ConnectedHealth

March 2, 2021

The Honorable Anna G. Eshoo
Chairwoman
House Committee on Energy and Commerce
Subcommittee on Health
Washington, District of Columbia 20515

The Honorable Brett Guthrie
Republican Leader
House Committee on Energy and Commerce
Subcommittee on Health
Washington, District of Columbia 20515

Dear Members of the Subcommittee:

We applaud you for examining federal policies around live audio and video healthcare visits with today's hearing, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." We appreciate this opportunity to weigh in on this important inquiry as the 117th Congress commences.

ACT | The App Association's Connected Health Initiative (CHI) represents a broad consensus of healthcare and technology leaders seeking a policy environment that encourages the use of connected health innovations. We seek essential policy changes that will help all Americans benefit from an information and communications technology-enabled American healthcare system. For more information, see www.connectedhi.com.

We share each of the goals expressed by several members of the Subcommittee to ensure telehealth services remain accessible after the public health emergency (PHE) expires and look forward to working with each of your offices to share solutions, consistent with the approach described in our previous testimony before the House Committee on Energy and Commerce and the Senate Health, Education, Labor, and Pensions Committee.[1] Connected health services drive value for patients, caregivers, and taxpayers and are essential tools to improve healthcare for all Americans, while reducing rising healthcare costs. We appreciate your consideration our views and look forward to collaborating on this vital issue.

The exceedingly broad restrictions on Medicare's coverage of telehealth services, found in Sec. 1834(m) of the Social Security Act, effectively bar coverage for telehealth services except for a small fraction of Medicare beneficiaries. Except in pilot demonstration programs in Hawai'i and Alaska, 1834(m) prevents Medicare reimbursement for the use of telehealth unless the patient is at a qualified originating site (which excludes their homes) and located in either a "rural health professional shortage area" or in a county that is outside of a Metropolitan Statistical Area (MSA).[2]

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[1] Testimony of Morgan Reed, Executive Director, The Connected Health Initiative, Hearing on "Health Care in Rural America: Examining Experience and Costs," Senate Committee on Health, Education, Labor, and Pensions (HELP), Subcommittee on Primary Health and Retirement Security (Sept. 25, 2018), *available at* http://actonline.org/wp-content/uploads/2018-09-13-Testimony-CHI-House-EC-Health-Sub.pdf; Testimony of Morgan Reed, Executive Director, The Connected Health Initiative, Hearing on "Examining Barriers to Expanding Innovative, Value-Based Care in Medicare," House Committee on Energy and Commerce, Subcommittee on Health (Sept. 13, 2018), *available at* http://actonline.org/wp-content/uploads/2018-09-13-Testimony-CHI-House-EC-Health-Sub.pdf.

[2] 42 U.S.C. 1395m(m)(4)(C).

These restrictions pose a serious barrier to the adoption of live voice and video interaction between caregivers and patients. Out of approximately $800 billion the federal government spends on Medicare each year, physicians billed just $29 million or so over the last year for which this data is available.[3] Where patients with private insurance can generally interact with their caregivers over live voice and video, Medicare patients are usually unable to exercise that option outside the PHE. Medicare patients must visit their physicians in person even when video or voice communication would be more cost-effective, safer, or otherwise better for the patient than incurring the time and resource costs necessary to travel to the office physically and linger in the waiting room.

Although the temporary general waiver of these restrictions was a welcome development during the COVID-19 pandemic, we strongly urge you to consider permanent statutory changes that negate the need for a waiver. To that end, we urge this Subcommittee to consider the **Telehealth Modernization Act (H.R. 8727, 116th / S. 368, 117th), which would minimize the various restrictions on "qualified originating site" to "any site at which the eligible telehealth individual is located at the time the service is furnished."**[4] We also note that the bill would **provide more flexibility for the Centers for Medicare and Medicaid Services (CMS) to enable more practitioner categories to provide telehealth services and retain the eligible telehealth services it added during the pandemic**[5] after the PHE expires (sections 2(b) and 2(c) respectively).

The statute should no longer exclude critical patient populations, and we should also endeavor to future-proof the statute. Accordingly, the Telehealth Modernization Act does not *require* Medicare to cover telehealth services in a broader range of clinical circumstances. Instead, it would remove the statutory restrictions put in place when video calls were impossible except in extremely limited circumstances, including when the patient was at another healthcare facility with the proper infrastructure. Technological capabilities surpassed the law by leaps and bounds in this case, as smart devices can facilitate telehealth visits no matter the location of the patient so long as there is a stable broadband connection. The expanding distribution of smart devices across demographics and geographic areas leaves these geographic and physical constraints on coverage woefully out of date.

