require around-the-clock monitoring, such as the home PT/INR monitoring described in HCPCS code G0249 . . . do not include additional direct PE inputs for data costs, and we do not believe it would be appropriate to include them for CPT code 99454.").

tions, which are far from standardized in the United States today, and employ full-time software engineers who design and engineer improvements, address software issues, and ensure the security of patient information.

We recommend that CMS reference Cadence's care model to understand the investment required to achieve meaningful clinical outcomes and cost savings when considering RPM reimbursement. We would be happy to provide CMS with additional data to illustrate these points.

4. CMS should remedy the geographic disparity in reimbursement.

Relatedly, we also encourage CMS to consider the geographic disparity in reimbursement for RPM, which disincentivizes the adoption of RPM in rural communities. While costs for in-person care may often vary geographically, the costs of furnishing digital health services tend to be more consistent and independent of the service location. Cadence and many other digital health providers deliver RPM solutions to patients using the same model of care and clinical workforce regardless of where patients live, meaning that identical services (including providing medical devices, educating the patient on the devices, monitoring physiological data on an ongoing basis, and delivering treatment management services) are reimbursed at different rates under CMS' formula. **For example, RPM reimbursement for data collection (CPT code 99454) in all of Missouri is 61% of what it is in San Jose, California, even though the costs associated with this service are largely the same regardless of where it is utilized.** Given the inherently remote nature of RPM and other digital health services, there is no rationale for CMS to reimburse at different rates based on geographic location.

Variation in reimbursement and lower reimbursement rates for RPM provided in lower-cost areas disincentivizes digital health companies from focusing on rural states and underserved communities that would benefit from such services. These are the same communities in which patients often face more barriers to accessing quality care than their urban counterparts. Three out of five federally designated health professional shortage areas are in rural regions,[15] and rural residents generally must travel farther than urban counterparts to access healthcare services.[16] RPM could help address these barriers, but if providers cannot recoup the costs of providing RPM services in rural areas they will not offer them. CMS should remedy the disparity in reimbursement so patients in rural areas are not cut off from valuable, innovative care.

B. *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) should receive RPM reimbursement commensurate with rates for similar services under the Physician Fee Schedule.*

Cadence is at the forefront of providing remote monitoring to patients in rural and underserved areas. Approximately one-third of our patients reside in non-urban areas, low-income areas, and/or minority census tracts.[17] To date, we have been unable to serve patients in RHC and FQHC settings due to the lack of separate reimbursement for these services.

We appreciate that CMS is instituting separate payment for RPM services in RHCs and FQHCs. This is an important first step toward expanding healthcare access to patients in rural and underserved communities.[18] However, the proposed reimbursement of $72 under G0511 is insufficient as the payment methodology for the

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[15] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034,* June 2021, *https://www.aamc.org/media/54681/download?attachment.*

[16] Government Accountability Office, *Why Health Care Is Harder to Access in Rural America,* May 16, 2023, *https://www.gao.gov/blog/why-health-care-harder-access-rural-america#:~:text=On%20average%2C%20rural%20residents%20are,limited%20access%20to%20health%20care.*

[17] Federal Housing Finance Agency, *Underserved Areas Data, https://www.fhfa.gov/DataTools/Downloads/Pages/Underserved-Areas-Data.aspx* ("Low-income area" is defined as: (a) census tracts or block numbering areas in which the median income does not exceed 80 percent of area median income (AMI), (b) families with income not greater than 100 percent of AMI who reside in minority census tracts, and (c) families with income not greater than 100 percent of AMI who reside in designated disaster areas); Federal Housing Finance Agency, *2022 Low-Income Areas File, https://www.fhfa.gov/DataTools/Downloads/Documents/Enterprise-PUDB/Low-Income_and_Designated_Disaster_Areas/LYA_README_2022.pdf* ("Minority census tract" includes any census tract that has a minority population of at least 30 percent and a median income of less than 100 percent of the area median income).

[18] *See* Centers for Disease Control and Prevention, *About Rural Health,* updated May 9, 2023, *https://www.cdc.gov/ruralhealth/about.html;* Centers for Disease Control and Prevention, *Diabetes Policy Brief, https://www.cdc.gov/ruralhealth/diabetes/policybrief.html.*

RPM components does not reflect the costs of providing RPM services. While some of the services under G0511 can be offered on a stand-alone basis, it is frequently the case that at least two RPM services (*e.g.,* daily data recordings under 99454 plus 20 minutes of treatment services under 99457) are offered simultaneously to meet a patient's needs. We strongly recommend that CMS consider increasing the reimbursement rate for G0511 to address the fact that many patients will receive multiple care management services that under the current proposed approach would need to be billed under a single bundled HCPCS code.

The reimbursement differential between RHC and non-RHC settings is stark. If a non-RHC provider bills for typical services provided to a new RPM patient under the 2023 Physician Fee Schedule national payment rates, in month 1 they will receive $118.27 ($19.32 for 99453, $50.15 for 99454, and $48.80 for 99457) and in month 2 and beyond they will receive $98.95 ($50.15 for 99454 and $48.80 for 99457), as opposed to $72 as proposed under G0511. It is unclear what justifies such a differential given that CMS itself acknowledges that these services require "additional resources" based on their "unique components."[19] We respectfully request that CMS modify reimbursement for these sites of service to match the national average payment rates for comparable RPM services under the Physician Fee Schedule, which better reflect the complexity of delivering RPM services. Allowing RHCs and FQHCs to bill codes 99453, 99454, 994547, and 99458 outside of the all-inclusive rate or prospective payment systems will also prevent disparities in care based solely on the site of service.

To the extent CMS moves forward with a single code for RPM reimbursement in RHCs and FQHCs, we recommend the creation of a new code for RPM services that is valued separately from the broader G0511 services code and better reflects the costs and needs of an RPM service. A separate RPM code would mitigate the rationing of care that is likely to occur given the current make-up of G0511. In its present form, G0511 can only be billed once per month despite the increasing number of services providers may offer under the care management umbrella. The list of services captured under care management already includes chronic care management (CCM), behavioral health integration (BHI), principal care management (PCM), and chronic pain management (CPM), and it continues to grow as items like community health integration are added.[20] The diversity of this list means practitioners will now be forced to choose if their patient will receive RPM *or* social determinant support. It is common, however, for Medicare beneficiaries to have multiple chronic conditions *and* social needs, leaving the G0511 code inadequate in covering their care.

It is notable that CMS is allowing non-RHC/FQHC practitioners to bill RPM or RTM concurrently with CCM/transitional care management/BHI, PCM, and CPM.[21] CMS' stated intention "is to allow the maximum flexibility for a given practitioner to select the appropriate mix of care management services, without creating significant issues of possible fraud, waste, and abuse associated with overbilling of these services."[22] We request this same flexibility for care management services billed under HCPCS G0511, so that patients at RHCs and FQHCs have the same access to care as other Medicare beneficiaries.

C. *CMS should reimburse under 99454 for monitoring associated with each device utilized in the delivery of RPM services.*

We are disappointed that CMS has reiterated that even when multiple medical devices are provided to a patient, services associated with all such devices—in particular, CPT code 99454, which covers the provision and use of medical devices—may be billed only once per patient, per 30-day period, and when at least 16 days

[19] 88 FR 52262, 52401 ("Allowing a separate payment for RPM and RTM services in RHCs and FQHCs is intended to reflect the additional resources necessary for the unique components of these services. The care coordination included in services, such as office visits, do not always adequately describe the non-face-to-face care management work involved in primary care. Payment for in-person encounters may not reflect all the services and resources required to furnish comprehensive, coordinated care management. As RPM and RTM services are described, particularly, collection and transmission of data and then further analysis and interpretation of the data are happening outside of the face-to-face visit.").

[20] 88 FR 52262, 52676 ("In section III.B.4. of this proposed rule, we are proposing a policy to include Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community Health Integration (CHI), and Principal Illness Navigation (PIN) services in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs.").

[21] 88 FR 52262, 52304 ("Practitioners may bill RPM or RTM, but not both RPM and RTM, concurrently with the following care management services: CCM/TCM/BHI, PCM, and CPM.").

[22] *Id.*

of data have been collected.[23] Cadence recommends that CMS discontinue this restriction and allow reimbursement for patient vitals recorded by each and all clinically necessary devices.

Limiting reimbursement under 99454 to once per 30-day period regardless of the number of devices used to record patient data is unsupported by clinical reasoning and conflicts with typical clinical practices. There are several scenarios where a provider managing the care of a patient with a single condition must be aware of two or more vital signs to make appropriate treatment decisions. For example, a provider must consider weight and blood pressure before safely managing the medications of a congestive heart failure patient—especially when prescribing and dosing GDMT, which involves four drug therapies. GDMT is proven to reduce mortality and morbidity for patients with heart failure with reduced ejection fraction, with the potential to mitigate the staggering annual costs of heart failure in the United States, which are estimated at over $30 billion.[24] Yet, over 78% of chronic heart failure patients are not prescribed GDMT.[25] CMS' current stance compounds this problem by barring adequate reimbursement for the multiple devices required to help providers implement GDMT. Cadence has firsthand experience with the financial consequences of CMS' reimbursement policy: even as we have observed a 3x increase in the percentage of heart failure patients on all four pillars of GDMT while on our program, one of the two devices needed to manage this condition is ineligible for reimbursement.

