Documents for the Record – 4/10/2024

Majority:

- April 8, 2024 – Letter submitted by the American Physical Therapy Association
- April 8, 2024 – Letter submitted by the Rehabilitation Therapy Coalition
- April 8, 2024 – Statement submitted by the Alliance for Connected Care
- April 8, 2024 – Statement submitted by the American Society of Health-System Pharmacists
- April 9, 2024 – Statement submitted by the Advanced Care at Home Coalition
- April 9, 2024 – Statement submitted by the American Occupational Therapy Association
- April 9, 2024 – Statement submitted by the Blue Cross Blue Shield Association
- April 9, 2024 – Statement submitted by the ERISA Industry Committee
- April 9, 2024 – Statement submitted by the National Multiple Sclerosis Society
- April 9, 2024 – Statement submitted by the Patient Access Network Foundation
- April 9, 2024 – Statement submitted by Transcarent
- April 10, 2024 – Letter submitted by Rep. Bilirakis
- April 10, 2024 – Letter submitted by the American Association of Cardiovascular and Pulmonary Rehabilitation
- April 10, 2024 – Statement submitted by the American Academy of Family Physicians
- April 10, 2024 - Statement submitted by ATA Action
- April 10, 2024 – Statement submitted by Moving Health Home
- April 10, 2024 – Statement submitted by the AARP
- April 10, 2024 – Statement submitted by the American Association of Nurse Practitioners
- April 10, 2024 – Statement submitted by the American College of Emergency Physicians
- April 10, 2024 – Statement submitted by the American College of Physicians
- April 10, 2024 – Statement submitted by the American Hospital Association
- April 10, 2024 – Statement submitted by the Federation of American Hospitals
- April 10, 2024 – Statement submitted by the Healthcare Leadership Council
- April 10, 2024 – Statement submitted by the Medical Group Management Association

Minority:

- April 9, 2024 – Letter submitted by letter the American Psychological Association Services, Inc.
- April 10, 2024 – Statement submitted by the American Medical Association
- April 10, 2024 – Statement submitted by the Children's Hospital Association

April 9, 2024

The Honorable Brett Guthrie
Chair, Subcommittee on Health
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eschoo
Ranking Member, Subcommittee on Health
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Cathy McMorris Rodgers
Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Re: House Energy and Commerce Subcommittee on Health Hearing: "Legislative Proposals to Support Patient Access to Telehealth Services."

Dear Chair Guthrie, Ranking Member Eschoo, Chair McMorris-Rodgers, and Ranking Member Pallone:

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 House Energy and Commerce Subcommittee on Health hearing, "Legislative Proposals to Support Patient Access to Telehealth Services." 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," 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 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 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 demonstrates that physical therapy-based cancer telerehabilitation programs deliver a net cost-benefit of approximately $4,000 per episode of care.

In the 118th Congress, APTA is supporting several legislative initiatives to expand patient access to physical therapy care in the rural and medically underserved areas, especially proposals to continue the delivery of care via telehealth. To permanently include physical therapists and physical therapist assistants as authorized telehealth providers in Medicare, APTA strongly endorses the bipartisan Expanded Telehealth Access of Act of 2023 (H.R. 3875/S. 2880). Separately, APTA is endorsing H.R. 7623 – the Telehealth Modernization Act – which proposes to make many of the pandemic-era telehealth flexibilities permanent.

The expansion of telehealth payment and practice policies under the Section 1135 waivers during the public health emergency, including permitting physical therapist services to be furnished via telehealth by PTs and PTAs across settings, has demonstrated that many health care needs can be safely and effectively met and that patients can have improved access to skilled care by leveraging these resources. This has been especially beneficial for those patients residing in rural areas who often have access to far fewer providers than other regions and may live a very considerable distance from medical facilities and other health care professionals.

Physical therapists and physical therapist assistants use telehealth as a supplement to in-person services to evaluate and treat a variety of conditions prevalent in the Medicare population, including but not limited to Alzheimer's disease, arthritis, cognitive/neurological/vestibular disorders, multiple sclerosis, musculoskeletal conditions, Parkinson disease, pelvic floor dysfunction, frailty, and sarcopenia.

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 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. Examples of PTs and PTAs using telecommunications technology to provide real-time, interactive care include the following:

- Physical therapy practitioners use telehealth technologies to conduct evaluations or reevaluations or provide quicker screening, assessment, and referrals that improve care coordination.

- Physical therapy practitioners provide interventions using telehealth by interacting with the patient in real time to provide instruction in exercise and activity performance; observe return demonstration and offer instruction in modifications or progressions of a program; provide caregiver support; and promote self-efficacy.

- Physical therapy practitioners provide 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 potentially produce even more optimal outcomes.

- Physical therapy practitioners use telehealth technologies to provide prehabilitation and conduct home safety evaluations.

- Physical therapy practitioners use telehealth technologies to observe how patients interact with their environment and/or other caregivers, and to provide caregiver education.

- Physical therapy practitioners can assess the influence of activity modification strategies and activities to determine effectiveness immediately rather than waiting for the next in-person visit.

- Physical therapists use telehealth to 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.

- Physical therapists can use technology to satisfy supervision requirements.

- A physical therapist can co-treat with another clinician who is treating via real-time audio and visual technology.

- A treating physical therapist can consult directly with another physical therapist or physical therapist assistant for collaboration and/or to obtain specialty recommendations to incorporate into an existing plan of care.

- Physical therapists use telehealth for quick check-ins with established patients.

Policy Recommendation

APTA supports the ability of Medicare beneficiaries in rural and underserved areas to maintain the option, when appropriate, to have physical therapist services provided via telehealth. Permitting services to be furnished via telehealth by PTs and PTAs has provided greater options for patients to access care. 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 before the expiration of the current waiver on Dec. 31, 2024.

We appreciate the opportunity to share our views on this issue. Should you have any questions, please contact APTA Congressional Affairs Specialist Steve Kline at [redacted]. Thank you for your time and consideration.

Sincerely,

Roger Herr
President, American Physical Therapy Association.

April 9, 2024

The Honorable Brett Guthrie
Chair, Subcommittee on Health
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member, Subcommittee on Health
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The Honorable Cathy McMorris Rodgers
Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
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The Honorable Frank Pallone
Ranking Member
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Re: House Energy & Commerce Committee Subcommittee on Health Hearing: "Legislative Proposals to Support Patient Access to Telehealth Services"

Dear Chair Guthrie, Ranking Member Eshoo, Chair McMorris Rodgers, and Ranking Member Pallone:

The Rehabilitation Therapy Coalition, including ADVION (formerly known as the National Association for the Support of Long Term Care), the American Health Care Association/National Center for Assisted Living (AHCA/NCAL), the American Occupational Therapy Association (AOTA), the American Physical Therapy Association (APTA), the American Physical Therapy Association Private Practice Section, the Alliance for Physical Therapy Quality and Innovation (APTQI), the American Speech Language Hearing Association (ASHA), and the National Association of Rehabilitation Providers and Agencies (NARA), write to thank you for your inclusion of the ***Expanded Telehealth Access Act (H.R. 3875)*** **and the** ***Telehealth Modernization Act of 2024 (H.R. 7623)*** in the upcoming Energy and Commerce Subcommittee on Health's hearing, "Legislative Proposals to Support Patient Access to Telehealth Services," on April 10, 2024.

The Rehabilitation Therapy Coalition represents rehabilitation therapy practices and practitioners including physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, speech, language, and hearing scientists serving Medicare beneficiaries nationwide, students for all the aforementioned healthcare professions, as well as companies that provide physical, occupational, and speech-language pathology in long-term and post-acute care settings nationally. We jointly support the permanent continuation of the ability for rehabilitation therapists to utilize telehealth where appropriate to deliver services to Medicare patients.

i. Expanded Telehealth Access Act (H.R. 3875)

Telehealth waivers have expanded and maintained Medicare patient access to rehabilitation therapy beyond the COVID-19 Public Health Emergency (PHE) and now it's time to permanently extend Medicare coverage of telehealth for rehabilitation therapy. The ability to provide consistent rehabilitation therapy services for Medicare patients with medical conditions or geographic and economic barriers alongside in-person care has allowed Medicare patients to continue progress with their established short-term and long-term plan of care goals as well as prevent unnecessary hospital admissions and readmissions, emergency department visits, urgent care visits, and prevent exacerbation of chronic conditions. A growing body of research further supports that telerehab services offer similar outcomes with equal or better beneficiary satisfaction than wholly in-person care.

The Rehabilitation Therapy Coalition remains committed to ensuring Medicare beneficiaries can continue access to physical therapy (PT) services, speech-language pathology (SLP) services, and occupational therapy (OT) services provided either in-person or via telehealth based on the patient's needs and preferences and the clinician's professional judgment. The Coalition has endorsed the ***Expanded Telehealth Access Act (H.R. 3875)*** and is pleased to see that the bill is part of the upcoming Energy and Commerce Subcommittee on Health's hearing, "Legislative Proposals to Support Patient Access to Telehealth Services."

The *Expanded Telehealth Access Act (H.R. 3875/S. 2880)* would permanently add physical therapists (PTs), speech language pathologists (SLPs), occupational therapists (OTs), and rehabilitation therapy assistants as Medicare telehealth providers in statute which will allow them to continue providing rehabilitation therapy services to Medicare patients via telehealth, when appropriate. It is important to note that this bill will not expand the scope of practice of any of these practitioners, rather it will allow Medicare reimbursement for the provision of rehabilitation therapy services provided via telehealth. Passage of this bill is essential as the Centers for Medicare & Medicaid Services (CMS) has indicated that while it does have the authority to create telehealth CPT codes, and has done so already, CMS does not have the authority to list rehabilitation therapists as telehealth providers in Medicare after the waivers extended by Congress expire at the end of 2024.

ii. Telehealth Modernization Act (H.R. 7623)

The Rehabilitation Therapy Coalition also supports the ***Telehealth Modernization Act of 2024 (H.R. 7623),*** led by Representatives Earl "Buddy" Carter, Lisa Blunt Rochester, Gregory Steube, Terri Sewell, Mariannette Miller-Meeks, Debbie Dingell, Jefferson Van Drew, and Joseph Morelle, which is also included in the upcoming hearing, "Legislative Proposals to Support Patient Access to Telehealth Services."

A crucial provision in the *Telehealth Modernization Act* would remove the current sunset of December 31, 2024, on the inclusion of OTs, PTs, and SLPs as Medicare telehealth

providers. By removing the 2024 sunset, this legislation would allow all these providers to provide Medicare telehealth services permanently. Another crucial provision of the bill would end Medicare telehealth restrictions on both the "geographic and originating site," permanently expanding access to telehealth for Medicare beneficiaries. **Additionally, it is critical that the expansion provisions make it clear that permanent inclusion of OT, PT, and SLP practitioners include both office-based and facility-based providers.**

iii. Conclusion

The Rehabilitation Therapy Coalition thanks you again for your inclusion of the ***Expanded Telehealth Access Act (H.R. 3875)*** **and** the ***Telehealth Modernization Act of 202*****4** ***(H.R. 7623)*** in the upcoming Energy and Commerce Subcommittee on Health hearing.

Both of these critical pieces of legislation will allow rehabilitation therapists to prevent delays in patient care and provide therapy to Medicare beneficiaries who otherwise may go without the treatment. While the country is experiencing a shortage of rehabilitation therapy providers, telehealth allows these essential healthcare services to be provided to patients in areas of the country where there are limited rehabilitation therapy providers available or coverage areas that are so wide that providers cannot reasonably travel the distances from site to site and provide the services.

We urge the Committee to support the advancement of ***H.R. 3875*** and ***H.R. 7623*** and are here to answer any questions you may have on our support for these bills. As the committee considers these bills, should you have further questions regarding supporting patients' access to rehabilitation therapy through telehealth services, please contact Cynthia Morton with ADVION at [redacted].

Sincerely,

ADVION (formerly known as National Association for the Support of Long Term Care)

Alliance for Physical Therapy Quality and Innovation (APTQI)
American Health Care Association/National Center for Assisted Living (AHCA/NCAL)

American Occupational Therapy Association (AOTA)

American Physical Therapy Association (APTA)

American Physical Therapy Association - Private Practice Section

American Speech Language and Hearing Association (ASHA)

American Society of Hand Therapists (ASHT)

National Association of Rehabilitation Providers and Agencies (NARA)

Statement for the Record:
"Legislative Proposals to Support Patient Access to Telehealth Services"
U.S. House of Representatives
Energy and Commerce Committee

Alliance for Connected Care
1100 G Street, NW, Suite 420, Washington, DC 20005

April 10, 2024

The Alliance for Connected Care (the "Alliance") appreciates the opportunity to submit testimony for this hearing on legislative proposals that will support patient's access to telehealth services. 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 organizations from across the spectrum, representing health systems, healthy payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth and remote patient monitoring.

Telehealth research continues to consistently show high patient satisfaction, no uptick in utilization, and strong clinical outcomes. We believe that 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.

Urgent Action is Needed

It is first important to note that telehealth policy flexibilities granted during the pandemic, and subsequently extended in 2022, have supported telehealth access nationwide, including more than 30 million Americans in Medicare and many of the 33 million Americans with High-Deductible Health Plans and Health Savings Accounts.

While we deeply appreciate the Committee's leadership in extending Medicare telehealth provisions through December 31, 2024, we encourage the Committee to act rapidly to provide certainty around the future of telehealth well in advance of December 2024. Recently, the Alliance convened well over 200 organizations on a letter, urging congressional leaders to act on telehealth with enough notice for these services to be included in federal payment rules, employer and health plan benefit decisions, and health provider workforce decisions.