Telehealth services can help address inequities by providing a means to access care regardless of where the patient lives or is located when seeking healthcare services. The current statute's narrow allowance for telehealth coverage only for certain rural patients with access to a physician's office arbitrarily deems those patients worthy of coverage while leaving urban and suburban populations uncovered. With smartphone ownership and use approximately the same at about 80 percent for Black, white, and Hispanic populations,[6] excluding all patients from coverage except those in a narrow set of locations exacerbates inequitable access to care.

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[3] *See* Eric Wicklund, "Medicare Spending on Telehealth Increases, But Barriers Remain," MHEALTH INTELLIGENCE (Aug. 28, 2017), *available at* https://mhealthintelligence.com/news/medicare-spending-on-telehealth-increases-but-barriers-remain.

[4] The Telehealth Modernization Act (S. 4375 / H.R. 8727, 116th Cong.) Sec. 2.

[5] *See* Press Release, "Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients," U.S. Dept. of Human Svcs. (Dec. 1, 2020), *available at* https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.

[6] Andrew Perrin and Erica Turner, "Smartphones help blacks, Hispanics bridge some – but not all – digital gaps with whites," FACTANK, PEW RESEARCH CTR. (Aug. 20, 2019), *available at*

Program integrity questions fail to justify the current restrictions on Medicare coverage of telehealth services.[7] CMS has all the same tools and authorities to combat program integrity issues for services provided via telehealth that it possesses for the other modalities through which care is delivered. Technologies that broadly enable live audio and video interactions are not a new service presenting new program integrity questions, they are a modality. Moreover, telehealth visits have an auditable digital footprint, which *does* help with fraud detection. And barring almost all originating site locations based on geography, as current law does, provides no discernible advantage from a fraud and abuse standpoint—except that almost no otherwise eligible beneficiaries could receive coverage. Finally, enabling coverage regardless of the location of a patient with mobile connectivity is key to ensuring access to telehealth services for patients who lack access to broadband at home, homeless populations who need access to remote care, and those who are unable to conduct a visit from their homes for any reason. Accordingly, a complete approach to addressing telehealth access for these populations should also include federal support for broadband infrastructure deployment and adoption. We applaud your leadership in addressing the digital divide, as it is a key component to addressing inequities in healthcare access as well.

We appreciate that this Subcommittee is focusing on the impacts of telehealth services during the pandemic and how federal healthcare laws can better empower providers, innovators, patients, and consumers to control costs and expand access to quality care. Tech-driven tools play a vital role in the improvement in quality and cost-effectiveness of healthcare, and that role has only broadened during the pandemic. Ensuring that CMS, Congress, and other federal agencies create a legal landscape that supports—rather than hinders—the use of and access to these tools is, therefore, of utmost importance.

Sincerely,

Graham Dufault
Connected Health Initiative

https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/.

[7] *See* Appendix for more background on Program Integrity concerns and removing restrictions on telehealth coverage.

The Connected Health Initiative (CHI), an initiative of ACT | The App Association, is the leading multistakeholder group spanning the connected health ecosystem seeking to effect policy changes that encourage the responsible use of digital health innovations throughout the continuum of care, supporting an environment in which patients and consumers can see improvements in their health. CHI is driven by the its Steering Committee, which consists of the American Medical Association, Apple, Boston Children's Hospital, Cambia Health Solutions, Dogtown Media, George Washington University Hospital, Intel Corporation, Kaia Health, Microsoft, Noom Inc., Novo Nordisk, The Omega Concern, Otsuka Pharmaceutical, Podimetrics, Rimidi, Roche, United Health Group, the University of California-Davis, the University of Mississippi Medical Center (UMMC) Center for Telehealth, the University of New Orleans, and the University of Virginia Center for Telehealth.

For more information, see www.connectedhi.com.