Effectively limiting reimbursement under 99454 to a single device also negatively affects patients with multiple conditions. For instance, a provider may have to monitor two or more patient vitals to make an appropriate treatment decision for a patient with multiple conditions, like for the many patients with both hypertension and type 2 diabetes (*i.e.,* the provider must monitor blood glucose level and blood pressure, respectively).

Simply put, reimbursement is appropriate under 99454 for all devices provided to a patient, regardless of the number of conditions being monitored. This stance is consistent with the guidance set out in the CPT code book, which contemplates the use of 99453 and 99454 in connection with one or more "device(s)."[26] Accordingly, we encourage CMS to revisit its position on this issue.

D. *We appreciate CMS' clarification with respect to data collection requirements for codes 99453 and 99454, and wish to emphasize that 16 days of data should not be required to bill treatment management services codes 99457 and 99458.*

The Proposed Rule states that, for RPM, "only one practitioner can bill CPT codes 99453 and 99454 . . . during a 30-day period, and only when at least 16 days of data have been collected on at least one medical device."[27] CMS also notes that this "data collection minimum[] appl[ies] to existing RPM and RTM *code families* for CY 2024,"[28] suggesting that at least 16 days of data must be collected over a 30-day period to seek reimbursement under RPM treatment management services codes 99457 and 99458.

To the extent this apparent clarification as to 99457 and 99458 was intentional, we urge CMS to reconsider it. A 16-day data collection requirement for these two codes is arbitrary and unreasonable, and neither CMS nor the American Medical Association has enunciated such a requirement in previous rulemakings or guidance. To the contrary, CMS itself has acknowledged "that a full 16 days of monitoring may not always be reasonable and necessary."[29]

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[23] *See* 86 FR 5020, 5021 ("In response to public commenters, we are clarifying that only one practitioner can bill CPT codes 99453 and 99454 during a 30-day period and only when at least 16 days of data have been collected on at least one medical device as defined in section 201(h) of the FFDCA. CPT language suggests that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected.").

[24] Centers for Disease Control and Prevention, *Heart Failure, https://www.cdc.gov/heartdisease/heart_failure.htm.*

[25] Kathir Balakumaran et al., *Evaluation of Guideline Directed Medical Therapy Titration Program in Patients with Heart Failure with Reduced Ejection Fraction.* Int'l J. Cardiol. Heart Vasc. (2018), *https://pubmed.ncbi.nlm.nih.gov/30480083/*.

[26] American Medical Association, CPT Codebook 2023, Professional Edition, p. 38.

[27] 88 FR 52262, 52304.

[28] *Id.* (emphasis added).

[29] 85 FR 84472, 84546.

As an initial matter, it would be unreasonable to apply the data collection minimum to 99457 and 99458 because these time-based services codes operate on a *monthly basis,* while data collection code 99454 operates on a *rolling 30-day basis.* Imposition of the data collection minimum to the time-based services codes would therefore mean that a provider who spends 20 minutes with a patient in a month would be prohibited from seeking reimbursement under 99457 if the patient began the RPM program in the middle of the month and only had 15 days for data collection—even if the patient submitted vitals on each of those 15 days.

Taking the example of a patient who submits 15 days of vitals in a given month and receives 20 minutes of treatment management services one step further, there is no basis—clinical or otherwise—to require the patient to submit one more day of vitals before reimbursement is appropriate for treatment management services. We are unaware of any medical literature that recommends or suggests recording 16 days of vitals is necessary or even standard to treat and manage a patient's particular condition. Meanwhile, any and all data recorded in a month informs care provided to a given patient, and the treatment management services may reasonably rely on 15 days' worth of data to remotely manage the patient's status and treatment plan. The treatment management services may be medically necessary and appropriate services without regard to whether the 16-day data transmission requirements are met for codes 99453 and 99454.

We respectfully request that CMS clarify that 16 days of data collection is not necessary to bill 99457 and 99458. Alternatively, CMS should make publicly available any additional basis, beyond the CPT code book instructions, for the 16-day requirement and explain why it limits coverage of RPM services that are reasonable and necessary for the treatment of a patient's condition.

II. Additional RPM and care management recommendations.

A. *CMS should not require direct supervision of clinical staff obtaining CCM consent from a beneficiary in an RHC or FQHC.*

Cadence supports CMS' proposal to permanently extend the COVID–19 Public Health Emergency flexibility that allowed clinical staff to obtain beneficiary consent for CCM services under the general supervision of the ordering provider in RHCs and FQHCs.[30] Permitting beneficiary consent to be obtained under general supervision rather than direct supervision expands access to valuable CCM services in the rural and underserved areas that need them the most.

Further, allowing beneficiary consent to be obtained under general supervision aligns with CMS' stance regarding all other CCM services, which are already designated care management services that may be performed under the general supervision of a physician or other qualified healthcare provider.[31] There is no compelling reason for beneficiary consent to be the only portion of CCM service that must be performed under direct supervision in RHCs and FQHCs, particularly because CMS has clarified that the billing requirements imposed on CCM services ensure that clinical staff are providing appropriate services even in the absence of direct supervision.[32] We applaud CMS for extending the same philosophy to obtaining beneficiary consent for the CCM services in RHCs and FQHCs.

B. *CMS should remove the medically unlikely edit (MUE) for 99458 or increase the number of reimbursable units.*

In response to CMS' request for general feedback as it develops payment policies for RPM,[33] we propose the removal or increase of the MUE associated with 99458. CMS has implemented a MUE that bars providers from billing four or more units of 99458 on a single date of service. As a result, any time beyond 100 minutes spent delivering care over the course of a calendar month triggers the MUE and cannot be billed, improperly restricting a provider's ability to monitor and manage patients

[30] 88 FR 52262, 52406.
[31] *See* 42 CFR 410.26.
[32] 78 FR 74229, 74426 ("We stated our belief that the additional requirements we impose for auxiliary personnel under the exception for general supervision for homebound patients in medically underserved areas should apply in these circumstances where we are allowing a physician to bill Medicare for chronic care management services furnished under their general supervision and incident to their professional services. In both of these unusual cases, these requirements help to ensure that appropriate services are being furnished by appropriate personnel in the absence of direct supervision.").
[33] *See* 88 FR 52262, 52305.

with chronic conditions who require individualized, frequent care throughout a calendar month.

While our data show that the MUE (more than [three] 99458 codes) are triggered for under 0.5% of patients monthly, it is critically important to ensure that payment is available for the care delivered to these patients. The vast majority have congestive heart failure and are experiencing abnormal vitals readings on a near-daily basis, requiring close monitoring and care to keep them out of the hospital.

C. *An established patient relationship is needed to order RPM services.*

We agree with CMS' continued requirement that there be an established relationship between the physician and patient prior to ordering RPM services. This ensures that the ordering physician understands the needs of the patient in advance of ordering RPM services and fits well with our vision for RPM as part of highly coordinated primary care services.

D. *CMS should move away from the 20-minute threshold for reimbursement under treatment management services codes 99457 and 99458.*

We welcome the opportunity to discuss with CMS improvements to the RPM treatment management codes, 99457 and 99458, as the 20-minute threshold does not adequately reflect how these services are delivered or utilized. There are situations in the delivery of RPM—*e.g.,* receipt of a patient vital or phone call requiring immediate intervention—that result in a significant amount of uncompensated care by providers due to limitations in how these codes are designed. Approximately 30% of our clinical team's time is uncompensated today, which is costly given our multidisciplinary team with a significant number of advanced practice providers.

Structuring the treatment management codes to resemble primary care services by offering reimbursement for care furnished during a time range (*e.g.,* 16 to 23 minutes) as opposed to the strict 20-minute rule would improve the long-term viability and reach of RPM. As noted above, RPM is mainly ordered by primary care physicians, and the services are often utilized similarly to telephonic, non-face-to-face evaluation and management codes. RPM treatment management services codes should be modernized to have comparable flexibility.

IV. Conclusion

We appreciate your consideration. Should you have any questions, require additional information, or wish to meet to review data supporting our comments, please contact Meryl Holt, Head of Legal, at meryl@cadencerpm.com.

Sincerely,

Christopher Altchek
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Statement of Gretchen Jacobson, Ph.D., Vice President, Medicare

Chair Cardin, Ranking Member Daines, and Members of the Subcommittee on Health Care,

Thank you for the opportunity to submit a statement for the record regarding your November 14th hearing, "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency."