Clinicians need telehealth to expand access to care and support strong patient relationships, and they value the flexibility created by the option for remote care when clinically appropriate. Important safety net providers like community health centers and rural health clinics have depended on these flexibilities, as have clinicians such as physical therapists, speech therapists and occupational therapists to extend access to patients. Current telehealth flexibilities have played a critical role in promoting access to vital health care services including advanced specialists (e.g. oncologists) and mental health services without a previous in-person appointment. This is particularly true for patients in rural and underserved areas, patients with mobility issues, and patients with transportation or other limitations that prevent them from accessing in-person care in a timely manner.

The Alliance has endorsed a range of telehealth legislation and urges the Subcommittee to advance bipartisan legislation including many of these proposals, as they would ensure continued access to permanent telehealth policies:

- **Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2023 (H.R. 4189),** introduced by Rep. Thompson (D-CA) and 37 bipartisan cosponsors, would expand access to telehealth services.
- **Telehealth Modernization Act of 2024 (H.R. 7623),** introduced by Rep. Carter (R-GA) and eight bipartisan cosponsors, would make permanent certain telehealth flexibilities under the Medicare program.
- **Telehealth Health Care Access Act (H.R. 3432),** introduced by Rep. Matsui (D-CA), would ensure coverage of mental and behavioral health services furnished through telehealth.
- **Expanded Telehealth Access Act (H.R. 3875),** introduced by Rep. Sherrill (D-NJ) and 52 bipartisan cosponsors, would expand the scope of practitioners eligible for payment for telehealth services under the Medicare program.
- **Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (H.R. 5541),** introduced by Rep. Latta (R-OH), would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

Core Statutory Challenges in Medicare

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

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 eliminating 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 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. **Rural residents, in particular, have to travel 40 miles farther than their urban counterparts.** While requiring specific sites of care for telehealth may have made sense when technology was new and unreliable, clinicians today are effectively deploying telehealth nationwide. There is no reason for our most vulnerable populations to have less access to care. In addition to broader legislation, the Alliance is supportive of Rep. Buchanan's (R-FL) and Steel's (R-CA) legislation, H.R. 134, to remove geographic requirements and expand originating sites for telehealth services

    - **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. The Alliance endorsed the Expanded Telehealth Access Act (H.R. 3875), introduced by Rep. Sherrill (D-NJ) and 52 bipartisan cosponsors, would expand the scope of practitioners eligible for payment for telehealth services under the Medicare program. As you are aware, the United States currently faces unprecedented workforce challenges. The patient-to-primary care physician ratio in rural areas is 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. Telehealth and RPM can help alleviate some of these workforce challenges. An Alliance 2022 survey 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. The Committee should direct CMS to work to ensure that all 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.

2. **Ensure Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and Rural Health Clinics (RHCs) 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 need to be updated to better align with the broader CMS payment environment. The Alliance for Connected believes the Equal Access to Specialty Care Everywhere Act of 2024 (H.R. 7149) would improve access to specialty health services, particularly in FQHCs, CAHs, and RHCs.

3. **Remove In-Person Requirements Under Medicare for Mental Health Services Furnished Through Telehealth and Telecommunications Technology.** The Alliance urges the Committee to advance legislation, such as H.R. 3432, the Telemental Health Care Access Act to remove in-person requirements for mental health services. Requirements for in-person visits prevent telehealth from helping those who often need it most – patients with transportation, mobility, frailty, or stigma barriers that prevent them from receiving in-person care. A recent study found that "introducing in-person requirements for visits and prescribing could cause care interruptions." The Alliance endorsed the **Telehealth Health Care Access Act (H.R. 3432)**, introduced by Rep. Matsui (D-CA), would ensure coverage of mental and behavioral health services furnished through telehealth.

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 five 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.

5. **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.

6. **Drive better and more coordinated care for those with chronic disease by ensuring adequate reimbursement for remote patient monitoring (RPM) technology**. 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. A payment floor should be set for RPM, given that there are generally fixed costs in providing major components of these services.

Additional Telehealth Concerns

The Alliance for Connected Care also urges the Committee to consider other barriers to telehealth.

1. **Push the Drug Enforcement Administration (DEA) to Act on Regulations Continuing the Prescribing of Controlled Substances via Telemedicine** – Special registration to prescribe controlled substances through telemedicine was originally called for in the Ryan Haight Act of 2008. 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. 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. DEA must bring forward a revised final rule with enough time for stakeholder feedback prior to the end of patient access on December 31st. Like telehealth, there are huge logistical burdens around pharmacies and providers that will require time to implement.

   Recently, the Alliance for Connected Care co-led a letter, signed by 214 organizations, requesting the DEA to expedite the release of a revised proposed rule to permit and regulate the prescribing of controlled substances through telehealth. DEA's national leadership is needed to set a clear path forward for the nation and to encourage more consistent definitions and aligned requirements from state regulatory bodies – to encourage care in our most underserved areas, without geographic barriers limiting access to care.

2. **Work with CMS to ensure providers rendering telehealth services from their home are able to offer services without reporting their home address on their Medicare enrollment or billing paperwork.** 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. While these changes are within CMS's regulatory authority, we look forward to working with members of the Energy and Commerce Committee to ensure CMS prioritizes the needs of telehealth providers in addition to patients. We appreciate the Committee's work on advancing the Medicare Telehealth Privacy Act of 2023 (H.R. 6364), but continue to remain concerned by the significant administrative burden of providers reporting their home address that would lessen access to virtual care.

3. **Encourage Additional Care Across State Lines** – 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. The Alliance also endorsed the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (H.R. 5541), introduced by Rep. Latta (R-OH), would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

   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 outlining these and other possible licensure solutions.

Recommendations for Fraud, Waste, and Abuse

A number of already disproven myths about telehealth have continued to persist. While broader understanding of the benefits and use of telehealth have come a long way, these outdated misconceptions continue to undermine policymaking and must be corrected.

Importantly, the Alliance and its members believe that an in-person visit requirement is never the right guardrail for a telehealth service – because these requirements harm patients with access challenges, such those who are frail or homebound, have transportation issues, or live in rural or underserved areas. Similarly, we believe that a clinician's time has the same value, no matter if they are supporting a patient virtually or in-person. 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.

The Alliance understands that with change sometimes comes risk, and that Congress holds ultimate authority for protecting the Medicare program from fraud, waste, and abuse. This being said, we note that **the Office of the Inspector General at HHS recently released a report, finding that telehealth provided to Medicare beneficiaries generally complied with Medicare requirements and did not lead to fraud. OIG had no policy recommendations for CMS.** We look forward to seeing additional reports which confirm this commonsense finding. We believe that, using the data we are currently collecting about the provision of telehealth services, the Medicare program and the Office of the Inspector General at HHS will

be able to target and differentiate nearly all fraudulent behavior from legitimate telehealth. Congress must trust this capability and authority, rather than creating barriers to access between Medicare beneficiaries and critical health services. It is important to note that the removal of the broad statutory restrictions under 1834(m) 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 Medicare and Medicaid Services (CMS) will remain to ensure Medicare only pays for high-quality, clinically appropriate telehealth care.

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 permanent 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** by requiring 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. These could include additional private-sector accountability tools for virtual-only providers, such as certifications that include education on billing and the avoidance of fraud and abuse in billing for telehealth services. Additionally, CMS could require that all providers must indicate their intent to provide telehealth services to Medicare beneficiaries during enrollment and 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 prior to 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.

April 10, 2024

The Honorable Chairman Brett Guthrie
House Energy and Commerce Committee
Health Subcommittee
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Anna Eshoo
House Energy and Commerce Committee
Health Subcommittee
272 Cannon House Office Building Office Building
Washington, DC 20515

Re: House Energy and Commerce, Health Subcommittee hearing on legislative proposals to support patient access to telehealth services.

Dear Chair Guthrie and Ranking Member Eshoo:

The American Society of Health-System Pharmacists (ASHP) writes you today on behalf of our 60,000 members, including pharmacists, student pharmacists, and pharmacy technicians, to thank you for holding today's hearing on legislative proposals supporting telehealth. On behalf of ASHP members, we support the Committee prioritizing and making telehealth authorities permanent. We also urge the Committee make additional flexibilities permanent regarding supervision requirements and diabetes self-management training (DSMT) programs in order to ensure patients in rural and underserved areas continue to receive access to critical pharmacy services via telehealth.

The telehealth flexibilities provided pursuant to the COVID-19 public health emergencies (PHE) have enabled ASHP's members to provide essential healthcare services remotely. Much has been learned through the use of telehealth services to enhance patient care and wellbeing. The success of telehealth services during the PHE, and since, has illustrated the value of telehealth long-term, particularly for patients with mobility issues and those in rural and/or medically-underserved areas.

Virtual Supervision: One specific telehealth flexibility that must be made permanent to enable long-term success is allowing direct supervision of auxiliary personnel such as pharmacists to be provided virtually. Prior to the PHE, to be reimbursed under Medicare Part B for services provided by auxiliary personnel incident to a physician's services, a physician was required to "directly supervise" such services, which required actual physical presence by the supervising physician (42 CFR 410.32(b)(3)(ii)). During the PHE, CMS permitted direct supervision to be effectuated through the use of audio/video real-time communication, thus protecting the health and safety of providers as well as expand access to services in rural and underserved areas. This has now become the norm. Unfortunately, pursuant to the final CY 2024 Payment Policies, this flexibility is set to expire December 31, 2024. We recommend this flexibility be extended permanently.

DSMT Training: The CARES Act permitted DSMT to be provided to patients through telehealth. Receiving DSMT through telehealth enables patients in rural and underserved areas to more easily access these critical services to manage their diabetes. However, the original guidance only provided this authority for nurses and pharmacists in federally qualified health centers, rural health centers, and

outpatient settings. We recommend legislation clarifying that DSMT services may be provided via telehealth regardless of the setting of care.

ASHP thanks you for considering these recommendations regarding telehealth, which will ensure patients continue to receive these important services. If you have questions or if ASHP can assist in any way, please contact Frank Kolb at [redacted].

Sincerely,

Tom Kraus
American Society of Health-System Pharmacists
Vice President, Government Relations

April 9, 2024

The Honorable Cathy McMorris Rodgers
Chair
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Brett Guthrie
Chair
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Chair Rodgers, Ranking Member Pallone, Chair Guthrie and Ranking Member Eshoo,

The Advanced Care at Home Coalition (the ACH Coalition), a group of like-minded stakeholders focused on creating a pathway to permanent coverage for advanced care at home services, writes to commend the Energy and Commerce Subcommittee on Health for considering the *Hospital Inpatient Services Modernization Act* discussion draft, led by Representatives Wenstrup and Blumenauer, at the April 10th hearing, "Legislative Proposals to Support Patient Access to Telehealth Services". The legislation would extend the Centers for Medicare & Medicaid Services (CMS) Acute Hospital Care at Home (AHCaH) waiver flexibilities through 2027. The ACH Coalition strongly supports the multi-year extension contained in this legislation, which demonstrates an ongoing commitment to increasing access to care in the home through hospital at home programs.

Today, 321 hospitals across 133 systems in 37 states are approved for the AHCaH waiver program.[1] The program provides an important pathway to safe, high-quality care for Medicare patients in the comfort of their homes. Studies of hospital at home programs regularly show significant reductions in 30-day readmissions, post-discharge emergency department visits and skilled nursing facility utilization.[2][3][4] As supported through recent testimony, patients choosing to receive hospital care at home as opposed to in the hospital can also better improve their mobility and improve their sleep, and patient satisfaction is consistently higher for patients receiving acute care in their homes.[5]

[1] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources
[2] Levine DM, Ouchi K, Blanchfield B, Saenz A, Burke K, Paz M, Diamond K, Pu CT, Schnipper JL. Hospital-level care at home for acutely ill adults: a randomized controlled trial. Annals of internal medicine. 2020 Jan 21;172(2):77-85.
[3] Federman AD, Soones T, DeCherrie LV, Leff B, Siu AL. Association of a bundled hospital-at-home and 30-day post-acute transitional care program with clinical outcomes and patient experiences. JAMA internal medicine. 2018 Aug 1;178(8):1033-40.
[4] Cryer L, Shannon S, Van Amsterdam M, Leff B. "Costs for 'Hospital at Home' Patients Were 19 Percent Lower, With Equal of Better Outcomes Compared to Similar Inpatients." Health Affairs, 2012.
[5] https://gop-waysandmeans.house.gov/wp-content/uploads/2024/03/Underhill-Testimony.pdf

Without Congressional action, this critical program will expire at the end of 2024. To preserve and expand this important and highly desirable option for Medicare beneficiaries and to ensure continued support for participating hospitals and health systems, **the ACH Coalition supports a multi-year extension of waiver flexibilities, as envisioned in the *Hospital Inpatient Services Modernization* discussion draft**. A multi-year waiver extension will provide the stability and predictability necessary for providers and plans to scale nascent programs to sustainable levels, while also allowing for increased provider and patient participation, enhanced data collection, and spreading of best practices to address equity and other challenges.

Establishing a new hospital-at-home program requires substantial clinical and administrative resources, time, and investment, both for providers of the services and for payers that wish to cover them. Furthermore, State Medicaid Agencies can be hesitant to participate in a program with an uncertain future. A longer extension may encourage additional State Medicaid agencies to participate in the AHCaH program, as there are currently fewer than ten Medicaid programs participating. The enablement of additional Medicaid program participation would promote socioeconomic, demographic, and geographic diversity among the patients who benefit from hospital-at-home, where appropriate.

While the ACH Coalition remains focused on the development of a permanent pathway for advanced care at home programs that is accessible, safe, high-quality, equitable, and innovative, we understand that policymakers seek more data and experience to fully analyze the value and outcomes of the program. A multi-year extension of the ACHaH waiver will allow for robust data collection, smart program growth, and an opportunity for more patients to have access to this model of care. We thank you again for including the *Hospital Inpatient Services Modernization Act* discussion draft in the Subcommittee on Health hearing and look forward to assisting you throughout the legislative process.

