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“The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care”

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Introduction

Good morning Chairwoman Eshoo, Ranking Member Guthrie, and members of the House Committee on Energy & Commerce, Subcommittee on Health. I am Fred Riccardi, president of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to nearly three million people with Medicare, family caregivers, and health care professionals each year, including through our national consumer helpline. Thank you for the opportunity to speak with you today about the future of Medicare telehealth coverage.

Medicare Telehealth Coverage

Medicare is the federal government program that provides health care coverage if you are over 65, under 65 and receiving Social Security Disability Insurance (SSDI) for a certain amount of time, or under 65 and living with End-Stage Renal Disease (ESRD). As you know, there are four parts of Medicare: Part A, Part B, Part C, and Part D:

- Part A provides inpatient/hospital coverage.
- Part B provides outpatient/medical coverage.
- Part C offers an alternate way to receive your Medicare benefits.
- Part D provides prescription drug coverage.

People with Medicare can choose to receive their Parts A and B benefits from Original Medicare, the traditional fee-for-service program offered directly through the federal government that was enacted in 1965, or from a Medicare Advantage plan, a type of private insurance offered by companies that contract with the federal government. This option was added in 1996.

Original Medicare covers three types of virtual services: telehealth visits, virtual check-ins, and e-visits. Each has different eligibility standards, provider requirements, and payment rules—many of which are outdated.¹ This system can be hard to understand, overly restrictive, and difficult to navigate, often leaving beneficiaries without meaningful access to remote care.²

A main limitation is that most telehealth visits are only available in narrow circumstances. Medicare rules, many of which have been waived during the COVID-19 public health emergency (PHE), require the beneficiary to live in a rural area and to travel to an “originating site”—such as a doctor’s office, hospital, or skilled nursing facility—for the service. There, they are connected with a “distant site” provider via real-time audio-video technology.

Virtual check-ins and e-visits can be furnished in the home, but Medicare restricts access in other ways, limiting eligibility to established patients; applying strict frequency limits; and excluding many providers. The services are also less robust than telehealth. Virtual check-ins can include brief telephone calls

¹ Centers for Medicare & Medicaid Services, “Medicare Telemedicine Health Care Provider Fact Sheet” (March 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>.

² Centers for Medicare & Medicaid Services, “President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak” (March 17, 2020), <https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak>.

between providers and patients, but e-visits offer no real-time communication, relying instead on portals that allow patients to message their providers and receive an answer back within seven days.

Medicare Advantage plans are required to cover the same virtual services as Original Medicare and can offer additional benefits, including telehealth to people in their own homes and in non-rural areas.³ This imbalance has led to further confusion, and an unequal system.

Medicare Telehealth Coverage During the COVID-19 Pandemic

The COVID-19 outbreak spurred significant changes in Medicare telehealth. While new information about the virus continues to emerge, it has long been clear that Medicare beneficiaries — people over 65 and those with disabilities — are at high risk of infection, serious illness, and even death.⁴ Congress quickly recognized these threats. As early as March 2020, lawmakers took steps to add telehealth flexibilities to the Medicare program. Such PHE-related legislative mandates, in addition to administrative actions, allowed the Centers for Medicare & Medicaid Services (CMS) to broaden Medicare telehealth coverage during the pandemic.

Under these authorities, the agency grew the list of reimbursable telehealth services and providers, waived geographic and originating site restrictions, loosened requirements about pre-established patient-provider relationships, and permitted services to be delivered via a wider array of devices and technologies. CMS also made changes to ease affordability, such as allowing plans and providers to waive or reduce cost sharing.⁵

These and other, related changes paved the way for more beneficiaries to receive more services via telehealth, using more types of technology, and from more locations, including their own home. The uptake was swift. Telemedicine use, particularly in Original Medicare, grew dramatically within a matter of weeks.⁶ Before the pandemic, approximately 13,000 beneficiaries received telemedicine in any given week. By the end of April 2020, that number had skyrocketed to 1.7 million.⁷

The PHE developments represent the biggest shift in Medicare telehealth policy and utilization since the services were created nearly 25 years ago. Although these expansions and waivers have addressed some systemic barriers, the beneficiary experience has been mixed.⁸ Some callers to our national helpline have reported greater access to care, while others are being left behind.