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most underserved communities.

My comments draw on research by Commonwealth Fund grantees and other experts on the policy considerations in determining how to handle expiring Medicare telehealth flexibilities.

A Policy Framework for Evaluating Telehealth Policy

Telehealth holds tremendous promise in improving patient care due to its convenience and ease of use. However, there have been concerns that unfettered access can

also run the risk of encouraging excessive use of services and increasing spending with unclear improvements on health. Telehealth's effects on disparities in access to care are also not clear-cut. While use of telehealth sharply increased during the pandemic, many questions remain unanswered about the effects of telemedicine on access to care, quality of care, spending, and equity, and how the effects differ across subpopulations.

Telehealth can be an important option for patients who face challenges in accessing in-person care (*e.g.,* inability to take time off work or transportation limitations) or who live in underserved areas. But there have been concerns that lack of access to the reliable broadband and technology necessary for telehealth visits may exacerbate barriers to telehealth care for certain communities. A study using 2018 data found that about 26% of Medicare beneficiaries lacked digital access at home, with higher proportions among those with low socioeconomic status, those 85 years or older, and in communities of color.[1]

Dr. Ateev Mehrotra and colleagues offered recommendations soon after the beginning of the pandemic, within a proposed framework that prioritizes both high-value medicine and simplicity in regulatory and payment policy.[2] They have updated those recommendations to encourage a nuanced approach toward permanent expansion of telehealth coverage.[3] They have highlighted several areas in which more information is needed to guide policy around telehealth coverage, including its effects on spending, patient outcomes, and equity. The researchers suggest that, if the data supports such policies, these types of nuanced policies could include structuring cost-sharing for telehealth services differently for low-value versus high-value services, reimbursing telemedicine visits at a lower rate than in-person services, increasing the use of alternative payment models, and requiring physicians to offer video visits if audio-only visits are also offered.

Audio-Only vs. Video Telehealth

As policymakers weigh how to approach coverage and payment for audio-only telehealth services, they should consider factors like what modality practices can provide, what providers offer, and what patients prefer.

A study by Dr. Ishani Ganguli and colleagues found that 43% of Medicare beneficiaries reported choosing telephone visits when given the option by their providers, even when video options were reportedly available.[4] Older beneficiaries and those with less access to technology were significantly more likely to choose telephone visits. This suggests the value of maintaining patients' access to audio-only services in instances where it's clinically appropriate, such as mental health care.

Importantly, the study also found that historically marginalized groups reported higher rates of telephone visits being offered but similar rates of uptake among those who were offered. To promote access to clinically appropriate telehealth services, policymakers should consider ways to help address practice-, clinician-, and patient-level barriers to video services. For practices, that could include financial resources to help build the necessary infrastructure to offer video visits. For clinicians, that could include regulatory or payment incentives, such as having providers certify that they offered both modalities to patients before receiving reimbursement for audio-only visits. To promote more equitable telehealth access for patients, policymakers could also build on recent efforts to close the "digital divide" by understanding and closing remaining broadband funding gaps, prioritizing new infrastruc-

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[1] Roberts, E.T., Mehrotra, A. Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. *JAMA Intern Med.* 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666. *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768771.*

[2] Ateev Mehrotra, Bill Wang, and Gregory Snyder, *Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?* (Commonwealth Fund, Aug. 2020). *https://doi.org/10.26099/7ccp-en63.*

[3] Mehrotra, Ateev, and Lori Uscher-Pines. "Informing the debate about telemedicine reimbursement—what do we need to know?." *N Engl J Med* 387.20 (2022): 1821–1823. *https://www.nejm.org/doi/full/10.1056/NEJMp2210790.*

[4] Ganguli, Ishani, et al. "Patient Characteristics Associated With Being Offered or Choosing Telephone vs Video Virtual Visits Among Medicare Beneficiaries." *JAMA Network Open* 6.3 (2023): e235242–e235242. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2802849.*

ture in underserved areas, and improving consumer outreach on FCC's program that subsidizes broadband services for eligible households.[5]

Telehealth for Behavioral Health Services

Tele-mental health care has robust evidence of efficacy across a range of modalities (*e.g.,* audio-only and video) and conditions (*e.g.,* depression and substance use disorder).[6] Research thus far has demonstrated that these services are safe, effective, and comparable in outcomes to in-person mental health services.[7]

A panel of mental health and substance use policy experts and researchers was convened by Dr. Beth McGinty and colleagues to assess consensus on how certain pandemic-era Medicare policy flexibilities might influence care and costs for beneficiaries with behavioral health conditions.[8] Most of the panelists agreed that policies expanding Medicare telehealth coverage would likely increase access to mental health and substance use disorder services, and would improve outcomes, but would also likely increase spending.

However, experts underscored the need to better understand how telehealth policies affect access among subgroups of beneficiaries. Are the policies leading to increased treatment uptake among beneficiaries who would not get care otherwise or beneficiaries who would get in-person treatment regardless? This would also determine the effects of these policies on beneficiaries' out-of-pocket spending (*e.g.,* whether spending stems from substitutive vs. additive telehealth services).

Interstate Licensure for Specific Physician Telehealth Services

To facilitate care by out-of-state clinicians, the COVID–19 pandemic prompted the federal government to temporarily relax the requirement that physicians be licensed in the state where their patient is physically located at the time of care in order to have the visit covered by Medicare. State licensing boards play an important role in verifying the education and training of physicians and ensuring the safety of patients. Yet, the surge in telehealth use during COVID–19 has prompted concerns from providers who seek to maintain a care relationship with a patient living in or traveling in another state.[9] Many health care compliance officers have interpreted "practice of medicine" across state lines to include follow-up calls and electronic communication. To avoid running afoul of licensing law, patients must travel to a physician's state of licensure or see a different physician for their health needs.[10] This policy affects not just beneficiaries traveling for leisure but also patients with complex or rare conditions who must seek out-of-state specialty care that is otherwise unavailable at home. For behavioral health, policy and research experts have largely agreed that waiving in-state licensing requirements for physicians and nonphysician practitioners would increase Medicare beneficiaries' access to behavioral health services, especially if telehealth for mental health and substance use disorders is sustained.[11]

Faculty at Harvard Law's Petrie-Flom Center and Center for Health Law and Policy Innovation facilitated a roundtable to identify consensus among physicians, patients, health systems, academics, and advocates on proposed telehealth licensure reforms.[12] The resulting consensus statement argues for the following exceptions to state-based licensure requirements, guided by principles of augmented patient access to care, clarity and uniformity, lower administrative burden and cost, and expedience:

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[5] Rachfal, C.L. "The persistent digital divide: Selected broadband deployment issues and policy considerations." CRS Report R47506. *Congressional Research Service* (2023). *https://crsreports.congress.gov/product/pdf/R/R47506; https://www.gao.gov/blog/closing-digital-divide-millions-americans-without-broadband.*

[6] Jacob C. Warren and K. Bryant Smalley, "Using Telehealth to Meet Mental Health Needs During the COVID–19 Crisis," *To the Point* (blog), Commonwealth Fund, June 18, 2020. *https://doi.org/10.26099/qb81-6c84.*

[7] *https://telehealth.org/bibliography/.*

[8] Beth McGinty et al., *Expert Consensus on the Impact of COVID-Response Medicare Policies on Mental Health, Substance Use Care, and Costs* (Commonwealth Fund, Oct. 2022). *https://doi.org/10.26099/5vgp-e157.*

[9] Shachar, C., Richman, B.D., Mehrotra, A., Providing Responsible Health Care for Out-of-State Patients. *JAMA.* 2023;330(6):499–500. doi:10.1001/jama.2023.10411. *https://jamanetwork.com/journals/jama/fullarticle/2807774.*

[10] *https://hls.harvard.edu/clinic-stories/telehealth-laws-need-to-be-updated-for-a-post-covid-health-system/.*

[11] Beth McGinty et al.

[12] *https://chlpi.org/resources/consensus-statement-for-telehealth-licensure-reforms/.*

- Follow-up care for established patient relationships;
- Screening for specialty referrals;
- Care incident to an existing care plan; and
- Care in the context of clinical trials.

The roundtable highlighted that exceptions to state licensure requirements for patient care have been made in other settings. The Sports Medicine Licensure Clarity Act created licensure exceptions for clinicians traveling with a sports team to another state, enabling them to provide care even if they are not licensed in the state in which the sporting event occurs. Similarly, the VA MISSION Act created exceptions for care within the Veterans Administration.

Important questions remain about the efficiency, effectiveness, and equity of telemedicine policy for Medicare beneficiaries. As more is learned about the patient outcomes and relative spending on telemedicine, Medicare coverage and payment policies should be guided by the evidence.