Sincerely,

Advanced Care at Home Coalition
(www.achcoalition.org)

American Occupational Therapy Association

House Energy & Commerce Health Subcommittee Hearing
Legislative Proposals to Support Patient Access to Telehealth Services
Comments of the American Occupational Therapy Association
April 10, 2024

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 enabled OTPs to provide services via telehealth to Part B Medicare beneficiaries during the COVID-19 emergency. Congress acted again in December 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, some divisions of CMS originally 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 has already been introduced to address this need. The Expanded Telehealth Access Act (HR3875/S2880) was introduced by Reps Mikie Sherrill and Diana Harshbarger and Senators Steve Daines and Tina Smith to specifically add OTPs, PTs, SLPs and audiologists as permanent telehealth providers in Medicare. AOTA endorses this bill. AOTA also endorses the Telehealth Modernization Act (HR7623) which is a comprehensive telehealth bill introduced by Rep Buddy Carter that includes a provision to establish OTPs and other therapists as permanent Medicare telehealth providers by removing the waiver sunset in statute.

The CONNECT for Health Act of 2023 (HR4189/S2016) would at least 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 and the fear that CMS would not react quickly to establish OTPs as permanent telehealth providers across all outpatient settings, AOTA does not believe this bill takes the steps necessary to ensure occupational therapy practitioners become permanent telehealth providers in Medicare. Congress already established all other existing telehealth providers in Medicare through legislation, and we believe it must also do so for OTPs and other therapists.

Some OT Services via Telehealth Cannot be Duplicated in Clinical Settings

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. Telehealth OT waivers have also opened a technological window into a patient's home that has created what is essentially a new and valuable service that would not exist otherwise.

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, hospital admissions and even institutionalizations 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

Although telehealth first emerged as a way to provide services during a pandemic, its value beyond that was quickly understood by OTPs, other therapists and Medicare beneficiaries. A growing body of research indicates that where telehealth rehab services are used, the same or similar outcomes can be achieved in fewer sessions than in-person alone, and patient satisfaction with services provided by telehealth for rehabilitation services is high.[1]

The AOTA Telehealth Position Paper[2] 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.[3] 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.[4]
- 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] Nguyen G, King K, Stirling L. Telerehabilitation use and experiences in occupational and physical therapy through the early stages of the COVID-19 pandemic. PLoS One. 2023 Nov 8;18(11):e0291605. doi: 10.1371/journal.pone.0291605. PMID: 37939089; PMCID: PMC10631673.

[2] 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.

[3] 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 EM, Polatajko HJ, Marziali E, Hunt A, Dawson DR (2013). Telerehabilitation for addressing executive dysfunction after traumatic brain injury. Brain Inj. 2013;27(5):548-64.

[4] 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.[5] 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.

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.

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

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 (H.R.3875/S.2880) or the Telehealth Modernization Act (H.R.7623) 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.

BlueCross BlueShield Association

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Statement for the Record

Submitted to U.S. House Committee on Energy and Commerce

"Legislative Proposals to Support Patient Access to Telehealth Services"

April 10, 2024

By: David Merritt, Senior Vice President of Policy and Advocacy

The Blue Cross Blue Shield Association (BCBSA) believes everyone should have access to affordable health care, no matter who you are or where you live. We share your ongoing commitment to improving telehealth services as an effective approach to expand access to care. We thank the Chairman and Ranking Member for holding this important hearing to discuss how telehealth can be a powerful tool to support communities with access challenges and meet the needs of patients who may have privacy preferences or barriers to in-person health care.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer or purchase coverage on their own. We are committed to delivering affordable and equitable access to high-quality care for every American.

Below are a few examples of how BCBS Plans are leveraging telehealth and other digital health solutions to expand access to care for all patients, drive personalized patient care plans and provide more seamless, connected care:

- **Blue Cross Blue Shield of Massachusetts** engaged Brightline Health as an in-network provider for children ages 3-17 and their parents. Brightline provides live online child psychiatry, psychotherapy and family support. The service addresses the need for wraparound care and bridges the gap in access to children's mental health care professionals.
- **Regence,** parent company of Regence BCBS health plans, has expanded telehealth access across Washington, Idaho, Oregon and Utah, which expands access to care in largely rural areas through strategic partnerships. With Talkspace, Regence members have access to more than 3,000 licensed mental health professionals for 24/7 support via secure messaging and live video sessions from the convenience of home. For members with substance use disorders, Boulder Care brings in-network access to virtual addiction treatment, as well as long-term support to

address social drivers of health such as stable housing and employment. Members are paired with a clinician, care advocate and peer coach for wraparound care.

- **CareFirst BlueCross BlueShield** announced the launch of a new WellBeing app that provides members a single point of entry to access CareFirst's suite of wellness tools, including personal health coaching powered by Asset Health, Noom's Weight and Diabetes Prevention Program, as well as on-demand online therapy and emotional wellness services.
- **Horizon Blue Cross Blue Shield of New Jersey and Regence** are both partnering with Equip to offer their members access to the online platform's evidence-based, virtual eating disorder treatment program. A 2022 peer-reviewed study on Equip's model found 80% of users achieved weight restoration goals, and family members felt less burdened taking care of their loved one.

These innovations deliver expanded access to affordable care. Congress can take action to expand telehealth even more:

Permanently extend certain telehealth flexibilities. As policymakers consider a permanent expansion of telehealth pandemic provisions, we recommend flexibility to address the care needs of each community, while enhancing trust and consumer protection against fraud and abuse through HIPAA-aligned privacy protections. To further these goals, BCBSA supports:

- Sections 101 and 102 of the CONNECT for Health Act (H.R. 4189), introduced by Representatives Mike Thompson (D-CA-04) and David Schweikert (R-AZ-01), which remove geographic and originating site restrictions under Medicare, enabling patients to access care in the comforts of their homes regardless of their location.
- In addition, we support sections 301-303 which provide resources, guidance and training for beneficiaries and providers. They also require the Secretary of the Department of Health and Human Services to review and develop quality measures for telehealth.

Prioritize solutions that help expand access to mental health and substance use disorder (MH/SUD) services. While the COVID-19 pandemic compounded existing challenges in Americans' ability to access appropriate MH/SUD treatment, it also spurred the health care system to promote the use of telehealth. This has been an especially effective tool in treating MH/SUD needs, as many Americans are unable to find the behavioral health care support they need. BCBS companies recognize the benefit of telemedicine in expanding consumer access to care when and where they need it, especially to treat MH/SUD. To continue to support these gains, particularly given the workforce and access challenges for MH/SUD services in large parts of the country, BCBSA supports:

- Sections 107 and 108 of the CONNECT for Health Act, which would repeal the six-month in-person visit requirement prior to receiving telemental services and waive telehealth requirements during Public Health Emergencies.
- Section 1 of the Senate Finance Committee's Telemental Health Discussion Draft, led by Senators Ben Cardin (D-MD) and John Thune (R-SD), which removes in-person visit requirements for rural and federally qualified health centers, removes geographic site restrictions,

and provides coverage of audio-only telehealth services when coverage of these services is "reasonable and necessary."

- Sections 7 of the Senate Finance Committee's Telemental Health Discussion Draft, which requires review and reporting on HIPAA-compliant telemental mobile apps.
- Section 107 of Better Mental Health Care, Lower-Cost Drugs and Extenders Act (S. 3430), led by Senators Ron Wyden (D-OR) and Mike Crapo (R-ID), which requires the Centers for Medicare & Medicaid Services to provide information on licensure requirements for telehealth providers, including ways to qualify through interstate licensing compacts.

Consider additional opportunities to expand the ability for patients to access telehealth services. Permanently extending certain pandemic telehealth flexibilities is critical to sustaining the increased access patients have today. However, those flexibilities do not address all access barriers that patients experience. To continue building on the work Congress has done in addressing barriers, BCBSA supports:

- H.R. 6033, Supporting Patient Education And Knowledge (SPEAK) Act of 2023, introduced by Representative Michelle Steel (R-CA-45), which establishes a task force to improve access to health information technology for non-English speakers.
- H.R. 5066, Tech to Save Moms Act, introduced by Representative Nikema Williams (D-GA-05), and Section 9 of H.R. 4605, Healthy Moms and Babies Act, introduced by Representative Buddy Carter (R-GA-01), which include provisions to establish demo programs to expand telehealth services for pregnant and postpartum women in Medicaid.

Conclusion

BCBSA commends the Committee for holding today's important hearing. We look forward to working with Congress to reduce barriers to care by supporting the expanded use of telehealth. If you have any questions or would like additional information, please contact me or Keysha Brooks-Coley, vice president of advocacy, at [redacted].

David Merritt

Senior Vice President, Policy & Advocacy
Blue Cross Blue Shield Association

THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE (ERIC)

TO THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

"LEGISLATIVE PROPOSALS TO SUPPORT PATIENT ACCESS TO TELEHEALTH SERVICES."

Chairman Guthrie, Ranking Member Eshoo, and Members of the subcommittee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled, "*Legislative Proposals to Support Patient Access to Telehealth Services*." We appreciate the subcommittee's interest in understanding the benefits of telehealth and its value for patients. ERIC supports several policies being considered by the subcommittee during the hearing, and we stand ready to provide our assistance as you work to advance legislation this year.

ERIC is a national advocacy organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and congressional district.

Our work on health policy is focused on driving affordable, high-value coverage for employees by promoting transparency and competition, building and improving markets to lower costs and improve quality, and improving flexibility for employers to innovate and design the best health coverage for their beneficiaries. Telehealth is a critical part of a comprehensive health benefit, and ERIC strongly supports policy changes which enhance the ability of our beneficiaries to obtain the care they need, when and where they need it, affordably and conveniently. Telehealth benefits reduce the need to leave home or work and risk infection at a physician's office, provide a solution for individuals with limited mobility or access to transportation, and have the potential to address provider shortages, especially related to mental health, and improve choice and competition in health care.

Nearly every ERIC member company offers comprehensive telehealth benefits and did so long before the COVID pandemic. As in most aspects of health insurance and value-driven plan design, self-insured employers have been the early adopters and drivers of telehealth expansion. With the onset of the pandemic, ERIC's member companies led the way in rolling out telehealth improvements – held back only by various federal and state government barriers. **ERIC encourages Congress to consider expanding telehealth policies so that those in government health programs as well as those in the private sector can better access virtual care.**

To that end, ERIC supports the subcommittee's interest in important telehealth flexibilities and improvements that could be enacted by the end of this year. Specifically, ERIC urges the subcommittee to support passage of the following bills:

- *Amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services* (H.R. 134), permanently allowing any site to serve as an originating site (i.e., the location of the beneficiary) for purposes of Medicare telehealth services, including a beneficiary's home.

- *KEEP Telehealth Options Act of 2023* (H.R. 1110), requiring the Centers for Medicare & Medicaid Services (CMS) to report on telehealth expansion under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) during the COVID-19 public health emergency and through December 31, 2024.

- *Telemental Health Care Access Act* (H.R. 3432), eliminating certain restrictions such as geographic location of the originating site and in-person requirements related to Medicare coverage of mental health services that are provided through telehealth.

- *Expanded Telehealth Access Act* (H.R. 3875), expanding the scope of providers eligible for payment for telehealth services under Medicare such as audiologists, occupational therapists, qualified speech language pathologists, and others.

- *CONNECT for Health Act of 2023* (H.R. 4189), allowing CMS to waive certain restrictions related to the types of technology that may be used for telehealth visits and allowing telehealth visits to take place at the patient's home.

- *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* (H.R. 5541), temporarily authorizing the interstate provision of mental health telehealth services during a declared national emergency by credentialed providers.

- *Supporting Patient Education And Knowledge (SPEAK) Act of 2023* (H.R. 6033), requiring the Secretary of Health and Human Services to form a task force focused on best practices for providing telehealth services to people with limited English proficiency.

- *Equal Access to Specialty Care Everywhere (EASE) Act of 2024* (H.R. 7149), requiring the Center for Medicare and Medicaid Innovation (CMMI) to test a model through the use of digital modalities to improve access to specialty health services for certain Medicare and Medicaid beneficiaries.

- *The Telehealth Modernization Act of 2024* (H.R. 7623), extending Medicare telehealth flexibilities, allowing for audio-only telehealth visits, and expanding the types of practitioners who can provide telehealth services to Medicare beneficiaries.

- *Amend title XVIII of the Social Security Act to make permanent certain telehealth flexibilities under the Medicare program* (H.R. 7711), eliminating certain in-person requirements for certain services that are telehealth visits.

- *Telehealth Enhancement for Mental Health Act of 2024* (H.R. 7858), establishing requirements to include a code or modifier on mental health service claims furnished through telehealth.

- *The PREVENT DIABETES Act* (H.R. 7856), establishing a diabetes prevention program for eligible Medicare beneficiaries.

- *Require the Secretary of Health and Human Services to issue guidance on furnishing behavioral health services via telehealth to individuals with limited English proficiency under Medicare program* (H.R. 7863), requiring the Secretary to issue best practices for providers, integrating digital platforms, and teaching patients with limited English proficiency.

- *Hospital Inpatient Services Modernization Act,* extending Acute Hospital Care at Home waiver flexibilities.

There are other important telehealth policies that are not before the subcommittee today, but nevertheless warrant the attention of its members and passage by Congress this year. Specifically, while the committee already voted favorably to report out the *Telehealth Benefit Expansion for Workers Act of 2023* (H.R. 824) Congress has not yet taken up this measure. This bill would allow employers to offer standalone telehealth benefits to millions of individuals who are not enrolled in the employer's full medical plan, such as part-time workers, interns, seasonal workers, persons on a waiting period, and others, by removing barriers presented under current law, such as the *Affordable Care Act* (ACA). Additionally, we implore the subcommittee to consider legislation to create national license reciprocity for telehealth providers, which would greatly expand patients' access to providers, especially mental health providers, who are in great shortage throughout the country.