Consider two recent Medicare Rights clients, Ms. S and Ms. L. They have never met but have much in common. They live in the same New York city neighborhood, are primary speakers of a non-English

³ Medicare.gov, “Medicare Advantage Plans Cover all Medicare Services” (last accessed February 26, 2021), <https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services>.

⁴ Centers for Disease Control, “If You Are at Higher Risk” (last accessed February 26, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>.

⁵ Centers for Medicare & Medicaid Services, “Information Related to Coronavirus Disease 2019—COVID-19” (March 10, 2020), <https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf>

⁶ See, e.g., Ateev Mehrotra, *et al.*, “The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices are Adapting to the New Normal” (June 25, 2020), <https://www.commonwealthfund.org/publications/2020/jun/im-pact-covid-19-pandemic-outpatient-visits-practices-adapting-new-normal>; Assistant Secretary for Planning and Evaluation, “Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic” (July 28, 2020), https://connectwithcare.org/wp-content/uploads/2021/01/HP_IssueBrief_MedicareTelehealth_final7.28.20.pdf.

⁷ Seema Verma, “Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19” Health Affairs (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

⁸ Rupa S. Valdez, *et al.*, “Ensuring full participation of people with disabilities in an era of telehealth” Journal of the American Medical Informatics Association (November 9, 2020), <https://academic.oup.com/jamia/article/28/2/389/5988542>.

language, are in Medicare Advantage plans, and are dually eligible for Medicare and Medicaid. They also both had COVID last year. During and after her diagnosis, Ms. S had access to her provider through virtual and in-person visits. She also received an iPad and training on relevant technologies. Ms. L, however, was not offered care via telehealth or in-person; her provider instructed her to go to the Emergency Room if she needed help. Despite similar circumstances, coverage, and diagnoses, their encounters with the PHE Medicare telehealth system could not have been more different.

Post-Pandemic Medicare Telehealth Coverage

The PHE telehealth flexibilities have helped many beneficiaries and their families safely and responsibly obtain needed care during the pandemic, likely leading to reduced virus transmission and improved individual and public health outcomes. While we applaud these successes, we note that not all beneficiary experiences have been positive—or studied. The impact of these changes on costs and health disparities also remains largely unknown, though preliminary research suggests inequities in accessing telemedicine across numerous demographic categories: age, race, ethnicity, preferred language, and income.⁹ As a result, we view calls to make the full PHE system permanent as premature. Entrenching the status quo without careful analysis risks locking in an unexamined expansion of services that was developed for and during a crisis, and which may not be well-suited beyond it.

We recognize the rapid shift to telehealth has led to pushes for rapid policymaking. We agree that modernizations are needed, but so is restraint. As you consider the future of this coverage, we respectfully ask you to move forward deliberately and collaboratively, collecting and following the data, and prioritizing beneficiary needs and preferences. Since this may take time and extend beyond the PHE period, we support the immediate establishment of a glide path. This would allow the temporary telehealth rules and waivers to phase out gradually, minimizing care interruptions.

Once this safeguard is in place, we urge you to work with CMS and stakeholders to build and implement an evidence-based telehealth improvement strategy that centers beneficiaries. This includes thoroughly examining the system pre-pandemic and currently—e.g., services provided; outcomes and quality; program integrity risks and safeguards; participation rates and utilization barriers; program and beneficiary spending; and impacts on health disparities—identifying areas for reform and developing needed solutions. Any resulting policy changes should be made through regular order, relying on legislative and regulatory processes that allow for public review and comment.

The following principles, grounded in our more than 30 years of experience helping people understand and navigate Medicare, are intended to support your efforts. When contemplating changes to Medicare telehealth coverage, we recommend advancing policies that: (1) Include robust **consumer protections and oversight** requirements; (2) Ensure the provision of **high-quality** care; (3) Meaningfully **increase access** to such care; and (4) Promote **health equity**.