Thank you again for the opportunity to provide comments for the record. Please contact Rachel Nuzum, Senior Vice President of Policy at the Commonwealth Fund at rn@cmwf.org and myself at gj@cmwf.org if we can be of further assistance.

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November 14, 2023

The Honorable Benjamin Cardin
Chairman
Senate Committee on Finance
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Steve Daines
Ranking Member
Senate Committee on Finance
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

Re: MGMA Statement for the Record—Senate Committee on Finance Subcommittee on Health Care's Hearing, "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency"

Dear Chairman Cardin and Ranking Member Daines:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for the opportunity to provide the following feedback in response to your hearing, "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." We appreciate your leadership in holding this hearing as permanent telehealth reform is critical to medical groups' ability to continue providing high-quality care to beneficiaries nationwide.

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.

MGMA has long supported commonsense telehealth policy reforms to expand access to care. Prior to the COVID–19 Public Health Emergency (PHE), the utilization of telehealth services was stymied by overly restrictive regulatory requirements—in 2016, only 0.25% of beneficiaries in fee-for-service Medicare utilized telehealth services.[1] The flexibilities enabled by Congress and the Centers for Medicare and Medicaid Services (CMS) in response to the COVID–19 PHE facilitated patients access to critical care through telehealth during the pandemic.

We appreciate Congress stepping in and extending many important telehealth flexibilities that were implemented during the COVID–19 PHE until Dec. 31, 2024, as part of the *Consolidated Appropriations Act of 2023 (CAA, 2023).* These policies have allowed practices to continue offering vital telehealth services to patients wherever

[1] Centers for Medicare & Medicaid Services, "Information on Medicare Telehealth," Nov. 15, 2018, *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf.*

they may be located. We offer the following recommendations on permanent reform that would build on telehealth's demonstrable success over the past few years:

- Expand access to telehealth services under the Medicare program by permanently removing current geographic and originating site restrictions for all services;
- Permanently cover and reimburse audio-only visits at a rate that adequately covers the cost of delivering that care;
- Appropriately reimburse providers for telehealth services to allow them to provide cost-effective, high-quality care;
- Support improving coverage of digital health by removing administratively burdensome billing requirements, such as the requirement to collect patient co-pays for virtual check-ins; and,
- Ensure continuity of care between a practice and its patients through telehealth.[2]

We propose the Subcommittee examine potential legislation to implement the polices listed above.

Pass the *CONNECT for Health Act of 2023 (CONNECT Act)*

The bipartisan *CONNECT Act* is supported by 60 senators including both Chairman Cardin and Ranking Member Daines. It would implement many important policies, such as permanently removing geographic requirements and expanding originating sites to include the patient's home and other clinically appropriate sites. Sections of last Congress' iteration of the bill were used in the *CAA, 2023,* to extend COVID–19 PHE policies through 2024.

MGMA thanks the Chairman and Ranking Member for their support of the *CONNECT Act* and urges the Subcommittee to pass the bill to make rational permanent reforms to telehealth.

Ensure Practitioners are Safe when Offering Telehealth Services from Home

In the recently finalized 2024 Medicare Physician Fee Schedule (PFS), CMS confirmed the continuation of its current policy of allowing practitioners to list their work address on their Medicare enrollment form while billing telehealth services from their home until Dec. 31, 2024. During the PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home addresses on their Medicare enrollment forms and allowed billing from their currently enrolled location. MGMA and other organizations raised the privacy, security, and administrative concerns with having practitioners report their home addresses as this information may be available to the public, and CMS responded by extending its current policy through 2024.

The House Committee on Energy and Commerce is holding a markup on the *Medicare Telehealth Privacy Act of 2023* tomorrow which would ensure CMS cannot make a practitioner's home address available to the public if they offer telehealth services from home. **We recommend the Subcommittee work with its congressional colleagues to pass legislation, such as the *Medicare Telehealth Privacy Act of 2023,* to adequately safeguard practitioners from security and privacy concerns resulting from reporting their home addresses.**

Conclusion

MGMA thanks the Subcommittee for its attention to making permanent telehealth reforms. We look forward to collaborating with the Subcommittee and its colleagues to craft sensible policies that will bolster medical groups' ability to offer high-quality telehealth care. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202–293–3450.

Sincerely,

Anders Gilberg
Senior Vice President
Government Affairs

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[2] MGMA, 2023 Digital Health Issue Brief, *https://www.mgma.com/getkaiasset/8bc9a2a9-0c0a-4526-b8ce-fb47520ed320/MGMA%202023%20Digital%20Health%20Issue%20Brief.pdf.*

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November 14, 2023

The Honorable Ben Cardin, Chair
Subcommittee on Health Care
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Steve Daines, Ranking Member
Subcommittee on Health Care
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

Dear Subcommittee Chairman Cardin and Subcommittee Ranking Member Daines,

Thank you for holding the hearing entitled, "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency" at the Subcommittee on Health Care within the U.S. Senate Committee on Finance and for your continued leadership to advance telehealth. On behalf of the Mental Health Liaison Group (MHLG) Telehealth Work Group, **we urge the committee to pass a provision permanently removing the telemental health in-person requirement** as passed within Section 123 of the *Consolidated Appropriations Act of 2021* (P.L. 116–260) prior to the implementation of the requirement on January 1, 2025.

Although the Centers for Medicare and Medicaid Services (CMS) extended in-person follow ups to every 12 months after the initial 6-month in-person visit with the final 2023 Medicare Physician Fee Schedule,[1] this provision remains unduly burdensome given the growing need for mental health services throughout the nation and acute behavioral health workforce shortages. The provision is counter to the intent of ensuring more Americans receive life changing care; and, in fact, could further exacerbate our nation's growing mental health crisis. As the committee is aware, there is no in-person requirement for individuals seeking medical services or substance use disorder treatment via telehealth.

According to CMS telehealth data[2] from January 1, 2020 to March 31, 2023, shows approximately 30% of Medicare beneficiaries utilized telehealth, underscoring the continued popularity of the modality among enrollees. We also know that Medicare beneficiaries utilize telehealth for a larger share of their behavioral health services[3]—43% of beneficiaries for behavioral health services versus 13% of beneficiaries for office visits (E/M visits). The MHLG Telehealth Work Group strongly supports in-person care when it is clinically appropriate; however, the current in-person requirement is applied to all patients with mental health conditions regardless of whether such a visit is needed or wanted.

As the committee continues to negotiate telehealth permanency provisions, we thank you for your leadership and look forward to working with you to ensure Americans receive the mental health services they need.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association of Nurse Anesthesiology
American Counseling Association
American Foundation for Suicide Prevention
American Psychiatric Association
American Psychological Association
American Telemedicine Association
Association for Ambulatory Behavioral Healthcare
Association for Behavioral Health and Wellness
Centerstone
Children's Hospital Association

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[1] *https://public-inspection.federalregister.gov/2022-23873.pdf.*
[2] *https://data.cms.gov/sites/default/files/2023-09/Medicare%20Telehealth%20Trends%20Snapshot%2020230821_508.pdf.*
[3] *https://oig.hhs.gov/oei/reports/OEI-02-20-00520.pdf.*

Inseparable
Meadows Mental Health Policy Institute
Mental Health America
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Mental Well-being
REDC
Wounded Warrior Project

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Dear Chair Cardin, Ranking Member Daines, and the members of the Senate Finance Health Subcommittee,

The National Association for Home Care & Hospice (NAHC) respectfully submits this statement for the record regarding the hearing titled "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." Our comments today focus on telehealth policy in the home care and hospice arena. Since 1982, NAHC has been the largest organization representing hospice, home health, and home care providers across the nation. Our members include a wide array of provider types, including nonprofit and proprietary, urban and rural, hospital-affiliated, public and private corporate entities, and government-run agencies.

Home health agencies and hospices have employed many forms of telehealth in the home setting for more than two decades. Telehealth has been a valuable tool for providing quality care in an efficient and effective manner. However, health care programs and payment systems need to be modernized to take full advantage of telehealth. Following are key policies applicable to telehealth for in-home care delivery:

- **Removal of all geographic restrictions on telehealth in Medicare and allowing the home to serve as a qualifying originating site**—The COVID–19 pandemic has clearly demonstrated the need for telehealth across settings and in all kinds of communities across the country—urban, rural, suburban, etc. The pre-pandemic originating site and geographic limitations are outdated and represent an impediment to the broader shift to and desire amongst patients, families and providers for more care in the home. We note that the Centers for Medicare & Medicaid Services (CMS) already has the statutory authority to determine the appropriateness of allowing various Medicare services to be delivered via telehealth; Congress should direct CMS to use this authority to add clinically appropriate services to the telehealth list that are evidence-backed and amenable to virtual delivery.
- **Allowing for the permanent use of telehealth in the recertification of a beneficiary for the Medicare hospice benefit (MHB)**—A hospice physician or nurse practitioner (NP) must have a face-to-face (F2F) encounter with every Medicare hospice patient to determine the continued eligibility of that patient prior to the 180th day recertification, and prior to each subsequent recertification. These encounters became difficult and dangerous as the COVID–19 virus spread and put vulnerable Medicare beneficiaries at high-risk of serious illness or death. In March 2020, Congress included a provision in the CARES Act (Section 3706) to specifically allow hospices to perform the F2F via telehealth for the duration of the PHE. As a result of the Consolidated Appropriations Act, 2022 (PL No. 117–103), this allowance was extended through the end of 2024. NAHC's hospice members report that being able to perform the F2F using telehealth has been a major success and should be permanently expanded. Hospices are able to collect all necessary clinical information, follow patient and family wishes for fewer visits during the pandemic, and allocate staff more effectively due to this flexibility. A 2020 study[1] found that patient and provider satisfaction with virtual F2F visits was high, and that there were no differences in hospice recertification recommendations when the F2F was performed either via telehealth or in-person.