Thank you for this opportunity to share our views with the subcommittee. ERIC and our member companies are committed to working with Congress to expand and improve telehealth for millions of patients in the private sector, and to defeat proposals that would impose government mandates that make the situation worse, not better. We urge Congress to enact these and other telehealth policies this year.

National
Multiple Sclerosis
Society

April 9, 2024

The Honorable Cathy McMorris Rodgers
Chair
Energy and Commerce Committee
2188 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chair
Subcommittee on Health
Energy and Commerce Committee
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
272 Cannon House Office Building
Washington, DC 205

Dear Chairwoman McMorris Rodgers, Ranking Member Pallone, Chairman Guthrie and, Ranking Member Eshoo:

Thank you for the opportunity to express our support for extending and expanding access to telehealth for Medicare beneficiaries. The National Multiple Sclerosis (MS) Society (Society) is pleased to see the Committee focusing on legislative solutions to support patient access to telehealth, which has become a key component of comprehensive, quality healthcare for people living with MS.

MS is an unpredictable disease of the central nervous system. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. An estimated one million people live with MS in the United States. Currently, there is no cure but access to comprehensive healthcare services is critical to minimize disability and achieve the best health outcomes for people with MS. Decisions about how to receive care—in an office setting or via telehealth—should be made through a shared decision-making process between a healthcare professional and patient. Effective, high-quality care along with research into MS combine to make significant progress towards a world free of MS.

The Society, founded in 1946, is the global leader of a growing movement dedicated to creating a world free of MS. To fulfill this mission, we fund cutting-edge research, drive change through advocacy, facilitate professional education, collaborate with MS organizations around the world, and provide services designed to help people affected by MS move their lives forward.

You will be hearing the testimony of Jeanette Ashlock, an MS Activist from Virginia who lives with MS and has greatly benefited from telehealth access. Jeanette will be speaking to how telehealth has allowed her to manage her chronic health condition and improve her health, saying:

> *I am among the many people living with MS who can manage their disease, and maintain their quality of life, because of the care I receive from a network of healthcare providers. Since*

Medicare removed many of the restrictions around telehealth, my ability to use telehealth for some of my care needs has become absolutely essential to me. I have used it for appointments with my primary care provider and some of my specialists, including my OBGYN. I have been able to talk to my providers for follow-up visits, for example after having lab work done, and to talk through new health issues as they come up. Many times, I've called and been told that I can't get an in-person visit for months, but I can get a quick telehealth visit right away. I've been able to stay on-schedule with my visits, and bring up issues right away, so I can prevent them from becoming more serious down the road.

Like many people with MS, I deal with some cognitive issues, including some memory problems—and it gets worse when I experience stress. But when I am doing a telehealth visit from my home, I am able to sit at my own kitchen table in front of my computer and have my pen and paper with my questions written down nearby, and I am so much more prepared. I am able to describe every symptom, and remember every single question I meant to ask, and take really good notes, instead of having to memorize what my providers are sharing with me. I am also better able to manage my fatigue when I can do visits from home, rather than driving to and from in-person appointments.

Telehealth may help increase access to high-quality neurology care, which is critical for ensuring the best possible health outcomes for people living with MS.

Multiple sclerosis is a complex, unpredictable disease of the central nervous system that requires specialized training in neuroimmunology for accurate and timely diagnosis and treatment. There is no test that can be performed to confirm a diagnosis of MS. The diagnosis of MS is a process of elimination that requires a skilled clinician with extensive neurological acumen.

In addition to an early and accurate diagnosis, timely treatment with an MS disease-modifying therapy (DMT) has been shown to effectively minimize relapses, slow disease progression and result in better health outcomes.[1] Access to quality, comprehensive and personalized healthcare for diagnosis and treatment is essential for the best possible quality of life.

When a person with MS seeks access to a neurology provider, either in-person or via telemedicine, they may be discussing:

- Strategies for managing the disease, often through the use of disease-modifying therapies (DMTs);
- Side effect and safety monitoring required for DMTs, often through lab tests and magnetic resonance imaging (MRI);
- Assessing and treating relapses;
- Managing symptoms;
- Promoting function through rehabilitation;
- Lifestyle modifications, like healthy food choices, exercise and smoking cessation; and
- The impact MS is having on their work, family and social life.

[1] Cerqueira JJ, Compston D a. S, Geraldes R, et al. Time matters in multiple sclerosis: can early treatment and long-term follow-up ensure everyone benefits from the latest advances in multiple sclerosis? *Journal of Neurology, Neurosurgery and Psychiatry*. 2018;89(8):844-850. doi:10.1136/jnnp-2017-317509

There are more than 20 DMTs approved by the U.S. Food and Drug Administration (FDA) for MS. Staying current on best practices in treating MS is challenging and requires a clinician who can dedicate time to be educated on the latest evidence. Each DMT has its own risk profile and requires knowledge of the strategies to mitigate those risks and the infrastructure to implement those strategies. Access to high-quality neurospecialty care is a crucial component of the high-quality care that people with MS need to achieve their best lives.

The use of telehealth in MS clinical practice has the potential to increase timely access to care, especially for individuals living in rural areas, people living with a disability or those who are experiencing health disparities.

A 2013 study supported by the American Academy of Neurology demonstrated that the demand for neurologists in the United States will grow faster than the supply of new neurologists. By 2025, it is projected that the United States will need 19% more neurologists than there will be in practice.[2] People with MS see the effects of this shortage of neurologists today and it creates a critical barrier to necessary neurologic care across the country, particularly in certain geographic areas.

The Society confirmed these projections in a recent study that explored spatial access to neurologists and MS specialty care. Our data revealed that almost a quarter (23%) of the United States population are living in MS specialist deserts—areas with inadequate access to quality healthcare services. In these counties, people with MS cannot reach an MS specialist in less than an hour. In addition, the Society's data demonstrated that more than half (59%) of all U.S. counties do not have a neurologist located within county lines.[3] The Society believes that extending flexibilities for telehealth has the potential to enhance timely access to specialized care.

For those individuals with MS living in rural areas with a low number of MS specialists, barriers to care related to travel can be significant.[4] These barriers can include: the actual time to travel to and from a physician visit, the cost of gasoline for a vehicle, taking time off work (either paid or unpaid), overnight lodging, and even airfare by the patient and potentially by a needed care partner. Research about the use of clinic to in-home telehealth in people with MS showed that the use of telehealth greatly reduced these burdens for people affected by MS. Additionally, this study demonstrated that telehealth visits avoided three people with MS from being sent to the emergency room, demonstrating not only an improved health benefit for the patient, but overall savings to the healthcare system.[5]

Evidence demonstrates the impact persistent health disparities have on access to care and health services. To mitigate these disparities, telehealth is helping to increase access and improve health outcomes in marginalized populations, including racial and ethnic minority groups and those residing in rural areas. Inequitable access to neurological care has been reported for Black and Hispanic individuals,

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[2] American Academy of Neurology: Neurology Resources | AAN. https://www.aan.com/PressRoom/Home/PressRelease/1178#:~:text=The%20study%20found%20that%20the%20estimated%2016%2C366%20US%20neurologists%20is,see%20a%20neurologist%20are%20increasing.

[3] Barnola1, A; Fiol1, J; Snyder, M; Khatri, V; Daggitt, M; Rhea Rijhsinghani, R; VerValin, J; Martonik, R; Amezcua, L. The Identification and Characteristics of Neurological and Multiple Sclerosis Care Deserts across the United States. Americas Committee for Treatment and Research in Multiple Sclerosis (ACTRIMS) Forum 2024. Palm Beach, FL. 2024.

[4] Lin CC, Callaghan BC, Burke JF, et al. Geographic variation in neurologist density and neurologic care in the United States. *Neurology*. 2021;96(3). doi 10.1212/wnl.0000000000011276

[5] Bove R, Garcha P, Bevan C, Crabtree-Hartman E, Green AJ, Gelfand JM. Clinic to in-home telemedicine reduces barriers to care for patients with MS or other neuroimmunologic conditions. *Neurology® Neuroimmunology & Neuroinflammation*. 2018;5(6). doi:10.1212/nxi.0000000000000505

rural communities, uninsured individuals, individuals living with a disability, and those with low socioeconomic status.[67] An increase in disease burden, greater disease severity and overall disability, and faster onset of disease progression have been reported for Black and Hispanic individuals living with MS. [8] Social determinants of health such as a lack of access to health insurance, lower education, lower employment rates, and transportation issues may impact health outcomes for people living with MS.[9] Additionally, the Society's analysis of spatial access to neurospecialty care showed that access to a neurologist increases with urbanicity, with 97% of individuals in urban areas having full access compared to only 13% of those in rural counties. One-quarter of the U.S. population is living in MS specialist desert counties, most of which are rural counties. Research has shown that teleneurology is a valuable tool for populations with transportation issues, those with limited access to neurological care in rural areas, and for individuals in urban areas with restricted access to specialty care.[10]

> *Morgan in Washington shares that telehealth has been a huge part of her MS treatment. "My family and I recently moved from Seattle to a new city and seeking a MS neurologist has been a challenge. Thanks to telehealth I have been able to stay connected with my MS doctor in Seattle at University of Washington. I am so grateful for telehealth as I continue to receive incredible medical care*."
>
> *Laura, a person living with MS in Virginia shared: "I am so thankful for telehealth as it has lifted enormous amounts of anxiety out of my life." Laura travels to the Shephard Center in Atlanta once a year to see her MS specialist but follows up throughout the year with her neurologist through telehealth. "Telehealth has been a massive blessing in my life," Laura said, "Otherwise I'd be traveling 8 hours for routine appointments and to get my infusions."*

Telehealth is an important component of any definition of high-quality, affordable access to comprehensive healthcare for people living with MS.

While MS neurological care and access to a DMT are essential to slowing the progression of the disease and long-term health outcomes, people with MS also need care to manage the day-to-day symptoms of MS. MS symptoms are variable and unpredictable. No two people have exactly the same symptoms, and each person's symptoms can change or fluctuate over time. MS symptoms can include fatigue, walking (gait) problems, spasticity, vision problems, bladder problems, cognitive problems, depression and emotional problems, and more.

Comprehensive MS care involves the expertise of many different healthcare professionals—each contributing in a unique way to the management of the disease and the symptoms it can cause. People living with MS usually rely on their primary care provider to address many issues, but are also usually

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[6] Summer, L; Schmidt, H; Minden, S; Falkenberg, N; Sun, L; McBurney, R; Loud, S; Wallin, M. 2022: Nov. Use of Telehealth Among People with Multiple Sclerosis Before and During the COVID-19 Pandemic. Telemedicine and e-Health. Vol29, No.8

[7] Amezcua L, Rivera VM, Vázquez TC, Baezconde-Garbanati L, Langer-Gould A. Health disparities, inequities, and social determinants of health in multiple sclerosis and related disorders in the US. JAMA Neurology. 2021;78(12):1515. doi:10.1001/jamaneurol.2021.3416

[8] Dobson R, Rice DR, D'hooghe MB, et al. Social determinants of health in multiple sclerosis. *Nature Reviews Neurology (Print)*. 2022;18(12):723-734. doi:10.1038/s41582-022-00735-5

[9] Dobson R, Rice DR, D'hooghe MB, et al. Social determinants of health in multiple sclerosis. *Nature Reviews Neurology (Print)*. 2022;18(12):723-734. doi:10.1038/s41582-022-00735-5

[10] Wechsler LR, Tsao JW, Levine SR, et al. Teleneurology applications. *Neurology*. 2013;80(7):670-676. doi:10.1212/wnl.0b013e3182823361

referred by their MS physician to other specialists in the community. The goal is comprehensive, coordinated care to manage the disease and promote comfort, function, independence, health and wellness.

In addition to the MS care provider, and the primary care provider, a comprehensive MS care team may also include:

- Rehabilitation specialists, such as physical therapists, occupational therapists, or speech pathologists, who provide interventions to restore or maintain function;
- Mental health specialists, including psychologists and psychiatrists;
- Ophthalmologists and neuro-opthalmologists, who treat visual problems that are related to the nervous system rather than to the eyes themselves; and
- Urologists, for the treatment of urinary system conditions.

The stories and perspectives of people living with MS demonstrate the value of telehealth for allowing people with MS to secure comprehensive care:

> *"Mental health support has been a cornerstone of my health care and self-care and I was so thankful to have a therapist in place who helps me maintain my stress and understand my anxiety" shares Andrea from Iowa. "Being able to continue to see her via telehealth was so important during the pandemic as not only was I dealing with my 'normal' mental health issues but on top of it, I was also working through postpartum depression and increased stress and an increased occurrence of my MS symptoms which included extreme fatigue." Andrea goes on to share: "I truly appreciate the opportunity now to decide if I would like to meet in-person or via telehealth with my therapist, which allows me to conserve my energy and use it where it is needed most, taking care of my two small children."*

Accessing healthcare providers and treatments, and managing one's healthcare, can represent an enormous amount of time and energy for people living with MS, and their care partners. Telehealth offers the option of conserving time and energy, in addition to allowing for expedient access to care, and the potential to prevent worsening of some health symptoms or problems.

Telehealth continues to help address health disparities prevalent in the U.S. Studies have reported high usage rates among a range of Medicare beneficiaries, including those in rural and urban areas, beneficiaries under and over age 65, and all races/ethnicities.[11] In fact, telehealth services have been used by more than 30 million Americans on Medicare, as well as by many of the 33 million Americans with High-Deductible Health Plans and Health Savings Accounts.