Consumer Protections and Oversight

In response to COVID-19, CMS relaxed several Medicare rules and restrictions. Some of these changes expanded coverage, but others suspended important beneficiary protections. While Congress appropriately takes time to determine next steps for these service-related flexibilities, the protections

⁹ Lauren A. Eberly, *et al.*, “Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic” JAMA (December 29, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488>.

that undergird this care cannot wait. They must be reinstated and strengthened as soon as practicable. Specific recommendations include:

- **Apply Standard Cost-Sharing.** During the PHE, providers may voluntarily waive cost-sharing obligations for Medicare telehealth services.¹⁰ Our recent casework reveals this has created confusion among beneficiaries and providers about their financial responsibilities. We are also concerned the discretionary nature of this policy may contribute to discrimination and health inequities. We appreciate this flexibility may be needed during the pandemic. Outside of the emergency period, however, we favor a return to the standard system, which imposes the same cost-sharing liabilities on telehealth and in-person services.
- **Improve Cost-Sharing Outreach, Education, and Documentation.** While the cost-sharing waiver is in place, we recommend adopting policies to reduce ongoing misunderstandings and misinformation.¹¹ Specifically, providers must be required to accurately disclose beneficiary cost-sharing obligations prior to the service, and to fully document such disclosures. CMS must strengthen its outreach, to better help consumers and providers understand their financial responsibilities. The agency must also ensure that cost-sharing waivers are not being applied in discriminatory or otherwise problematic ways, and that plans and providers are not engaging in deceptive marketing, outreach, or billing practices, intentionally or unintentionally.
- **Strengthen Beneficiary Consent Safeguards.** Currently, providers may obtain a beneficiary's consent for care via telehealth at the time the remote service is provided, rather than prior to it. In our experience, when these events co-occur, beneficiaries are more likely to agree to the service without fully understanding their financial obligations. This can lead to confusion and billing surprises, as well as mistrust and fraud reporting. The complexity and novelty of telehealth may make this even more likely.¹² We support sunseting this waiver in favor of advance consent and written notification processes that are designed to facilitate informed decisions and may also combat certain types of fraud.
- **Reinstate Face-to-Face and in-Person Requirements.** Similarly, the temporarily waived face-to-face and in-person requirements for certain evaluations and certifications relating to hospice, inpatient rehabilitation facilities, and national and local coverage determinations must not be made permanent. These in-person visits are important for proper care delivery and planning, as well as for patient safety and program integrity. As Medicare Rights' helpline callers have observed, these benefits are not easily achieved via remote care. They often report the virtual assessments are of poor quality and little use.
- **Protect Patient Privacy.** Privacy laws and protections must apply to all telehealth interactions between the beneficiary and their provider, and personal health data must also be kept secure. The privacy protection waivers, including the Health Insurance Portability and Accountability Act (HIPAA) enforcement discretion policy, should end with the PHE, and non-HIPAA compliant

¹⁰ Juliette Cubanski and Meredith Freed, "FAQs on Medicare Coverage and Costs Related to COVID-19 Testing and Treatment" (December 4, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/faqs-on-medicare-coverage-and-costs-related-to-covid-19-testing-and-treatment/>.

¹¹ Anna Wilde Mathews & Robbie Whelan, "As Covid-19 Cases Rise, Insurers Reduce Coverage for Virtual Doctors' Visits" Wall Street Journal (September 30, 2020), <https://www.wsj.com/articles/as-covid-19-cases-rise-insurers-reduce-coverage-for-virtual-doctors-visits-11601494901>.

¹² Gabriela Weigel, *et al.*, "Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond" (May 11, 2020), <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>.

devices and apps must not be allowed to benefit from the use or sale of health information. We also endorse more systemic improvements, such as updating privacy laws to reflect new technologies.