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[1] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7276118/*.

- **Create a payment pathway for services delivered via telehealth by Medicare home health agencies (HHAs)**—Telehealth has been part of the tools employed by HHAs for two decades. HHAs can use telehealth for evaluation and assessment of a patient's condition, teaching and training of self-care and rehabilitative activities, wound care, direct therapy services, medication management, and more. During the PHE, Congress also instructed CMS to encourage HHAs to utilize telehealth. However, unlike for other providers and practitioners, Medicare does not pay for an HHA's use of telehealth. In fact, the use of telehealth as a physician-ordered alternative to in-person visits can reduce the level of reimbursement significantly to HHAs. This occurs because HHAs receive a payment for a bundle of services for a 30-day period except when the number of in-person visits falls below a care-specific "low utilization" level. Accordingly, an HHA that combines telehealth with in-person visits can dramatically cut its reimbursement while not correspondingly reducing its costs. While a physician, nurse practitioner, physician assistant, therapist, or other caregivers would receive payment for each and every telehealth encounter in the home, an HHA cannot. Congress has previously, on a bipartisan and bicameral basis, supported Medicare coverage of HH-delivered telehealth in limited situations, namely federal PHEs (see the 117th Congress' Home Health Emergency Access to Telehealth (HEAT) Act).[2] However, we know enough about the value of virtual visits from Medicare HHAs to do more than recognize them solely in the reimbursement model during a public health emergency. Therefore, Congress should allow CMS to waive prohibitions against reimbursement for telehealth services in the Medicare Home Health benefit on a permanent basis.
- **Coverage of remote patient monitoring in home health**—The CY 2021 Home Health (HH) PPS final rule amended 42 CFR 409.46(e) to include remote patient monitoring (RPM) services consistent with the plan of care for the individual on the HH cost report as allowable administrative costs. And beginning January 1, 2023, HHAs may voluntarily report RPM use on payment claims using a new G-code (code G0322). Despite these promising steps to advance the tracking and reporting of RPM use in Medicare HH, as is the case with more traditional telehealth services, there is no actual reimbursement mechanism for HHAs that employ RPM in the course of serving patients and families. The lack of a sustainable payment source for this valuable tool limits the number of HHAs that are able to utilize it and dilutes the potential RPM holds to support more proactive, timely, and responsive care in the home. Therefore, Congress should allow CMS to waive prohibitions against reimbursement for RPM services in the Medicare Home Health benefit.

We appreciate the opportunity to submit comments on this hearing. We look forward to ongoing work on these important issues and stand ready to support efforts on a collaborative basis to strengthen care delivery through improved telehealth availability. If you have any questions about this letter or its contents, please contact Calvin McDaniel at cmcdaniel@nahc.org.

NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS
1009 Duke Street
Alexandria, VA 22314

On behalf of the over 5,400 Rural Health Clinics (RHC) across the nation, we sincerely appreciate the opportunity to provide a statement for the record.

The RHC program, first created in 1977, provides outpatient care for over 60% of rural America[1] and 11% of the entire country (approximately 37 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America.

Telehealth represents a massive opportunity to improve access to care in rural areas, and we appreciate the Committee's continued efforts to best understand its impact and value as we consider post-2024 Medicare telehealth policy.

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[2] *https://www.congress.gov/bill/117th-congress/senate-bill/1309?q=%7B%22search%22%3A%5B%22HEAT+home+health+telehealth%22%5D%7D&s=1&r=1.*

[1] *https://www.narhc.org/News/29910/Sixty-Percent-of-Rural-Americans-Served-by-Rural-Health-Clinics.*

Rural Health Clinics and FQHCs were not included[2] in HHS' emergency expansion of telehealth policy. For a few weeks at the beginning of the COVID–19 pandemic, fee-for-service providers were able to offer telehealth services to their patients, while RHC and FQHC patients were forced to come in-person to receive a Medicare-covered healthcare service. The CARES Act[3] rectified this issue and allowed RHCs and FQHCs to serve as distant site providers but that legislation did not allow RHCs and FQHCs to bill for telehealth normally. Instead, the CARES Act created a "special payment rule" that paid RHCs outside their normal All-Inclusive Rate methodology at a level that is significantly less than what RHCs receive for in-person services. This stands in stark contrast to traditional physician offices which receive payment parity between in-person and telehealth services.

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, billed whenever an RHC provides one of the 200+ telehealth services reimbursable by Medicare, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth properly, which hinders their ability to properly participate in Accountable Care Organizations and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that telehealth should work this way for all services, not just mental health services.

In the 2023 report on *Medicare and the Health Care Delivery System,* MedPAC provided RHC-specific telehealth recommendations. Their RHC recommendations, and NARHC's responses are below.

Ultimately, MedPAC recommends that if Congress decides to permanently cover distant-site telehealth services in RHCs and FQHCs that they continue to reimburse at the rate "based on PFS rates for comparable telehealth services," which is effectively an endorsement of the current G2025/special payment rule.

- First, MedPAC stated that "paying FQHCs and RHCs their standard rates for all telehealth services would increase costs for the program and beneficiaries . . . Depending on beneficiaries' supplemental insurance coverage, these high payment rates (especially for RHCs) could discourage access because of high out-of-pocket spending." MedPAC reported that **RHC Medicare spending for telehealth was just 3% and 2% of total Medicare spending for RHCs in 2020 and 2021, respectively.** Even if granted payment parity, we believe it is highly unlikely that this would significantly increase overall Medicare program spending, despite the significant potential benefits for safety net providers and patients.
- Secondly, MedPAC raised the concern that "practitioners who furnish telehealth services do not need to be physically located in an underserved area, so the higher rates for FQHC- and RHC-provided telehealth services would not be necessary to ensure access." NARHC agrees with MedPAC that there are currently no limitations as to where a provider offering telehealth services can be located, but if telehealth flexibilities are to continue long-term, NARHC believes that some guardrails may need to be created to ensure that **only safety-net providers serving safety-net patients may receive the enhanced reimbursement rates.** We do not want to create a loophole that allows patients and clinicians in well-served suburban or urban areas to route their telehealth billing through the RHC and take advantage of the RHC reimbursement methodology. Further, the MedPAC recommendation would disincentivize rural providers from investing in telehealth technologies and services due to low reimbursement, while incentivizing urban and suburban providers to offer telehealth services to rural patients with no physical proximity to them.
  - Potential guardrails could include requiring the provider to be in the clinic, some type of service area requirement, or an occasional in-person visit and

[2] *https://www.narhc.org/News/28244/NARHC-Sends-Letter-to-Trump-Administration-on-Telehealth-Services-During-Covid-19-Pandemic.*
[3] *https://www.narhc.org/News/28271/CARES-Act-Signed-Into-Law.*

we look forward to continued engagement with the Committee as to additional options.

- ➢ Third, MedPAC stated that "Paying standard rates for telehealth visits could also be a disincentive to furnish in-person care since telehealth visits likely cost less than in-person visits due to reduced facility costs. Providers should make decisions about what mode of care is most beneficial to the patient based on clinical considerations, not on what is most financially advantageous." NARHC is not confident that there is strong evidence, particularly in rural areas, clearly demonstrating that telehealth costs less to provide than in-person services. While we disagree with the assumption that RHC providers would choose a less clinically advantageous mode of care for their patients based on reimbursement, the fact remains that the strongest way to ensure that clinical considerations remain the primary consideration is to pay parity between in-person and telehealth visits. In its efforts to avoid an incentive to focus on telehealth, MedPAC's recommendation here is creating a significant financial incentive to not invest in and recommend telehealth.
- ➢ Finally, MedPAC provided the rationale that, "Because telehealth services can be delivered to beneficiaries outside FQHCs' or RHCs' local service areas, paying these providers rates far above PFS rates could increase costs for the Medicare program and beneficiaries (without improving access) in areas that are not underserved and could undermine competition (as clinicians compete to bill under the highest-paid facility as opposed to competing for patients based on quality and service)." MedPAC is raising the concern that if RHCs received payment parity for telehealth and in-person visits, there would be a financial incentive for RHC providers to provide telehealth services to non-rural, medically underserved patients and yet still receive a higher reimbursement than fee-for-service rates. NARHC agrees that with **no** guardrails there is the potential for abuse of the benefit. However, simply offering lower reimbursement to safety net providers through a crude special payment rule is not an appropriate guardrail. This continues to limit safety net providers' ability to invest in these important technologies. by Congress for mental health services provided via telehealth.