Effectiveness of and experience with telehealth for people with MS and MS healthcare professionals:

Research studies in the use of telehealth in MS care were underway before the COVID-19 pandemic, allowing for an understanding of telehealth utilization pre- and during the pandemic. These studies conclude that telehealth is an efficient and convenient way to deliver and receive many aspects of MS care, increasing both access and convenience.

A significant proportion of the MS patient population expressed a preference for using telemedicine for at least some of their healthcare across a range of areas including general MS care, mental health

[11] [1] U.S. Department of Health and Human Services Office of Inspector General Data Brief September 2022, OEI-02-20-00522

services, primary care and diet/nutrition services.[12] People with MS find that using telehealth helps them manage various health appointments, as well as manage their MS symptoms, limit their or a care partner's time away from work and minimize travel time to and from appointments. For those with debilitating fatigue, traveling a distance to a medical appointment may mean that the individual is not able to do anything else that day. People with cognitive challenges say they are better able to relax and focus in the comfort of their own home, as opposed to a medical facility.

> *Jackee in New Jersey shared that telehealth is an innovative and effective way for her to live well and stay active. Jackee uses a power wheelchair on a daily basis and faces mobility challenges when she tries to gain access to inaccessible healthcare facilities. Telehealth is always accessible for Jackee, and she doesn't have to worry about inclement weather, if her mobility van needs repair or driving 90 minutes each way to her doctor's office.*

In a survey of MS healthcare providers across a number of disciplines (neurologists, advanced practice providers, social workers, rehabilitation providers and mental health providers) 93% of respondents were very or somewhat satisfied with their most recent telemedicine visit, with nearly 75% saying they would definitely like to continue using telemedicine.[13] Providers reported benefits including increased access to services and specialists for patients, convenience for providers, better interactions with patients and greater convenience for patients. In qualitative interviews that were done, health care providers noted the benefits of seeing their patient's home environments and that it was easier for caregivers or family members to attend the visits. Finally, 94% of MS healthcare providers and 81% of people with MS reported they want to continue using telehealth after the COVID-19 pandemic.[14][15]

Telehealth is effective in managing chronic conditions and comorbidities.

While there may be claims that expanding telehealth costs money due to increased healthcare utilization, research has demonstrated that telehealth can be a cost-effective tool in managing both chronic conditions and comorbidities. Effective management can lead to long-term savings by preventing worse health outcomes. Additionally, following the initial cost of technology adoption, telehealth visits should be cheaper than in-person visits and create savings in the long term. The Society believes that any cost assumptions related to telehealth and healthcare utilization should also factor in savings from prevention of worsening health outcomes, as well as the benefits of effective monitoring and addressing healthcare challenges early. The benefits of telehealth are clear, and the Society believes that ensuring access to virtual visits is worth federal investment.

As with many chronic health conditions, comorbidities are common for people with MS. Comorbidities are additional health conditions that may be present and can add complexity to care and achieving optimal health outcomes. Comorbidities in MS are associated with higher relapse rates, greater physical

[12] Summer, L; Schmidt, H; Minden, S; Falkenberg, N; Sun, L; McBurney, R; Loud, S; Wallin, M. 2022: Nov. Use of Telehealth Among People with Multiple Sclerosis Before and During the COVID-19 Pandemic. Telemedicine and e-Health. Vol29, No.8

[13] Keszler P, Maloni H, Miles ZJ, Jin S, Wallin MT. Telemedicine and Multiple sclerosis: A survey of health care providers before and during the COVID-19 pandemic. *International Journal of MS Care*. 2022;24(6):266-270. doi:10.7224/1537-2073.2021-103

[14] Keszler, P; Maloni, H; Miles, Z.; Jin, S.; Wallin, M. George Washington University, VA Multiple Sclerosis Center of Excellence-East. (2021, Feb. 25). Telehealth Utilization and Perceptions of Multiple Sclerosis Health Care Providers. ACTRIMS 2021 Forum. https://www.abstractsonline.com/pp8/#!/9245/presentation/197

[15] Wallin, M, personal communication, 2021, March 4. Preliminary Data: 2020 Patient Telehealth Satisfaction Survey.

and cognitive impairments, lower health-related quality of life, and increased mortality.[16] Common MS comorbidities include hypertension, high cholesterol, diabetes and depression. Published studies indicate that telemedicine is a useful tool for disease management, including a study that looked specifically at literature on hypertension, diabetes and rheumatoid arthritis management.[17]

The National Multiple Sclerosis Society supports legislative solutions to extend and expand access to telehealth.

Since 2020, Congress and the Trump and Biden Administrations have significantly increased access to telehealth by waiving restrictions and broadening which services are covered. As a result, many providers and patients across the MS community have embraced telehealth.

The Society's current telehealth policy priorities include:

- **Extend and protect access beyond December 2024:**
  The Society is supportive of many of the legislative provisions under consideration that would extend existing telehealth flexibilities and coverage, as well as proposals to make reasonable expansions of telehealth access. The Society supports both the CONNECT for Health Act, as well as the Telehealth Modernization Act, and provisions within several of the other bills that are the subject of this hearing. At a minimum, the Society strongly urges Congress to extend existing access to telehealth beyond the end of calendar year 2024 for Medicare beneficiaries.

- **Inclusion of a variety of providers covered by these flexibilities (including behavioral health providers):**
  The Society is supportive of the progress made to allow greater access to more types of healthcare providers, for more types of services and treatments. Of particular importance for people with MS is the access to behavioral health providers, due to the high comorbidity of MS and mental health issues. Depression in its various forms is one of the most common symptoms of MS. Studies have suggested that clinical depression is more frequent among people with MS than it is in the general population, with a lifetime risk for a major depressive disorder of 60%. Anxiety—commonly coupled with depression—is three times more common in people living with MS.[18] Left untreated, depression and anxiety reduce the quality of life and may worsen existing symptoms. As a result, the impact of these mental health symptoms can impact critical aspects of cognitive functioning in MS, including working memory, processing speed, abstract reasoning, and executive functioning.[19] Due to this need for access to behavioral health providers, and the ongoing nationwide critical shortage of behavioral health providers currently taking patients, telehealth is an important tool that helps bridge the gap to mental healthcare for people with MS and others.

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[16] Marrie, RA; Fisk, J; Fitzgerald, K. Etiology, effects and management in comorbidities in multiple sclerosis: recent advances. *Front Immunol*. 2023; 14: 1197195. Published online 2023 May 30. doi: 10.3389/fimmu.2023.1197195

[17] Ma Y, Zhao C, Zhao Y, et al. Telemedicine application in patients with chronic disease: a systematic review and meta-analysis. *BMC Medical Informatics and Decision Making (Online)*. 2022;22(1). doi 10.1186/s12911-022-01845-2

[18] Σκώκου M, Soubasi E, Gourzis P. Depression in Multiple sclerosis: A review of assessment and treatment approaches in adult and pediatric populations. *ISRN Neurology (Print)*. 2012;2012:1-6. doi:10.5402/2012/427102

[19] Silveira C, Guedes R, Maia D, Curral R, Coelho R. Neuropsychiatric symptoms of multiple sclerosis: state of the art. *Psychiatry Investigation (Seoul Print)*. 2019;16(12):877-888. doi:10.30773/pi.2019.0106

- **Allow FQHCs and Rural Health Clinics to be considered originating sites:**
  As an important safety net of providers, FQHCs and Rural Health Clinics (RHCs) are a critical resource for low-income populations living in underserved rural and urban areas, by providing access to comprehensive primary and preventative care services, employing interdisciplinary teams and patient-centric approaches, delivering care coordination, and encouraging collaboration with community resources. The Society urges the Committee to continue to allow FQHCs and RHCs to serve as originating sites for telehealth-delivered services (including non-behavioral-health services), beyond the end of 2024.

  People living with MS are among the over 9.6 million rural residents served by a health center program. This access to services is crucial to those with MS living in rural areas—who are facing the aforementioned barriers to care and experiencing health disparities. Telehealth benefits individuals living with neurological conditions like MS cared for in RHCs by facilitating timely connection with specialty care. Additionally, telehealth services may reduce patient transfers and ultimately help tertiary care centers by keeping beds open for patients in need of critical care.[20]

- **Extend audio-only flexibilities:**
  Offering the option of audio-only services is critical for providing appropriate care for each patient and situation, and decreasing barriers to care. Without access to audio-only services, those with limited or no access to broadband services may not be able to use telehealth as an effective means of care. Highlighting this need is data from the Federal Communications Commission (FCC) that 7.2 million locations in the U.S. lack access to high-speed internet service[21]. Additionally, for patients with cognitive symptoms or for whom ever-evolving technology provides significant challenges, audio-only care may be the only viable option in accessing telehealth services.

- **Ensure that telehealth policy increases access to healthcare:**
  The past few years have demonstrated that telehealth is valued by both patients and healthcare providers, and has great potential to increase access to needed healthcare. As legislative solutions are considered, we urge the committee to ensure that these solutions do not create barriers for access to care. Examples of barriers include strict provisions on originating sites, requiring an in-person visit as a blanket policy when it may not make sense for the individual patient or physician, and prohibiting telehealth if a patient is not in the same state (which is especially problematic for established patients or care areas of documented shortages). For example, a proportion of the Medicare population may live in warmer climates during the winter months, returning to their permanent residences in warmer parts of the year. It is unrealistic to believe they would not require care during this time period, or would be easily able to find a new specialist for just a few months. Additionally, the challenges related to finding any mental health care provider is well-documented. This difficulty is even more pronounced when searching for a mental health provider who is knowledgeable about MS, so the provider can understand when mental health challenges may be directly related to the disease itself.

[20] Telehealth use in rural Healthcare Overview - Rural Health Information Hub.
https://www.ruralhealthinfo.org/topics/telehealth#:~:text=Telehealth%20allows%20small%20rural%20hospitals%20and%20clinics%20to,to%20travel%20long%20distances%20to%20access%20specialty%20care.
[21] National Broadband Map 3.0: Thankful for continued improvements. Federal Communications Commission. Published November 17, 2023.
https://www.fcc.gov/news-events/notes/2023/11/17/national-broadband-map-30-thankful-continued-improvements

Conclusion

Once again, the Society is thankful to the leadership and members of this Committee for holding this hearing, hosting this important conversation, and advancing meaningful legislation to secure telehealth access for millions of Medicare beneficiaries. People with MS are among those who have benefited from the removal of restrictions on telehealth during the pandemic, and the flexibilities that allowed them to gain new and meaningful access to care via telehealth. People with MS are also among those who have found that telehealth has many benefits: it plays a role in helping prevent health symptoms or conditions from getting worse, it helps optimize their health, and thus can creates savings for them and for the health system overall. For those with a chronic health condition such as MS, accessing care via telemedicine can help mitigate some of the issues that arise related to the symptoms of their disease—a value that cannot be overstated.

The National MS Society believes that the patients and their providers should continue to have the choice whether to meet in-person or use telehealth when appropriate, far beyond the end of this calendar year. Lauren from Indiana describes how valuable telehealth is for optimizing her health and living well:

> *"Thanks to telehealth, I have been able to continuously access healthcare in several different domains, challenging personal schedule, and the extreme fatigue and body aches that MS often leaves me with. Whether it's talking to my neurologist about new symptoms, to my therapist about managing MS on top of managing all of the other stressors that comes with being in your 20s, or with my PCP when I feel generally unwell." Lauren feels fortunate to have the opportunity to seek care in a way that just a decade ago would have seemed unfathomable.* ***"Telehealth has been undoubtedly transformative for me and others who struggle to balance daily living with our demanding health needs."***

We thank this Committee for prioritizing these policies, which can have an enormous impact on people's health outcomes, and for inviting Jeanette Ashlock to tell her story to shed light on this important issue.

If you have any questions, please direct your staff to contact Bryant Robinson at [redacted].

Respectfully,

Bari Talente

Bari Talente
Executive Vice President, Advocacy and Healthcare Access
National MS Society

PAN Foundation

1032 15th Street, NW, Suite 413,
Washington, DC 20005

Statement for the Record:

"Legislative Proposals To Support Patient Access To Telehealth Services"

House Energy and Commerce Committee

April 10, 2024

The Patient Access Network Foundation (PAN Foundation), appreciates the opportunity to submit testimony for the hearing *Legislative Proposals To Support Patient Access To Telehealth Services*. The PAN Foundation is a national patient advocacy organization and charitable foundation that for two decades, has been dedicated to helping underinsured people living with life-threatening, chronic, and rare diseases get the medications and treatments they need by assisting with their out-of-pocket costs. Additionally, through our national and grassroots efforts, we advocate for improved affordability and access to care. Since 2004, we have provided more than 1.1 million underinsured individuals with $4 billion in financial assistance.

Telehealth services provide access to healthcare and should continue to be an option, particularly for those in rural and underserved areas. We urge the Committee to ensure the Medicare telehealth services initially provided during the public health emergency are maintained and made permanent.

As you are aware, telehealth can help expand access to care and maintain continuity of care for patients. For people with Medicare, access to telehealth services is especially important. From July to September 2020, 15.1 million people with Medicare had a telehealth visit with a doctor or other healthcare professional, according to the Kaiser Family Foundation—nearly half of beneficiaries whose providers offered telehealth services. A federal report found that older adults and individuals from underserved communities benefited the most from expanded telehealth access during the COVID public health emergency. Since 2021, Medicare beneficiaries telehealth utilization has stabilized at 15 percent demonstrating the integration of telehealth into care delivery.

COVID telehealth flexibilities should be made permanent to include expanding coverage of telehealth services, removing barriers to access such as geographic restrictions, expanding originating sites to include a patient's home and other clinically appropriate sites, and removing unnecessary in-person visit requirements for tele-mental health services.