- **Strengthen Data Collection and Evaluation.** CMS and other federal agencies, as appropriate, must collect and publicly release data on all Medicare-covered telehealth services, including the type of services being provided; instances and patterns of fraud, waste, and abuse; program integrity vulnerabilities and safeguards; beneficiary experience and preferences; programmatic and beneficiary spending; health outcomes; and quality measurements. Such monitoring can inform future policymaking, as well as help verify people are receiving the care they want and need in a way that is affordable for beneficiaries and sustainable for the program.
- **Combat Fraud.** Financial and other scams targeting people with Medicare are, sadly, not new. But the rise of telehealth may put beneficiaries and the program at greater risk for certain types of fraud—including efforts to trick patients into accessing services they neither want nor need, exaggerations about the level of care provided, claims that care was provided when it was not, or even completely fictional provider-patient relationships.¹³ These potential problems should be one of the factors policymakers consider when contemplating permanent telehealth changes, as should mitigation strategies. Consumer protections (e.g., advance, written notice and consent to services) and program safeguards (e.g., monitoring and preventing upcoding and gaming of the risk adjustment system) should be adopted wherever possible and strictly enforced. We also urge putting these and other program integrity concerns in the appropriate context: most providers have good intentions and want to serve their patients as best they can. We must not be so attuned to the risk of fraud that we cut off access to care unnecessarily, punishing the many for the sins of the few.

High Quality Care

The determination of what telemedicine services may be appropriately delivered via any given modality must be a clinical one, and subject to revision based on data about efficacy, beneficiary satisfaction, and outcomes. Efforts to evaluate, update, and improve the system should be continuous, to ensure that at any given time, the care being provided is of the highest possible quality. Specific recommendations include:

- **Update Service and Provider Coverage as Clinically Appropriate and Supported by Evidence.** All covered telehealth services and providers must be clinically appropriate, as determined through CMS processes. Changes to the list of allowable telehealth services and providers should be made through notice-and-comment rulemaking—rather than through sub-regulatory guidance or statute—to maximize policy responsiveness, program nimbleness, and public engagement. Any coverages that are found to not meet clinical or other standards should be addressed quickly and seamlessly, to avoid breaks in or inappropriate care.
- **Update Modality, Device, and Technology Coverage as Clinically Appropriate and Supported by Evidence.** Two-way audio video devices are important, but they are not the only possible

¹³ Alicia Diaz, “Federal watchdog raises concerns about increasing telehealth fraud during pandemic” STAT (February 21, 2021), <https://www.statnews.com/2021/02/22/federal-watchdog-raises-concerns-about-increasing-telehealth-fraud-during-pandemic/>.

modality. Seldom reimbursed prior to the pandemic, audio-only visits can make telehealth available to people who lack the technology or strong internet signals needed for useful video communications—potentially reducing disparities and improving health. Indeed, initial reports indicate people with Medicare have relied on such devices for care during the PHE: one-third of beneficiaries that received a telemedicine service between March and June 2020 did so using audio-only technology.¹⁴ But these services are not without risks. Audio-only telehealth may be of lower quality and lead to unnecessary care;¹⁵ fraud is also a concern.¹⁶ Policymakers must balance the potential gains with the potential harms. To that end, decisions about what kind of care can be delivered safely and effectively using different modalities, including through audio-only interfaces and other non-broadband technologies, should rely on clinical determinations and outcomes and be subject to rigorous and ongoing oversight and data collection. Any eventual expansions must put guardrails in place to protect beneficiaries.

- **Ensure Appropriate Provider Relationship Requirements.** Where appropriate clinical and evidentiary support is present, telehealth services should be available to both new and established patients. As with other potential expansions, any such changes should be accompanied by robust oversight and data collection to confirm that beneficiaries are receiving the care they need, and that clinicians are providing the care they claim to be.
- **Promote Continuous Quality Improvement.** Policymakers must continuously study, evaluate, and adjust Medicare telehealth, to make sure it keeps pace with evolving technologies and beneficiary needs. This includes using and developing telehealth-specific quality measures that capture beneficiary satisfaction and outcomes. When service components are found to be clinically ineffective, or to worsen health, reduce access to care, or widen disparities, they must be swiftly corrected or curtailed.