We are pleased that the CONNECT for Health Act and other pieces of legislation introduced this Congress would eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs and we urge Congress to rectify this issue, at the latest, as part of any telehealth extension legislation.

Conclusion

The National Association of Rural Health Clinics thanks the Senate Finance Subcommittee on Health for organizing this hearing. We hope that the above statement helps illuminate the unique telehealth policy position of the 5,400 Rural Health Clinics across the country. Should the Committee have any questions, the NARHC is happy to serve as a resource, you may reach us by phone at (202) 543–0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.

NATIONAL HEALTH COUNCIL
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November 28, 2023

The Honorable Ron Wyden
Chair
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Michael Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The National Health Council thanks the Senate Committee on Finance for holding a hearing on November 14, 2023, titled, "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." Access to telehealth is a significant issue from the patient's perspective, and we appreciate the opportunity to provide this input in addition to the providers you heard from directly at the hearing.

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable, equitable health care. Made up of more than 150 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

The COVID–19 pandemic highlighted and underscored the benefits of telehealth in providing increased access, ease of use, and comfort with the health care system for patients with chronic diseases and disabilities. To help quantify the patient needs in telehealth, the NHC conducted eight 30-minute listening sessions with staff from the NHC's patient-organization members.[1] One of the key themes that arose during the listening sessions was that telemedicine can help reduce disparities; however, if it is done incorrectly, it can also exacerbate disparities. Another theme was that patients should be able to voice their preference for the type of provider visit they can have, whether it is in-person, on the phone, or virtually. Concerns over transportation, mobility, condition type, geography, and privacy could all change a patient's preference.

While doctors' offices are operating similar to before the pandemic, the promise of telehealth is as real as ever for patients living in rural and underserved communities, those with mobility and transportation limitations, people with rare diseases working with far away specialists, the immunocompromised, and many others.

Telehealth should be an option for patients and providers, when preferred and clinically appropriate, and should not supplant in-person care. Making current Medicare telehealth authority permanent to ensure continuity of care and access to medically necessary services for Medicare beneficiaries should be a top priority for Congress before the current authorities expire next year. In addition, payment policies, including cost-sharing requirements, and provider networks must still support access and in-person availability.

During the pandemic, the NHC joined 34 other national patient advocacy and health organizations on a set of Principles for Telehealth Policy. We urge you to use these principles as a guide for any telehealth legislation in order to ensure that the needs of patients are met.

First, we believe telehealth policy can improve access through equitable coverage, with services covered by all health plans including, but not limited to, Medicare, Medicaid, the ACA Marketplace, and other federal and state regulated commercial health plans.

Second, telehealth policy should ease technology barriers. Telehealth services should be equitably available through easily usable technologies that are accessible to people with disabilities, with limited English proficiency, and limited technology. The option of audio-only communication is especially important for rural and low-income populations, as many of these patients lack internet access.

Third, telehealth policy should preserve and promote patient choice. A patient should have the opportunity and flexibility to choose whether they will access care in-person or via telehealth technologies. In addition, patients should have limited out-of-pocket costs for telehealth services and be no more than what they'd pay for an in-person visit. Insurers should not incentivize nor disincentivize patients from using one care site over another—the choice should be based on the right care setting for the patient's individual needs.

Fourth, telehealth policy should remove geographic restrictions, which place a burden on and can limit both patients and providers when evaluating treatment options for optimal care. This includes allowing providers to practice across state lines through telehealth services increasing access to care and improve care coordination for patients, particularly in underserved areas.

Recommendation: Make the current Medicare telehealth flexibilities permanent. And address payment and regulatory barriers that limit access to telehealth while preserving access to in-person care when preferred and /or needed.

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[1] *NHC-Telemedicine-Briefing-one-pager.pdf (nationalhealthcouncil.org).*

We know that better access to health care equals better outcomes in the long run—ultimately reducing cost—and telehealth is proving to be a valuable tool that should be protected and enhanced in this regard.

Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,

Randall L. Rutta
Chief Executive Officer

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November 14, 2023

U.S. Senate Committee on Finance
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

Re: November 14, 2023 Health Subcommittee Hearing on "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency"

Dear Chairman Cardin and Ranking Member Daines:

The Partnership to Advance Virtual Care (PAVC) is pleased to submit this statement for the record following the Health Care Subcommittee's November 14, 2023 hearing titled "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency."

PAVC's Background and Mission

PAVC is comprised of health systems, health IT vendors, chronic care specialists, behavioral health providers, and primary care stakeholders that are leading innovation in telehealth care delivery. We focus the collective voice of the industry to advocate for regulatory and legislative policies that improve access to and delivery of telehealth services.

The COVID–19 public health emergency (PHE) accelerated the revolution in telehealth care delivery. During the pandemic, enhanced access to telehealth services served as a lifeline to patients across the country, allowing patients to access critical health care services while keeping vulnerable patients out of clinics and hospitals. With the winding down of the PHE over the course of the past year, and its official end on May 11th, telehealth continues to play an important role in our health care delivery system, ensuring continued access to high-quality health care services and to improve health equity. These services should continue to be leveraged in order to enhance patient experiences, improve health outcomes, and reduce health care costs.

Recommendations for Committee Action

PAVC appreciates the committee's focus on Medicare telehealth permanency. While the Consolidated Appropriations Act, 2023 (CAA, 2023) extended key telehealth flexibilities through December 31, 2024, it is imperative that Congress address these extensions prior to the expiration date. As noted in its final CY 2024 Medicare Physician Fee Schedule (PFS) rule, the Centers for Medicare and Medicaid Services (CMS) has stressed its limited ability to provide coverage and payment beyond the current December 31, 2024, expiration date. Without further congressional action on these provisions, CMS' ability to contemplate changes for CY 2025 and beyond will be hindered. Enacting legislation to further extend Medicare telehealth provisions in advance of the release of the proposed PFS rule for CY 2025—which is expected in July 2024—would ensure the least amount of disruption for patients and providers alike.

Consistent with PAVC's mission, we urge the committee to consider and advance legislation that would:

- **Permanently extend pandemic-era Medicare telehealth flexibilities.**
- **Permanently extend the telehealth safe harbor for first-dollar coverage for those with health savings account (HSA)-eligible high deductible health plans (HDHPs).**
- **Allow for the classification of telehealth services as excepted benefits.**

Permanent Extension of Medicare Telehealth Flexibilities

The key Medicare telehealth flexibilities extended through December 31, 2024, by the CAA, 2023 include:

- Waivers to the geographic and originating site restrictions.
- Expansions to the list of eligible practitioners.
- Eligibilities for federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- Allowing telehealth to be provided through audio-only telecommunications.
- Allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care.
- Delaying the in-person visit requirement before a patient receives tele-mental health services.

PAVC was pleased this 2-year extension was enacted, as it provides some length of certainty for patients and providers. However, permanency remains a priority and the extension deadline is quickly approaching. PAVC has identified the following legislative barriers that would severely restrict patient access to care through telehealth if not permanently changed:

- ***Geographic and originating site restrictions.*** Before the pandemic, Medicare required that the patient be located in a rural or certain health professional shortage area and use telehealth in an approved originating site, such as a hospital or physician office. Together, these restrictions functionally prevent beneficiaries from accessing telehealth from a variety of appropriate and more accessible locations, including their home. Only about 2 percent of beneficiaries reside in zip codes that meet the traditional geographic and originating site criteria.
- ***Qualifying providers.*** Under current policy, the CMS would have to revert back to policies that restrict the types of providers that can deliver reimbursable care virtually to Medicare beneficiaries. Commonly accessed providers like physical therapists, occupational therapists, and speech language pathologists would no longer be able to bill for telehealth services.
- ***FQHC and RHC expansion.*** Without this COVID–19 flexibility, FQHCs and RHCs will not be allowed to serve as distant site telehealth providers. This would prevent low-income and geographically isolated individuals from utilizing telehealth visits to maintain continuity of care with their existing provider or connect with clinicians best equipped to meet their needs. This would create barriers to affordable treatment for the rural and underserved populations who often need it most.
- ***Audio-only communications.*** Permanently allowing telehealth to be provided through audio-only communications is an important component of ensuring continued access to care. This is particularly relevant in rural communities, where unavailable or unreliable broadband access could preclude patients from accessing telehealth through other means.
- ***Face-to-face requirement for hospice care.*** Permanently allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care is another component of ensuring continued access to care, particularly in isolated rural and underserved communities.
- ***In-person requirement for mental telehealth services.*** Enhanced access to mental telehealth services during the pandemic improved the lives of many Medicare patients across the country. This included waiving the in-person requirement for telehealth treatment of certain mental health conditions. There is no compelling clinical reason to legislatively mandate an in-person visit for all Medicare patients for the expanded range of eligible mental health services. Whether a patient requires an in-person visit prior to commencing their mental telehealth treatment should be left to the clinical judgment of her health care provider. The nature of mental and behavioral health care services does not require in-person assessments with legislated frequency. In cases where an in-person visit would be warranted, providers can exercise their clinical judgment.