It is also important to allow the use of audio-only equipment for a wide range of Medicare services, to ensure that telehealth is accessible to underserved groups. Audio-only visits will ensure that those in areas with limited or no broadband won't lose access to critically needed services. Among Medicare beneficiaries who had a telehealth visit, 56 percent reported accessing care using a telephone only. Among Medicare beneficiaries who are over 75, live in

rural areas, identify as Hispanic, or have Medicare and Medicaid, a majority reported using audio-only telehealth services.

Specifically, the PAN Foundation supports the following bills being discussed in today's hearing:

- Creating Opportunities Now for Necessary and Effective Care Technologies for Health Act or the CONNECT for Health Act (H.R. 4189) that permanently removes geographic and originating site restrictions and provides HHS authority to waive telehealth restrictions in statute.

- Telehealth Modernization Act (H.R. 7623) that permanently removes geographic restrictions on originating sites, allows the home of the beneficiary to serve as the originating site for all services, allows federally qualified health centers and rural health centers to furnish telehealth services, and coverage of audio-only telehealth services.

- Telemental Health Care Access Act (H.R. 3432) to remove in-person requirements for mental health services.

Further we are concerned that the Drug Enforcement Administration (DEA) has yet to issue regulations continuing the teleprescribing of controlled substances. The PAN Foundation joined 214 organization in letter urging DEA to expedite the release of a revised proposed rule. There needs to be sufficient time for a comment period and to finalize the rule before the flexibilities expire on December 31, 2024. Otherwise, patients will fall through the cracks and lose access to medications critical to maintaining their health. We recommend the Committee urge DEA to issue a proposed rule expeditiously.

Once again, the PAN Foundation urges the Committee to 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 by the provider or patient.

Please don't hesitate to contact Amy Niles, Chief Advocacy and Engagement Officer at [redacted] if you would like further information.

Thank you again for your time and attention to these important matters.

Statement for the Record

House Committee on Energy and Commerce

Subcommittee on Health

Hearing on, "Legislative Proposals to Support Patient Access to Telehealth Services"

April 10, 2024

About Transcarent
Transcarent was founded to change the healthcare status quo and offer greater choice and control for those that pay for care, including healthcare consumers (our Members) and employer-sponsored group health plans.

As the One Place for Health and Care, Transcarent supports self-insured employers by making it easy for people to access high-quality, affordable care. With a personalized app tailored for each Member, an on-demand care team, and a connected ecosystem of high-quality, in-person care and virtual point solutions, Transcarent eliminates the guesswork to guide Members confidently to the right level of care. Transcarent Members have access to care through the clinicians in Transcarent's affiliated virtual clinic as well as from high-quality providers in their local communities.

Transcarent is committed to helping employers and their employees cut through the complexity of the healthcare system and the benefits landscape. We believe that properly aligned incentives and easy access to high-quality care is the foundation for accomplishing this. It results in a measurably better experience, improved health, and lower costs for individuals and their employers.

As evidenced during the COVID-19 pandemic, virtual care and telehealth were critical for millions of Americans and have proven to be an invaluable tool to ensure ongoing access to high-quality, affordable care. Data supports the value of telehealth and virtual care services for all Americans. Increased flexibility and enhanced access mean increased preventive care and early detection, translating to earlier treatment of conditions, and mitigating the need for higher acuity care.

The Transcarent Clinic
Through the Transcarent Clinic, Transcarent's affiliated virtual clinic, Members receive on-the-go high-quality care on their terms for their most frequent and fundamental health needs through the ability to immediately chat with a doctor via text or video. By removing wait times and giving them the answers they need when they need them, we're helping Members avoid costly and inefficient emergency department and urgent care visits.

Personalized support during and between visits makes it easier for Members to stay on top of preventive care screenings, referrals, and post-visit care. Additionally, our flexible, discreet chat or video modalities enable Members to access care without the need for a quiet place.

While some may question the value of virtual care encounters, the Transcarent Clinic is proving time and again that our clinicians are providing high-quality care while saving consumers and employers on their healthcare expenses. When we say "high-quality" we mean it. Here's one example. Transcarent's antibiotic stewardship commitment includes an active review of our prescribing practices and auditing of visits with antibiotic prescriptions. This explains why our antibiotic prescription rate is 22.8 percent as compared to the national benchmark of 37 percent[1] and our steroid prescription rate is just .36 percent compared to

[1] mHealth Intelligence, https://mhealthintelligence.com/news/vendor-affiliated-telehealth-providers-prescribe-antibiotics-more-often

the national benchmark of 11.8 percent[2]. Despite the presumption that less prescriptions correlate to unsatisfied patients, 96 percent of our Members rated the Transcarent Clinic with 5 stars for a 4.8/5 satisfaction rating.

We are also actively saving consumers and employers costs while still achieving great outcomes. Here are some examples:

- $263 cost reduction per visit based on average cost for alternative options and Member utilization of virtual primary care[3]
- 93 percent resolution rate for virtual clinic visits[4]
- 45 percent reduction in emergency room (ER) and urgent care visits[5]

Overarching Policy Priorities

There are several general policy principles we believe Congress should consider to ensure that more Americans can reliably access telehealth and virtual care services, when and how they need them.

Transcarent believes:

- Telehealth policies should be modality-neutral, allowing the patient and their physician to determine if a particular modality meets the standard of care.
- Physicians should be able to practice telehealth across state lines.
- Telehealth and virtual care should improve health inequities and accessibility of healthcare, including for those who are not native English speakers.
- Employers should be able to offer telehealth as an excepted benefit to part-time and seasonal workers, as well as those not on their group health plan as a means to expand access to high-quality, affordable care.
- Employers should continue to be allowed to offer telehealth and virtual care services to those on high-deductible health plans (HDHPs) without requiring individuals to first meet their deductible.

Modality-Neutral Approach

The modality (video, audio-only, text-based) used to deliver care should be determined by the patient and their physician and should be held to the same standard of care as services provided in-person. Telehealth should not be limited to any specific technology if it is safe, effective, appropriate, and able to be fully integrated into clinical workflows.

The growth of text-based care, which, with the right systems and tools, is broadening access to telehealth and virtual care as not everyone has real-time video capabilities due to lack of broadband or the lack of a private space in which to speak with a physician, but access to text is common with 97 percent of Americans owning a cellphone[6]. When we asked people delivering packages, stocking shelves, and working in factories 'what worked best for them,' they all said the same thing: make it simple to use, make it fast, and make it available whenever I want it. At Transcarent, that means you can access care on your phone, by text, with no wait times, 24 hours a day, 365 days a year.

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[2] Centers for Disease Control and Prevention (CDC), https://www.cdc.gov/antibiotic-use/stewardship-report/2020.html

[3] Determined using alternative care responses, Post-visit survey, Mar 2021 - Mar 2023

[4] Transcarent Book of Business

[5] Transcarent Book of Business

[6] Pew Research, https://www.pewresearch.org/internet/fact-sheet/mobile/

Congress should not seek to predefine how care is delivered; instead, this should be left to the physician to determine if the standard of care can be met using a particular modality.

Licensure Portability
Congress should act to ensure that access to care and care continuity are not hindered simply based on the physician and patient being in different states. Federal, and state, policies should ensure efficient licensure options exist not just during public health emergencies, but beyond, as workforce shortages and scattered expertise have and will continue to exacerbate health inequity.

Just as a patient may live in one state and drive to a hospital or physician office in another, so too, should patients be able to see their physician virtually regardless of where they live. This is especially valuable for ongoing relationships with specialists or surgeons after a procedure or treatment that may have warranted significant travel but can more efficiently be maintained through virtual follow-ups.

Improving Health Equity and Accessibility
It is important to ensure that all healthcare services are not just high-quality and affordable but are also accessible for all who need them, regardless of what language they speak. Transcarent supports the SPEAK Act (H.R. 6033,) to improve healthcare technology, including telehealth and other consumer resources for non-English speakers.

Telehealth as an Excepted Benefit
Transcarent strongly supports the bipartisan legislation the Committee advanced in 2023 that amends the Public Health Service Act, Employee Retirement Income Security Act (ERISA,) and the Internal Revenue Code of 1986 to treat telehealth services as excepted benefits, the Telehealth Benefit Expansion for Workers Act (H.R. 824.)

The bill would allow employers to continue to offer workers stand-alone telehealth benefits, similar to a dental and vision plan, and onsite medical clinics, in addition to traditional healthcare plans. If enacted, it would build upon ERISA to enable all workers, including part-time and seasonal workers, to access telehealth benefits. This bill would be a continuation of the pandemic policy established by the Departments of Labor, Health and Human Services (HHS) and Treasury 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 public health emergency.

Because this flexibility was not extended in a timely fashion, access to telehealth for some workers is no longer available. As H.R. 824 continues to make its way through the legislative process, interim action is needed so that access to critical telehealth services can be restored. We encourage the Committee to advocate for the inclusion of a multiyear extension of the PHE (Public Health Emergency) non-enforcement policy in the next health-related package that moves through Congress.

Pre-deductible Telehealth Coverage
We encourage Congress to swiftly enact The Telehealth Expansion Act (H.R. 1824) to deliver more high-quality, affordable care to hardworking Americans ahead of its scheduled expiration at the end of 2024. Reaching the deductible threshold of at least $1,600 for an individual and $3,200 for a family can create a significant financial strain. Given that more than half of all private sector workers were enrolled in a high-deductible health plan (HDHP)

in 2021, this policy makes it easier for many American workers to utilize telehealth services that improve ease and access to care and reduce expensive ER and urgent care visits.

The Future of Health and Care Delivery

Telehealth is a proven, high-quality, and cost-effective means to connect Americans to the care they need when they need it. It is a service that is essential for vulnerable populations and the approximately 30 million Americans residing in health deserts[7]. Removing access to this care can serve to exacerbate the current disparities in the accessibility and affordability of health and care for all Americans.

Today, we have more technology at our disposal than ever before. We can bring care into the home, we can facilitate access to world-renowned specialists from one coast to the other, we can better predict individuals at-risk for certain conditions and we can personalize care plans to ensure optimal outcomes. We have the tools to improve access and bend the cost curve, now we need to remove the policy barriers so we can use them. We appreciate the Committee's consideration of the importance of not only continuing but expanding access to high-quality, affordable telehealth and virtual care services for all Americans.

[7] Health Leaders Media, https://www.healthleadersmedia.com/innovation/contributed-content-left-stranded-millions-healthcare-deserts-battle-access-life-saving#:~:text=Gaping%20disparities%20exist%2C%20and%20on,live%20in%20%22healthcare%20deserts.%22

April 9, 2024

The Honorable Diana DeGette
U.S. House of Representatives
2111 Rayburn House Office Building
Washington, DC 20515-4329

The Honorable Gus Bilirakis
U.S. House of Representatives
2306 Rayburn House Office Building
Washington, DC 20515-4329

RE: Support for H.R. 7856, the PREVENT DIABETES Act

Dear Representatives DeGette and Bilirakis:

Thank you for your continued leadership in expanding access to care and championing innovative models that address diabetes prevention and support those Americans living with diabetes. The undersigned organizations strongly support the PREVENT DIABETES Act, which would broaden access to diabetes prevention services by aligning the Medicare Diabetes Prevention Program (MDPP) with the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (DPP), make MDPP a permanent benefit in Medicare, ensure seniors can participate in the program more than once, and expand access to all CDC-recognized delivery modalities including virtual diabetes prevention platforms in the program.

Almost 1 in 3 adults aged 65 and older have diabetes. According to the Centers for Medicare & Medicaid Services (CMS), medical care for seniors with diabetes and its complications cost the U.S. $205 billion in 2022, most of it paid by Medicare. According to the CDC, some 98 million Americans have prediabetes, including 27.2 million who are aged 65 and older. Without a significant course correction, those numbers will only grow.

In 2017, Medicare began covering access to the CDC's National Diabetes Prevention Program through the MDPP. The program's objective is to reduce the incidence of type 2 diabetes by providing beneficiaries with prediabetes access to an intensive program that includes long-term dietary changes, physical activity, and other behavioral changes to reduce the risk of developing type 2 diabetes. These interventions—based on a curriculum developed and approved by CDC and, importantly, furnished by organizations evaluated by CDC—were proven to work during rigorous model testing through the Center for Medicare and Medicaid Innovation (CMMI).

However, MDPP participation has been limited. As of the end of 2022, cumulative MDPP enrollment stood at 4,848 Medicare beneficiaries, which is striking considering more than half a million participate in the CDC's National DPP program when offered through their health plan or employer. Many congressional districts lack in-person MDPP locations to

serve the tens of thousands of at-risk constituents otherwise eligible for these services under Medicare.

We believe one of the most significant factors contributing to low enrollment in MDPP is the lack of alignment with the CDC Diabetes Prevention Recognition Program (DPRP) requirements, including MDPP's restrictions with respect to eligible suppliers and limiting the benefit to in-person programs, which prevents Medicare beneficiaries from taking advantage of the same virtual DPP programs that have greatly expanded access to DPP services under the CDC DPRP.

Your legislation would expand access to life-changing preventative services by taking the lessons learned from the MDPP CMMI Expanded Model and making diabetes prevention program services a permanent benefit within Medicare. Importantly, it would also allow *all* CDC Fully Recognized organizations and modalities of delivery—including organizations already recognized by CDC to furnish DPP services virtually—to participate while keeping important oversight, accountability, and program integrity protections in place.

It is past time that we prevent diabetes before it occurs and thereby minimize its terrible impact on the lives of our nation's seniors and the resulting skyrocketing healthcare costs borne both by seniors and federal health programs. We lend our support to that effort and this important legislation.

Thank you for your leadership.