Increase Access to Care

Telehealth should serve as an additional access point—supplementing, but not supplanting, in-person care. Some beneficiaries and their families may prefer telehealth for certain services. Virtual options can reduce caregiving burdens, require less time spent off work, and allow remote caregivers and loved ones more interaction with providers, as requested by the patient. But others may find telemedicine to be unavailable, unworkable, or uncomfortable. An effective Medicare program must support the full range of beneficiary needs and preferences. Specific recommendations include:

- **Remove Geographic and Site Restrictions.** Under current law, Original Medicare generally can't pay for telehealth for beneficiaries in urban areas, or at all unless the beneficiary goes to a qualifying health care facility to connect with a doctor remotely. These restrictions may have been appropriate in 1997 when the services were created, but they no longer reflect the technology landscape or the beneficiary experience.¹⁷ Preliminary 2020 Medicare claims data bears this out—beneficiaries across the country are accessing telehealth during the pandemic,

¹⁴ Seema Verma, "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19" Health Affairs (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

¹⁵ Lori Uscher-Pines, *et al.*, "Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic" JAMA (February 2, 2021), <https://jamanetwork.com/journals/jama/fullarticle/2776166>.

¹⁶ The U.S. Department of Health and Human Services Office of Inspector General, "2020 National Health Care Fraud Takedown" (last accessed February 26, 2021), https://oig.hhs.gov/documents/root/230/2020HealthCareTakedown_FactSheet_9dtlhW4.pdf.

¹⁷ Centers for Medicare & Medicaid Services, "Information on Medicare Telehealth" (November 15, 2018), <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf>.

including 22% of beneficiaries in rural areas and 30% of beneficiaries in urban areas.¹⁸ Medicare Advantage and many commercial insurers currently reimburse for telehealth services without geographic or originating site limitations.¹⁹ Congress must allow Original Medicare to do the same.

- **Properly Align Payment Incentives.** During the PHE, CMS is paying providers the in-person rate for qualifying services furnished via Medicare telehealth. This means providers are receiving higher reimbursements for virtual services than they did before the pandemic. Making this payment change permanent could create financial incentives that undermine access to in-person care, putting beneficiary health and agency at risk. We urge policymakers to ensure Medicare telehealth payments are sufficient, sustainable, and properly structured.
- **Safeguard Network Adequacy.** Medicare Advantage network adequacy rules exist to make sure enrollees can access needed care. Troublingly, the 2021 Part C & D rule dilutes these consumer protections with respect to certain telehealth services.²⁰ We urge you correct this. Care that is only available virtually must not count toward meeting network adequacy standards.
- **Examine Interactions with Other Systems.** All post-PHE changes, which should be promulgated through normal legislative or regulatory procedures, must ensure that interrelated existing protections are either sufficient or updated in a coordinated way. For example, access to telehealth must not create loopholes that allow offices and facilities to skirt Americans with Disabilities Act (ADA) compliance, and privacy laws may need to expand to cover the growing number of entities that have access to Personal Health Information (PHI).
- **Equalize Access in Original Medicare and Medicare Advantage.** Telehealth service expansions must be identical in Original Medicare (OM) and Medicare Advantage (MA), so that all beneficiaries have equal access to care. We also support correcting existing imbalances that allow MA plans to offer telehealth services that OM cannot.

Promote Health Equity

Older adults and people with disabilities, in particular those in underserved communities, can disproportionately lack access to or comfort with the devices and internet services that are a necessary component of telemedicine.²¹ Some PHE flexibilities may be appropriate longer-term policies, but careful planning and evaluation is needed to make sure that any expansions or other changes advance health equity goals. Specific recommendations include:

- **Prioritize Underserved Communities.** Congress must direct funding and other aid to communities with low rates of technology access and use—including Black Americans, Latino Americans, Indigenous people, other people of color, individuals with disabilities, and people

¹⁸ Seema Verma, “Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19” Health Affairs (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

¹⁹ MedPAC, “Mandated Report: Telehealth Services and the Medicare Program” (March 2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0.

²⁰ Medicare Rights Center, “Comments on Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly” (April 6, 2020), <https://medicarerights.org/pdf/medicare-rights-2021-c-d-rule-comments.pdf>.

²¹ Yohualli Balderas-Medina Anaya, *et al.*, “Telehealth & COVID-19: Policy Considerations to Improve Access to Care” (May 2020), <https://latino.ucla.edu/wp-content/uploads/2020/05/Telehealth-COVID-19-Report.pdf>.

with limited English proficiency—to improve utilization.²² Community-based organizations are uniquely positioned to provide these vital services and supports.