Taken together, the extension of these provisions will allow for continued progress toward wider adoption and utilization of telehealth for Medicare providers and beneficiaries in a post-PHE health care system. PAVC encourages the committee to advance these policy extensions.

Permanent Extension of HDHP Safe Harbor (S. 1001)

The safe harbor for first-dollar coverage for telehealth services for those with HSA-eligible HDHPs was also extended through December 31, 2024 as part of the CAA, 2023. This has allowed employers and health plans to provide coverage for telehealth services on a pre-deductible basis for the more than 32 million Americans with HSA-eligible HDHPs.

This commonsense policy has helped ensure families could access vital telehealth services—including virtual primary care and behavioral health services—prior to having met their deductible. The ability to offer pre-deductible telehealth services for employees is a meaningful expansion of health care access and is popular among consumers. Notably, according to unpublished estimates from Employee Benefit Research Institute (EBRI), over 50 percent of individuals with an HSA live in zip codes where the median income is below $75,000 annually. This flexibility also enabled expansions of access to care for individuals who may otherwise have neglected essential care due to high out-of-pocket costs. Further, a survey by NORC and AHIP found that "73 percent of commercial telehealth users said Congress should make permanent the provisions that allowed for coverage of telehealth services before paying their full deductible."

We appreciate your efforts earlier this year, Senator Daines, to reintroduce legislation with Senator Cortez Masto (D–NV) to permanently extend the HDHP safe harbor. PAVC strongly supports the Telehealth Expansion Act (S. 1001) and urges the committee to include it in any forthcoming telehealth extension package, to ensure that this important source of patient access does not lapse.

Classification of Telehealth Services as Excepted Benefits

Another important telehealth access issue outside of Medicare is the treatment of telehealth services as excepted benefits under the Public Health Service Act, the Employee Retirement Income and Security Act of 1974, and the Internal Revenue Code of 1986.

During the PHE, federal agencies issued guidance that they would take a non-enforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan for the duration of the PHE. With the end of the PHE in May, this flexibility will come to an end at the conclusion of the current 2023 plan year.

Without action from Congress, the end of this flexibility will be acutely felt at the end of 2023, as most new plan years begin January 1, 2024. To ensure workers do not lose access to critical services at the end of the year, we urge the committee to include a temporary, short-term extension of the PHE non-enforcement policy in any end-of-year legislative package. Doing so will provide Congress with additional time to consider and advance a longer-term solution to ensure continued access to telehealth services for millions of workers.

Summary and Conclusion

The COVID–19 pandemic greatly accelerated the adoption of telehealth care delivery. Advances in telehealth have made health care more accessible and equitable nationwide, and PAVC strongly believes that these advances should remain part of our health care system.

We welcome the opportunity to discuss these issues further. Please do not hesitate to contact me directly if PAVC can serve as a resource to the committee, as you work to advance legislation addressing telehealth policy.

Respectfully,

Rachel Stauffer
Executive Director

LETTER SUBMITTED BY ANDREW SMITH

Comments on Improving Medicare Finances

Medicare was started in the mid-1960s thanks to President Johnson. Think of people's longevity back then versus now. And all the new drugs, medical equipment, surgeries and procedures and better education of those in the healthcare field today.

Everyone on Medicare pays the monthly premium of $170/month. Then a person relies on a supplement program for medical and drug prescription that varies in cost depending on what type of policy a person chooses. There could be co-pays involved. But maybe not everyone picks up a supplement for medical.

Medicare is financed by working people who pay 1.45% of their W–2 income as well as their employer. But what happens to the spouse who does not work? That person is entitled to Medicare but has not paid one cent into the Medicare Trust Fund. Or the new immigrant becoming a U.S. citizen in their 40s. They are entitled to Medicare but may have paid only since they started working in the U.S. Or maybe bring in a senior person like a grandparent.

There is no Medicare tax on investment income under a certain income level. The person who invests for a living is entitled to Medicare but may not be paying into the Medicare Trust fund.

When someone loses their job, they are not paying into the Medicare Trust Fund until they get back working. If the economy is bad, that person could be jobless for over a year or more not paying into the Medicare Trust Fund.

Many government workers have retirement policies that don't rely on Medicare for retirement healthcare. A whole segment of the population could be paying into the Medicare Trust Fund.

Question should be on the raising of the 1.45% Medicare Trust Fund tax to maybe 2% on W–2 income for the employee and employer. And maybe the family that the spouse not working paying some money into the Medicare Trust Fund.

The Affordable Care Act of 2010 included a provision for a 3.8% "net investment income tax," also known as the Medicare surtax, to fund Medicare expansion. But only applies to a certain income level. A Medicare surtax of 3.8% is **charged on the lesser of (1) net investment income or (2) the excess of modified adjusted gross income over a set threshold amount.** The threshold is $250,000 for joint filers, $125,000 for married filing separately, and $200,000 for all other filers.

Relying on drug prescription negotiations to decrease the cost is just one method to help on cost control. But if the amount is only 50 drugs, how much does that save Medicare?

So where else can Medicare get the income to feed the trust fund? **Should a national tax be used and on what type of product or service and how much?**

Is anyone looking at this side of the Medicare equation?

Andrew Smith
Santa Rosa, CA

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November 14, 2023

The Honorable Benjamin L. Cardin
Chairman
U.S. Senate Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

The Honorable Steve Daines
Ranking Member
U.S. Senate Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

Dear Chair Cardin and Ranking Member Daines,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide feedback on the important issues raised during the Subcommittee's hearing "Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency." Founded in 1964, STS is a not-for-profit organization representing more than 7,700 surgeons, researchers, and allied healthcare professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

We thank you for holding this hearing to address the critical issues facing physicians and patients, including increasing access to care through telehealth expansion. We appreciate the opportunity to share our perspective on the interventions needed to ensure the proven benefits of telehealth services continue to be available for patients when appropriate.

Data collected during COVID–19 demonstrates the positive impact telehealth has had on both patient clinical outcomes and patient experiences. A 2020 study by the National Institutes of Health (NIH) found telemedicine to be beneficial in both acute care and chronic disease management. Results from the study suggest that it is equivalent to in-person care for health outcomes in certain conditions and may also decrease short-term hospital and emergency department utilization. Additionally, research shows that the use of telehealth provides access to care despite geographic barriers, reduces burden on medical infrastructure, and lessens exposure to infectious diseases for all participants. Advances in technology and the advent of more sophisticated equipment has increased the extent of patient monitoring via telemedicine and has resulted in increased physician and patient satisfaction. Enacting permanent telehealth policy will help provide more predictability and help foster greater investment into this critical tool.

Currently, many essential Medicare telehealth flexibilities are set to expire on December 31, 2024. The **STS encourages Congress to enact a permanent extension of these flexibilities to ensure that patients can maintain a stable relationship with their health care provider via telehealth services, which is especially important for rural and underserved communities.** The STS appreciates the Committee's long-time leadership on this issue, including during the COVID–19 pandemic, and even earlier in the 2018 CHRONIC Care Act. Going forward there are two legislative proposals that STS would like to bring your attention to: S. 2016, the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, and S. 1636, the Protecting Rural Telehealth Access Act.

STS supports the CONNECT for Health Act to ensure that Medicare patients can maintain a stable relationship with their health care provider via telehealth services, which is especially important for rural and underserved communities. Given the uncertainty of whether the Centers for Medicare and Medicaid Services (CMS) will extend telehealth provisions past 2024 independently, this legislation is necessary to facilitate that connection. Additionally certain barriers are rooted in statutory restrictions that require action by Congress, such as geographic and originating site restrictions. Nearly two-thirds of the Senate has cosponsored this legislation, showing the broad consensus around these important issues.

We also support the Protecting Rural Access to Telehealth Act. This legislation would make permanent Medicare coverage of telehealth services allowed during the COVID–19 pandemic and specifically recognizes the important and unique role of audio-only services. In many situations, audio-only telehealth provides the only means for essential care, especially for those who do not have adequate internet coverage or have difficulty operating a computer.