Respectfully,

American Diabetes Association
American Heart Association
American Medical Association
American Podiatric Medical Association
American Telemedicine Association
Association of Diabetes Care & Education Specialists
ATA Action
Butterfly Network
Connected Health Initiative
Consumer Technology Association
Diabetes Advocacy Alliance
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Eagle Telemedicine
eMed

Endocrine Society
Fabric
Go2Care, Inc
Health Innovation Alliance
Health Recovery Solutions (HRS)
Healthcare Leadership Council
Homeward Health
National Association of Chronic Disease Directors (NACDD)
National Council on Aging
National Kidney Foundation
Nest Collaborative
Noom, Inc.
Northwell Health
Omada Health, Inc.
Ovum Health
Partnership to Advance Virtual Care (PAVC)
Philips North America
Providence
Sanford Health
Teladoc Health
The Global Telemedicine Group
University Hospitals Cleveland
WeightWatchers
YMCA of the USA

AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation

April 10, 2024

The Honorable Cathy McMorris Rodgers
Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chair, Health Subcommittee
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member, Health Subcommittee
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

RE: Reinstating Virtual Access to Cardiopulmonary Rehabilitation Services in the Home

Dear Chairs Rodgers and Guthrie, and Ranking Members Pallone and Eshoo,

Thank you for convening a hearing to examine legislative proposals to support patient access to telehealth services. As you work to advance critical telehealth legislation before the end of the year, we urge you to include the bipartisan ***Sustainable Cardiopulmonary Rehabilitation Services in the Home Act*** **(H.R. 1406)** introduced by Representatives John Joyce (R-PA-13) and Scott Peters (D-CA-50). We greatly appreciate that the Health Subcommittee included this legislation in the October 19, 2023 hearing titled "*What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors*."

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) is a multidisciplinary professional association comprised of health care professionals who serve in the fields of cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR). Members include cardiovascular and pulmonary physicians, nurses, exercise physiologists, physical therapists, behavioral scientists, respiratory therapists, dietitians, and nutritionists. Founded in 1985, AACVPR is dedicated to our mission of reducing morbidity, mortality, and disability from cardiovascular and pulmonary disease through education, prevention, rehabilitation, research, and disease management.

This hearing is an important recognition of the potential for virtual care to improve the overall health of our patients, reduce hospital admissions, and decrease mortality. We note that the bipartisan *Sustainable Cardiopulmonary Rehabilitation Services in the Home Act* (H.R. 1406) would allow Medicare beneficiaries to receive CR/ICR/PR services virtually in their homes through the use of real-time, audio-visual communications technology. This hybrid delivery of hospital-based CR/ICR/PR services was effective during the pandemic and allowed patients to continue to access these beneficial treatments. Unfortunately, patients lost virtual delivery of these services in the hospital setting when the public health emergency (PHE) expired on May 11, 2023. Although Congress, through passage of the *Consolidated*

Appropriations Act, 2023, appropriately ensured that patients maintain access to virtual "telehealth" CR/ICR/PR services through December 31, 2024, this telehealth extension only applies to CR/ICR/PR services provided in physician offices, which represents less than five percent of CR/ICR/PR programs. It is vital that Congress act to maintain this life-saving access to virtual CR/ICR/PR services beyond the COVID-19 pandemic for the >95% of Medicare beneficiaries who access these services in the hospital setting.

Importance of Patient Access to Cardiac and Pulmonary Rehabilitation in the Home

Approximately 16.5% of Medicare beneficiaries have chronic obstructive pulmonary disease (COPD). The common symptoms of chronic lung disease include shortness of breath, fatigue, reduced muscle function, strength and ability to exercise, depression, and anxiety. PR is the standard of care for patients with chronic lung disease and its related symptoms. PR is a comprehensive intervention based on thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and self-management intervention aiming at behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

PR is well established to be an effective therapeutic strategy to improve exercise tolerance, quality of life, breathlessness, and mood. Recent research has shown that Medicare patients who underwent PR within three months following hospitalization for COPD exacerbation had a 37% better survival rate at one year compared to those not attending PR.[1] Despite the evidence supporting the important role PR plays in reducing hospitalization and improving survival, a published study found that two-fifths of Medicare beneficiaries with COPD in a national sample, and eight in nine of those in rural areas, have poor access to PR[2].

Heart disease continues to be the leading cause of death for Medicare beneficiaries. According to the Centers for Medicare and Medicaid Services (CMS), 42% of Medicare beneficiaries aged 65 years and over have at least one heart condition. The Million Hearts Initiative[3] partners federal agencies and organizations such as AACVPR with the goal of raising national CR participation rates to 70% of eligible patients. Currently, less than 25% of Medicare beneficiaries who are eligible for CR attend even one session.

CR involves an individualized and personalized treatment plan, including evaluation and instruction on physical activity, nutrition, stress management, and other health related areas for patients who have experienced a heart attack, angina, cardiac surgery (such as coronary bypass or valve surgery), coronary artery angioplasty or stents, heart failure, or heart transplantation. CR provides patients the opportunity to control heart disease symptoms such as chest pain or shortness of breath, lessen the physical and emotional effects of heart disease, and improve their stamina and strength.

Patients who participate in CR see reduced hospitalizations, decreased emergency department utilization, and lower mortality rates, and scientific studies have shown that people who complete a CR program can

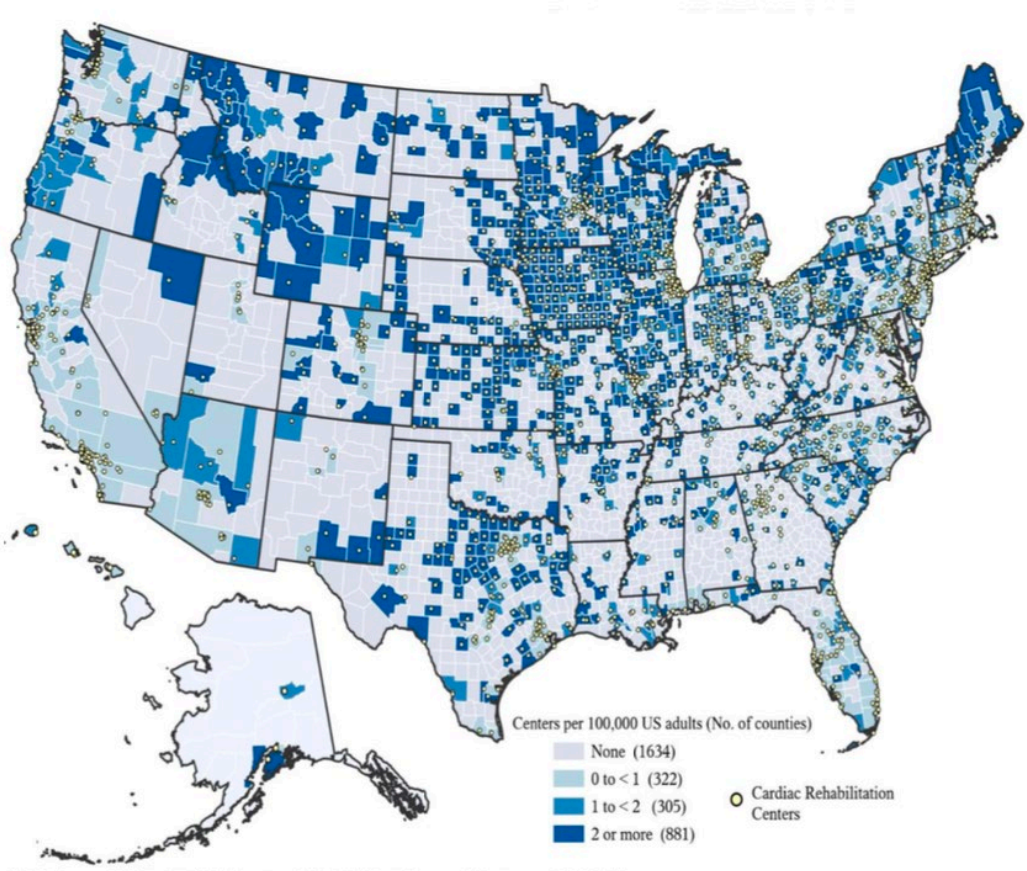
[1] Lindenauer PK, Stefan MS, Pekow PS, et al. Association between initiation of pulmonary rehabilitation after hospitalization for COPD and 1-year survival among Medicare beneficiaries. JAMA. 2020 May 12;323(18):1813-1823. doi: 10.1001/jama.2020.4437

[2] Malla G, Bodduluri S, Sthanam V, Sharma G, Bhatt SP. Access to pulmonary rehabilitation among Medicare beneficiaries with chronic obstructive pulmonary disease. Ann Am Thorac Soc2023;20:516–522

[3] https://millionhearts.hhs.gov/index.html

increase their life expectancy by up to five years. Nevertheless, a recently published article[4] found that "a total of 40 largely urban counties comprising 14% of the United States population age ≥65 years had disproportionately low CR access and were identified as CR deserts." It is estimated that there are a total of 2,351 CR centers in the U.S. – only one center per 100,000 adults.

Cardiac Rehabilitation Center Locations, 2018



In 2018, there were 2,351 cardiac rehabilitation centers in the United States for a rate of 1.0 centers per 100,000 adults.
Sources: American Community Survey 5-year estimate, adults 18+, 2014-2018; American Hospital Association Survey, Cardiac Rehabilitation Center locations, 2018.

Success of COVID-Era Flexibilities and Current Impediments of Access to Virtual CR/ICR/PR Services

During the pandemic, hospitals were allowed to provide some outpatient services through virtual means (real-time, audio-visual communications technology) to Medicare beneficiaries in the home. Hospital-based CR/ICR/PR programs were included in these PHE waivers which proved to be very beneficial since some centers shut down and staff re-deployed due to the pandemic. Beneficiaries living in rural areas or areas without a brick-and-mortar CR/ICR/PR program demonstrated comparable benefits to those patients who participated in center-based CR/ICR/PR programs. Virtual access also benefited patients facing other barriers to consistent participation in their treatment plan, such as those without transportation or the financial means to regularly travel to an in-person CR/ICR/PR center.

[4] J Am Coll Cardiol. 2023 Mar 21;81(11):1049-1060.doi: 10.1016/j.jacc.2023.01.016

When the PHE expired on May 11, 2023, virtual delivery of these services in the hospital setting also ceased to be an option. Congress, through passage of the *Consolidated Appropriations Act, 2023*, appropriately ensured that patients maintain access to virtual "telehealth" cardiac and pulmonary rehabilitation services through December 31, 2024. **However, the current telehealth extension only applies to CR/ICR/PR services provided in physician offices, which represents less than 5% of programs. CMS does not have the authority to allow virtual delivery of hospital outpatient services, including CR/ICR/PR, beyond the expiration of the PHE, necessitating legislative action by Congress.**

Sustainable Cardiopulmonary Rehabilitation Services in the Home Act (H.R. 1406)

The *Sustainable Cardiopulmonary Rehabilitation Services in the Home Act* was introduced in the House of Representatives by Reps. John Joyce, MD (R-PA) and Scott Peters (D-CA), and companion legislation (S. 3021) was introduced in the Senate by Sens. Kyrsten Sinema (I-AZ), Marsha Blackburn (R-TN), and Amy Klobuchar (D-MN). The bill would improve patient access to CR/ICR/PR services by permanently allowing Medicare patients to receive these services via virtual telecommunications technology (real-time, audio-visual) in the beneficiary's home (which would serve as the originating site), wherever the home is located throughout the country, including when those services are furnished by hospitals as distant site providers. Additionally, virtual direct supervision by physicians, physician assistants, nurse practitioners, or clinical nurse specialists would be allowed through real-time, audio-visual communications technology.

In addition to AACVPR, the bill is supported by the American Association for Respiratory Care, American College of Chest Physicians, American College of Cardiology, American Thoracic Society, and the COPD Foundation. Thirty-five patient and provider groups, health systems, and industry organizations have sent a letter[5] in support of the legislation.

Again, we thank the committee for its focus on telehealth and look forward to working with you to ensure that Medicare beneficiaries have access to CR/ICR/PR services, including through home-based rehabilitation. Rehabilitation care only works when done consistently, and patients who do not engage in CR/ICR/PR for extended periods of time are likely to stop rehabilitation all together.

Best regards,

Hank Wu, MD, MPH
President
American Association of Cardiovascular and Pulmonary Rehabilitation

Mollie Corbett

Mollie Corbett
Executive Director
American Association of Cardiovascular and Pulmonary Rehabilitation

CC: The Honorable John Joyce, The Honorable Scott Peters

[5] https://heartrehabcare.org/s/Virtual-CR-PR-Sign-On-Letter-For-Distribution-2024-01.pdf

AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 10, 2024

The Honorable Brett Guthrie
Chairman
House Energy and Commerce Committee,
Health Subcommittee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
House Energy and Commerce Committee,
Health Subcommittee
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, thank you for your bipartisan leadership to address issues impacting family physicians and their patients through today's hearing entitled "Legislative Proposals to Support Patient Access to Telehealth Services."

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.[i] According to a recent AAFP survey, 9 in 10 family physicians practice telehealth today.

The AAFP supports 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.

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 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.

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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. It is with these considerations in mind that the AAFP offers the following policy recommendations in response to today's hearing:

Promoting the Patient-Physician Relationship

Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities and vulnerable populations. As discussed in the Academy's comments 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 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.

In light of these concerns**, the AAFP supports 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 from the Department of Health and Human Services (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 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 appreciates the Committee is considering a bill to permanently remove section 1834(m) geographic and originating site restrictions. The AAFP has advocated for the removal of these restrictions to ensure that all Medicare beneficiaries can continue to access care at home. The COVID-19 pandemic 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 these 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 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.[ii] 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 tele-mental health services will unnecessarily restrict access to behavioral health care. For this reason, **the AAFP strongly urges the committee to pass the Telemental Health Care Access Act (H.R. 3432),** which would remove the statutory requirement that Medicare beneficiaries be seen in-person within six months of being treated for mental and behavioral health services through telehealth.