Appendix

Telehealth and Program Integrity

Millions of Americans turned to live audio and video visits with healthcare providers during the COVID-19 pandemic, and Congress needs to make decisions that will permanently affect how Americans, in particular Medicare patients, may access these telehealth services on a permanent basis. Live audio and video interactions are an increasingly important part of healthcare services for every demographic in a broadening set of care scenarios. However, although the U.S. Department of Health and Human Services (HHS) has existing mechanisms in place to address overutilization, fraud, waste, and abuse, policymakers rightfully seek to better understand how removing statutory barriers to telehealth coverage might impact the fiscal stability of Medicare. We believe removal of those statutory barriers is the most fiscally responsible course of action for a number of reasons.

In terms of program integrity, it is important to note that nearly all recent U.S. Department of Justice (DOJ) actions are related to telemarketers—or physicians using technology—to unnecessarily prescribe durable medical equipment (DME), genetic testing, pharmaceuticals, or other medical equipment. Historically, improper billing of Medicare for telehealth services is low and is similar to improper billing of face-to-face care.

- Analysis of Medicare telehealth services claims data from the PHE indicates that **fears of overutilization are overstated**:
    - An analysis of Medicare fee-for-service (FFS) claims data indicates that new patient office visits conducted via telehealth **accounted for just 3.6 percent** of all FFS Medicare telehealth spending when the pandemic first shocked the U.S. healthcare system—and when 1834(m) restrictions were first generally waived—between March 16 and June 30 of 2020.
    - Accordingly, claims data also indicate that after an initial spike, telehealth usage **has subsided as a percentage of ambulatory visits and is flattening out** as the pandemic wears on.
        - *Findings based on claims data **weigh heavily against predictions of dramatic uptake** by new Medicare telehealth users exerting uncontrollable fiscal pressure on the Medicare system.*
- HHS already has strong mechanisms to deal with various kinds of Program Integrity (PI) concerns with Medicare telehealth services:
    - Improper Billing:
        - Audit records from HHS' Office of Inspector General (OIG) 2018 report evaluating telehealth payments prior to the public health emergency (PHE) suggest that the primary source (**over 63 percent**) of improper telehealth payments were from Medicare beneficiaries being outside the statutory geographic limits set in Section 1834(m).
        - From this data, OIG determined that improper payments for telehealth services were at least **partially the result of claim forms omitting a**

designated field for originating-site location and practitioners being unaware of various telehealth requirements.
        - *If statutory geographic restrictions are lifted, the data here suggest that the **bulk of improper payments for telehealth services are:***
            - ***Unlikely to expand** with increased access to telehealth services; and*
            - ***Unlikely to be addressed by continuing geographic restrictions on coverage**, or by imposing an in-person requirement, which would more likely cause the billing friction leading to improper payments to persist.*
        - OIG proposed **a number of measures to prevent future improper billing events** involving telehealth services and HHS is implementing those now.
    - Kickbacks and Other Illegal Arrangements:
        - DOJ ramped up enforcement of the Anti-kickback Statute and Stark Law, and OIG expects to release a report this year on "Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks." In one recurrent fraud scheme, **fraudsters contact target patients via telephone, pay kickbacks to providers to write unnecessary prescriptions for durable medical equipment (DME),** and then send the equipment to target patients while billing Medicare.
            - DOJ and HHS OIG have the tools they need—including partnership with the U.S. Postal Service—to detect these schemes and stop them.
- In addition to all Medicare coverage and payment and fraud and abuse authorities applying to telehealth services just as they do any other Medicare covered service, the existing Medicare claims process allows **the Centers for Medicare and Medicaid Services (CMS) to effectively track and audit all** telehealth services billed to Medicare **via a specific modifier code (Modifier 95).** The Modifier 95 describes "synchronous telemedicine services rendered via a real time interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. The Modifier 95, along with listing the Place of Service (POS) equal to what it would have been for the in-person service, is also applicable for telemedicine services rendered during the COVID-19 Public Health Emergency. The requirement to code with the Modifier 95 enables CMS to properly track and audit telemedicine services and is a powerful tool for rooting out fraud, waste, and abuse.
- Telehealth can help reduce long-term costs by enabling caregivers better access to patients to employ preventive measures and avoid costly escalation events:
    - This compendium of research includes a variety of studies confirming that responsible use of telehealth services facilitates cost-effective care.
    - The University of Virginia's (UVA's) care coordination and remote patient monitoring program, which relies on telehealth visits among other digital health tools, **reduced hospital readmissions by 40 percent**, regardless of payer, since it began in 2012.
        - *Hospital readmissions impose outsized costs—about $26 billion annually—on the Medicare system, and reducing them through the use of telehealth is a smart investment.*