Lastly, we want to highlight our concerns over provider safety for those offering telehealth services. The provision of remote health care services offers great benefit to patients receiving the services and to the providers offering them. Allowing appropriately licensed and credentialed providers to practice telehealth from their home improves patient access to healthcare services, reduces healthcare costs, while maintaining and meeting patient demand for care. However, **it is not practical, workable, or safe to require a provider to publicly report their home address as their practice location.** Medicare providers should not be compelled to share their personal information, especially when it relates to their home addresses. In an environment in which threats against healthcare professionals have markedly increased, the safety and privacy of physicians must be paramount. During the pan-

demic, CMS allowed providers to report their practice address instead of their home address when billing telehealth services. In the 2024 Medicare Physician Fee Schedule final rule, CMS extended these protections until December 31, 2024. However, to continue the goal of ensuring safety for providers, we believe this provision needs to be extended indefinitely. **We urge the Committee to consider the Telehealth Privacy Act of 2023 which would directly address these concerns.**

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director of Health Policy, at mpeltzman@sts.org or Derek Brandt, Vice President of Government Affairs, at dbrandt@sts.org, should you need additional information or clarification.

Sincerely,

Thomas E. MacGillivray, M.D.
President

UNC HEALTH
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UNC Health is North Carolina's largest not-for-profit, academic, integrated system owned by the state of North Carolina. Our primary focus, approach and commitment is to improve North Carolinians' health in the 21st century. Headquartered in Chapel Hill and affiliated with the University of North Carolina School of Medicine, UNC Health is composed of 14 hospitals, 20 hospital campuses, one virtual hospital and more than 800 clinic locations across North Carolina. Founded with N.C. Memorial Hospital in 1952 the healthcare system was established November 1, 1998, by N.C.G.S. 116–37.

Our mission is to improve the health and well-being of North Carolinians and others whom we serve. We accomplish this by providing leadership and excellence in the interrelated areas of patient care, education and research.

Executive Summary

- Telehealth is an important modality of health care delivery that increases patient access to high quality care in our rural, urban, and underserved communities.
- Pre-pandemic regulations, policies, and financial disincentives created barriers that prevented the use and expansion of telehealth in both primary and specialty care settings.
- The COVID–19 pandemic flexibilities listed below that have been extended through 2024 have allowed for significant expansion of telehealth services in the outpatient setting, providing easy access and use of audio- only and audio-video visits for patient in all geographic locations.
  - Use of audio-only visits.
  - Payment parity for telehealth visits.
  - Removal of regulations that limited when a telehealth visit can take place and where the patient has to be located.
- It is imperative that we make these flexibilities permanent to ensure the continued growth of telehealth and improve access to health care for all patients.

Telehealth trends at UNC Health

Over the last few years, there has been a significant surge in the use of telehealth to deliver high quality health care, mainly driven by the increased flexibilities brought on by the COVID–19 pandemic. Some of these flexibilities included the removal of geographic barriers in providing telehealth, coverage of audio-only telehealth, and reimbursing audio/video visits at the same rates of reimbursement as in-person visits. And while it's been noted that rates of telehealth utilization have decreased since the height of the pandemic, in 2023 UNC Health has continued to serve communities across our state with an average volume of 18,424 primary care and specialty care telehealth visits per month (8.48% of all outpatient visits), with about 24% of these telehealth visits being audio-only visits. The pandemic era flexibilities demonstrated that by removing specific barriers, we can deliver more timely and higher quality primary and specialty care to our patients both in rural and urban settings. Allowing easy access to both modalities of telehealth is crucial to providing equitable care across our state. UNC Health supports making certain pandemic era flexibilities, such audio-only visits, payment parity, and the removal of specific regulations, permanent. The ability for us to expand telehealth and deliver

better care to more patients across North Carolina is largely due to the coverage of all telehealth visits and the expanded payor parity with video visits. We are concerned that if pre-pandemic telehealth restrictions go back into place after December 31, 2024, telehealth visits will drop, and we will see regression in access to care for patients across our state at a time when we are expanding our Medicaid program.

Access to Care

Not all patients have equal access to care, but telehealth can alleviate some of this. Living in a rural area may mean you're required to travel long distances to receive care. Working multiple jobs or being unable to leave work for an appointment means your care is delayed. Our patients consistently report that telehealth allows them to seek out health care they would have otherwise avoided which leads to poorer overall outcomes and higher societal costs. Access to telehealth reduces barriers to care like transportation, missing work, and childcare, while still providing access to primary and specialty care.

Loss of Payment Parity

Allowing providers to charge for telehealth as they charge for in-person visits is essential to the success of telehealth. Billing for in-person visits no longer requires physical elements to be completed, but rather places the focus on patient complexity, medical decision-making, and time. Because a physical exam is no longer a requirement, and because complexity can be the same for telehealth and in-person, the elements required to bill for in-person care can and should align with the elements required to bill for telehealth.

In addition, most telehealth is provided by clinicians who see patients both in-person and virtually, meaning overhead expenses, employee salaries, and other expenses are not reduced just because a provider sees a portion of their patients virtually. In fact, the brick-and-mortar office is still necessary based on the nature of the practice. Telehealth is often used in a hybrid model where a patient will come in when bloodwork or a physical exam is needed but will see their provider virtually when possible. Therefore, telehealth providers do not have lower expenses than in-person-only providers and payment parity is necessary for all telehealth providers.

Loss of Audio-Only Coverage

Audio-only telehealth continues to be used by many patients as their point of access to care and should be covered by insurance. At UNC Health, we conduct an average of 4,455 audio-only visits per month. As stated above, many patients, including rural patients without easy access to in-person care, do not have access to Wi-Fi or a device with a camera which would give them access to telehealth via video visits, meaning they use audio-only telehealth. Nationwide broadband initiatives and other programs working to expand internet access may reduce the need for audio-only visits in the future while moving to video visits, but we have not yet reached a state where this is the case.

While audio-only visits often work for both patient and provider, without insurance coverage for audio-only visits, clinicians will not be able to provide audio-only visits and will require patients to come in-person, reducing the access to care provided by telehealth and creating inequities.

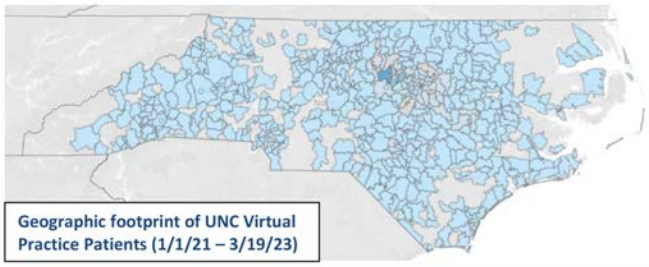
Regulation Barriers

The telehealth guardrails listed below are not evidence-based and are not clinically necessary. These guardrails also create barriers to accessing telehealth and should be permanently removed.

In-Person Guardrail: UNC Health believes that there is no clinical benefit to requiring a patient to be seen in-person before utilizing telehealth or periodically while also utilizing telehealth. The complexity of and reason for visits are often the same for in-person and telehealth. The results of the visits are also the same: evaluation, diagnosis, treatment, prescriptions, a summary of the visit and patient education. Since in-person and telehealth visits are equivalent, there is nothing to be gained by requiring a patient to come in person before they're able to receive care via telehealth. While some visits require patients to come in-person, there is often no medically necessary reason to require a patient to be seen in-person when the same visit can be had via telehealth.

Geographic Guardrail: Telehealth use should not be limited to rural populations. Upon first thought, it makes sense that rural areas would need telehealth more due to the barriers to in-person care such as logistics and cost of transportation. Upon second thought, many patients in urban areas also have barriers to transportation

like rural patients. Many urban areas do not have public transportation, are not pedestrian-friendly, or may not be safe to walk. This leaves patients in urban areas in the same position as patients in rural areas: they need telehealth to access care. UNC Health serves both rural and urban populations through telehealth, shown on the map below.



Originating Site Guardrail: It should not be a requirement for patients to access telehealth onsite at a healthcare facility. While patients who don't have access to the technology needed for telehealth may benefit from telehealth delivery at their local clinic, requiring a patient to receive telehealth at a healthcare site negates one of the main benefits of telehealth—removing accessibility barriers. Patient's homes have served as functional sites to receive telehealth for the last few years without detriment and only positive outcomes. Furthermore, there is a societal benefit in not exposing others to contagious diseases if they can be treated at home. There is no need to require a patient to travel to a specific site to receive telehealth services.

Summary

While this document is not comprehensive, it does contain a list of first steps the Senate should take to ensure viability of and access to telehealth. In short, the telehealth flexibilities enacted due to the COVID–19 pandemic are still imperative for telehealth today and should not expire on December 31, 2024. Permanently ensuring payment parity, permanently removing guardrails not backed by evidence, and allowing audio-only coverage past 2024 are essential elements to the continued success of telehealth and maintaining access to high quality health care for all patients.

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