- **Collect and Analyze Data.** Telehealth expansions must not exacerbate health, racial, or income disparities. To align future policymaking with these goals, federal agencies must purposefully collect and publicly report data on telehealth use and barriers, including detailed demographic data (e.g., race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socioeconomic status, insurance coverage, and geographic location). Data collection and analysis must be culturally competent and consistent with patient privacy laws.
- **Close the Digital Divide.** Research indicates one-third of adults age 65 and older never use the internet and almost half lack at-home broadband. The digital divide is even greater for Black older adults: 55% do not go online and 70% do not have broadband access at home.²³ Congress must reduce these disparities, in part by improving beneficiary access to digital literacy training, reliable broadband, and remote technologies.
- **Support Workforce and Infrastructure Development.** Advancing equitable access to telehealth will require investing in non-health care systems—like telecommunications and technology infrastructure—as well as reforming the health care workforce in ways that build capacity and economic security.
- **Protect Beneficiary Rights.** Policymakers must monitor the marketing and provision of Medicare telehealth services to guarantee compliance with anti-discrimination rules and guidelines, including requirements around the use of interpreters and the provision of materials in alternative formats and non-English languages.

Conclusion

Through our work with people with Medicare and their families, we frequently hear from beneficiaries who are struggling to access and afford needed services.²⁴ Many face limited financial resources, rising health care and prescription drug costs, antiquated coverage and enrollment rules, systemic inequities, and burdensome program requirements. In addition to these longstanding barriers, older adults and people with disabilities, and particularly those of color, have been among the hardest hit by the COVID-19 pandemic and its economic fallout.²⁵

Because of the risks COVID-19 poses to many people with Medicare, Medicare Rights greatly appreciates congressional and administrative efforts to widen Medicare telehealth coverage during the PHE. Amid calls to make these sweeping changes permanent, we caution that rushed policymaking can yield

²² Older Adults Technology Services from AARP (OATS) & the Humana Foundation, “Aging Connected: Closing the Connectivity Gap for Older Americans” (January 2021), https://agingconnected.org/wp-content/uploads/2021/01/Aging-Connected_2021.pdf.

²³ Monica Anderson and Andrew Perrin, “Tech Adoption Climbs Among Older Adults” (May 17, 2017), <https://www.pewresearch.org/internet/2017/05/17/tech-adoption-climbs-among-older-adults/>.

²⁴ Medicare Rights Center, “2018-2019 Medicare Trends and Recommendations” (October 9, 2020), <https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations>.

²⁵ See, e.g., Hannah R. Abrams, *et al.*, “Characteristics of U.S. Nursing Homes with COVID-19 Cases” (last accessed February 26, 2021), <https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16661>; Robert Gebeloff, *et al.*, “The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes” (September 10, 2020), <https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html>; Samantha Artiga, *et al.*, “Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19” (April 7, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/>.

undesirable results, such as perverse incentives and exacerbated inequities. Going forward, we urge a thoughtful and evidence-based approach that centers the needs and preferences of people with Medicare. To allow time for that, we support a glide path, and contemporaneous heightened oversight, to prevent a beneficiary's access to services from ending the moment the public health emergency does.

Critically, other near-term improvements are also needed to promote access to affordable, high-quality care. Throughout the PHE, we have consistently heard from Medicare-eligible individuals who are unable to quickly connect with their earned benefits. Most have to wait several months to sign up and several more for coverage to begin. These are dangerous gaps in general, and for at-risk populations during a pandemic in particular. A COVID-19-specific Medicare Special Enrollment Period (SEP) for Premium Part A and Part B and expanded Equitable Relief would help, creating pathways for older adults and people with disabilities to obtain needed care.²⁶

Thank you again for the opportunity to be here today. I look forward to working together to advance a system that works for all beneficiaries.

²⁶ See, e.g., Leadership Council of Aging Organizations, "Letter on COVID-19 Relief" (February 23, 2021), <https://www.lcao.org/wp-content/uploads/2021/02/lcao-chair-letter-to-hill-on-covid-relief.pdf>; Medicare Rights Center, "Letter to Senate Leaders on COVID-19 Relief Priorities" (July 29, 2020), <https://www.medicarerights.org/pdf/072920-covid-letter.pdf>.