As acknowledged in the AAFP's comments last year 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-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.[iii,iv,v]

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.[vi] 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.[vii] 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 this 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.[viii]

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.[ix] **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. 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.

Addressing Disparities in Telehealth Access

While the rapid expansion of telehealth has yielded many benefits for patients and clinicians, not everyone has benefited equally. Without sufficient investment and thoughtful policies, telehealth could actually worsen health disparities. For example, individuals with limited English proficiency (LEP) face more pronounced barriers to accessing appropriate care via telehealth and are less likely than patients who speak English fluently to use telehealth. One study showed that patients with LEP are half as likely to use telehealth services. Among proficient English speakers, 12.3 percent used telehealth compared to only 4.8 percent of patients with LEP.[x] In addition, patients with LEP are more likely to have adverse events, especially those attributable to communication failure.[xi]

Therefore, the AAFP is supportive of the *Supporting Patient Education And Knowledge (SPEAK) Act* (H.R. 6033) to create a task force of government officials, telehealth and health care industry experts, and consumer organizations. This taskforce would identify solutions and best practices to aid patients with LEP in accessing telehealth services.

The AAFP has also supported legislative proposals to analyze telehealth utilization and patient outcomes broken down by race and ethnicity, geographic region and income level. We have called for the collection and reporting of this data, as well as data stratified by gender and language, in order to fully understand the impact that the expansion of telehealth has had on different patient populations.

The AAFP urges passage of one of these proposals, the Knowing the Efficiency and Efficacy of Permanent (KEEP) Telehealth Options Act (H.R. 1110), which is before the Subcommittee today. This bill would require HHS, the Medicare Payment Advisory Committee (MedPAC), and the Medicaid and CHIP Payment and Access Commission (MACPAC) to each conduct reports on telehealth use and issue recommendations on improvements to and expansion of telehealth services. The bill would also require MedPAC and MACPAC to issue reports on improvements to or barriers in access to telehealth services during the PHE.

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 [redacted].

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

Founded in 1947, the AAFP represents 130,000 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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[i] 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.

[ii] 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

[iii] 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

[iv] 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

[v] "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

[vi] 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.

[vii] Ibid.

[viii] 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

[ix] Uscher-Pines L, McCullough CM, Sousa JL, 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

[x] Jorge A. Rodriguez, Altaf Saadi, Lee H. Schwamm, David W. Bates, Lipika Samal, Disparities in telehealth use among california patients with limited english proficiency, Health Affairs 40, No. 3, 2021, Pages 487-495, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00823

[xi] Chandrika Divi, Richard G. Koss, Stephen P. Schmaltz, Jerod M. Loeb, Language proficiency and adverse events in US hospitals: a pilot study, International Journal for Quality in Health Care, Volume 19, Issue 2, April 2007, Pages 60–67, https://doi.org/10.1093/intqhc/mzl069

April 10, 2024

The Honorable Brett Guthrie
Chair of House Energy and Commerce Health Subcommittee
2125 Rayburn Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member of House Energy and Commerce Health Subcommittee
2125 Rayburn Office Building
Washington, DC 20515

Re: ATA Action Statement for the Record for House Energy and Commerce Health Subcommittee Hearing "Legislative Proposals To Support Patient Access To Telehealth Services"

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 comprehensive telehealth legislation that would ensure access to care for millions of Medicare beneficiaries.

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 continues to hold relevant bipartisan hearings to collect important information on virtual care as you contemplate telehealth policies post CY2024. ATA Action urges Congress to act sooner rather than later this year on telehealth to provide certainty for patients and providers across the country and provide U.S. healthcare systems enough time to implement appropriate virtual tools, technologies, programs, and processes moving forward.

Specifically, we urge Congress to make permanent the Medicare telehealth flexibilities implemented during the COVID-19 Public Health Emergency (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

[1] PRINT_ATA-TAW-Hill-Day-handout_9.11.23.pdf (americantelemed.org)

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. We encourage Congress to consider enacting **the Expanded Telehealth Access Act (H.R. 3875, S.2880)** which would permanently allow all therapist services rendered via telehealth to be reimbursed by Medicare and give the HHS secretary authority to expand the list of telehealth providers.

- **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)**, 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.

Fortunately, Congress, in a bipartisan, bicameral fashion, agrees with the principles laid out above with telehealth champions introducing key legislation to make these flexibilities permanent including ATA's top priorities – **CONNECT for Health Act (H.R. 4189, S. 2016) and the Telehealth Modernization Act (H.R. 7623, S.3967).** We are also supportive of the recently introduced Advancing Access to Telehealth

[2] Shortage Areas (hrsa.gov)

Act (H.R. 7711). Again, we urge Congress and the House Energy and Commerce Committee to come together to pass permanency legislation well before the end of 2024.

Additional telehealth priorities before the Committee, supported by ATA Action , include the imminent expiration of the acute hospital care at home program by year-end and the expansion of the virtual diabetes prevention program:

- **Preserve the Medicare Acute Hospital Care at Home Program (AHCaH)**
  As COVID-19 spread quickly, Congress and CMS needed to find ways to free up hospital beds and prevent mass spreading. As a result, the AHCaH program was created which essentially allows patients with acute diagnosis to be treated within their homes rather than at the hospital. Since the implementation of this waiver, more than 300 hospitals across 129 health systems in 37 states are operating under the waiver—with no guarantee of payment permanence.[3] Clinical outcomes of the AHCaH program have been outstanding. Lower readmission rates, high patient satisfaction, and lower costs of care are some of the proven benefits of this program.[4] We applaud Congress for extending this program through CY2024 along with the other Medicare telehealth flexibilities but urge Congress to act permanently to ensure Medicare beneficiaries will not lose access to HaH programs that have demonstrated to provide excellent clinical outcomes and lower the costs of care. ATA is supportive of **Representatives Wenstrup and Blumenauer's discussion draft** that extends the waiver program until 2027.

- **Expanding Access to Medicare Diabetes Prevention Program**
  We are strongly supportive of expanding current health care programs to allow for the use of all types of virtual modalities, such as the Medicare Diabetes Prevention Program. ATA Action supportive of the **PREVENT DIABETES Act (HR 7856)** which would allow all CDC recognized delivery modalities, including virtual diabetes prevention platforms, to participate in the program while keeping important oversight, accountability, and program integrity protections in place. Enacting this legislation is imperative to help address the ongoing diabetes crisis in the United States which impacts 1 in 5 Medicare beneficiaries.

While we commend the Committee for convening this hearing, we wish to highlight the below two policy matters omitted from today's hearing that if neglected will result in significant gaps in care.

- **Remote Prescribing of Controlled Substances**
  Another important issue that is top of mind for many within the healthcare industry is the remote prescribing of controlled substances. Before the pandemic, the Ryan Haight Act mandated an in-person visit before prescribing controlled substances via telehealth. This requirement was waived during the pandemic and is set to end at the end of 2024. This has significantly increased access to essential treatments for millions of patients. The DEA is supposed to release proposed rules this year outlining a special registration process for telehealth prescriptions of controlled substances. This process could verify providers' credentials and history to protect against misuse, allowing qualified providers to receive DEA approval for virtual prescribing. We kindly request that Congress continues to urge DEA to maintain these critical and lifesaving flexibilities by either publishing a special registration process soon or extending the current flexibility post-2024.

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[3] "Approved Facilities/Systems for Acute Hospital Care at Home." CMS QualityNet. January 26, 2024. https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.
[4] Acute-Hospital-At-Home-Background-10.22.pdf (americantelemed.org)

- **Reinstate Virtual Cardiac Rehabilitation (CR)**
  We applaud Congress for recognizing the importance of telehealth and extending a majority of the flexibilities through the end of CY2024. Unfortunately, there was a critical telehealth flexibility omitted leaving a tremendous gap in care. This flexibility allowed patients to complete cardiac rehab programs from home rather than having to travel to a hospital, rehab center, or physician's office. This expired at the end of the PHE on May 11, 2023, which led many of these virtual CR programs to shut down. These virtual CR programs cannot be reopened unless Congress takes immediate action. Therefore, it is imperative that this issue is addressed as soon as possible by enacting the **Sustainable Cardiopulmonary Rehabilitation Services in the Home Act** (**H.R. 1406**, **S.3021**) which would permanently restore access to virtual cardiac rehabilitation for hundreds of thousands of Medicare beneficiaries.

As Congress contemplates telehealth policy, we wanted to provide the Committee with key studies and research that dispel myths that telehealth leads to increased health care costs, overutilization, and is more suspectable to fraud, waste, and abuse than in-person care. For example:

- **Telehealth is Cost Effective:** Telehealth has been proven to reduce costs for hospitals and provider organizations, as well as for consumers. Several recent studies have shown that a telehealth consultation is as good as, and in some instances better than in-person care. Telehealth also enables consumers to receive care sooner, hence reducing disease progression and costs of care.[5,6,7]

- **Telehealth Does Not Lead to Overutilization:** Telehealth has proven to reach vulnerable and underserved patients that otherwise would never have received care in the first place due to limited transportation, childcare, time off of work, etc. Many studies have proven that utilization of telehealth has decreased and leveled off since the midst of the pandemic.[8]

- **Telehealth is Not More Vulnerable to Fraud, Waste, and Abuse (FWA):** Telehealth is not more susceptible to FWA than in-person services. The Office of Inspector General (OIG) recently released a report that found Medicare telehealth did not increase fraud, waste, and abuse. Specifically, during the first nine months of the PHE -- March 2020 to November 2020 -- Medicare practitioners correctly billed for telehealth evaluation and management services in 95% of cases. There have been a few recent OIG and Department of Justice (DOJ) Medicare cases that have been mislabeled as "telefraud" when it is traditional telemarketing scams which have been around for decades. ATA Action does appreciate and understand this valid concern but there are current federal and state mechanisms and guardrails in place that are working to protect consumers and oversee providers.[9] (See here for ATA's newest federal and state telehealth guardrails document)

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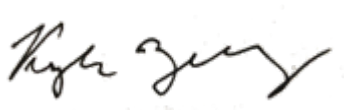
[5] Li, KY, Kim, PS, Thariath, J, Wong, ES, Barkham, J, & Kocher, KE. (2023). Standard nurse phone triage versus tele–emergency care pilot on Veteran use of in-person acute care: An instrumental variable analysis. *Acad Emerg Med*.;*30*: 310-320.
[6] Ascension. (n.d.). Task Force on Telehealth Policy. https://connectwithcare.org/wp-content/uploads/2020/08/Ascension-Telehealth-Data.pdf
[7] National Committee for Quality Assurance. (n.d.). Findings and Recommendations: Telehealth Effect on Total Cost of Care. https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-findings-and-recommendations-telehealth-effect-on-total-cost-of-care/
[8] Patients-Providers-and-Plans-Increase-Utilization-of-Telehealth-Recent-Stats-2.18-2.pdf (americantelemed.org)
[9] Telehealth-Integrity.pdf (americantelemed.org)

ATA Action is here as a resource and looks forward to continuing to work with the Committee to ensure that the appropriate telehealth policies are permanently implemented in a timely manner without arbitrary and unnecessary barriers to care such as in-person, brick and mortar, or geographic requirements. Thank you for all your historic and current work on telehealth. Please reach out to [redacted] if you have any questions.

Kind regards,



Kyle Zebley
Executive Director
ATA Action

Moving Health Home
An Alliance to Advance Home-based Care Policy

Statement for the Record:
"Legislative Proposals to Support Patient Access to Telehealth Services"
U.S. House of Representatives
Energy and Commerce Committee

Moving Health Home
1100 G Street, NW, Suite 420, Washington, DC 20005

April 10, 2024

Moving Health Home (MHH) appreciates the opportunity to submit testimony for this hearing on legislative proposals that will support patient's access to telehealth services. MHH is a coalition of health care organizations with a bold vision to make the home a site of clinical service. Our members share in the belief that experience during the pandemic has accelerated the day when care in the home is an accessible option for patients.

For our members, clinical care in the home refers to a spectrum of health services provided in the home or place of dwelling outside of a facility, such as hospital-level or acute care, primary care office, skilled nursing and therapy services, and hospice. It can mean a house call from a primary care doctor or nurse, a physical therapy session, a laboratory and diagnostic service, a home infusion, or a full complement of hospital-level services. At the core, we want to remove regulatory barriers to ensure all patients may choose to receive clinical care in the home and take advantage of the convenient, high-quality care that comes when patients receive home-based care.

Patients have indicated that they want to receive care at home, with the demand for services provided in the safety of a patient's home soaring during the pandemic. In fact, according to a recent survey, 85 percent of adults say it should be a high priority for the federal government to expand Medicare coverage for at-home health care. At the same time, an overwhelming majority of people who have received care in the home were satisfied (88 percent) and would be likely to recommend to family and friends (85 percent). We believe older adults should have the opportunity to choose the best site of care for their medical needs and preference, whether that be in the home or the facility.

Telehealth is an important enabler to facilitating and supporting the movement to home-based care. From remote patient monitoring for Hospital at Home programs to nurses using telehealth to bring specialists into rural areas during an in-home visit, telehealth must be part of the future of home-based care. MHH generally supports efforts to make permanent the telehealth pandemic flexibilities. We request the Subcommittee push forward the telehealth legislative proposals, in particular permanently allowing the home of the beneficiary as a permissible originating site for telehealth services.

Additionally, we greatly applaud the Subcommittee for including and considering the Hospital Inpatient Services Modernization Act as introduced by Representatives Wenstrup (R-OH) and Blumenauer (D-OR), which would provide a 3-year extension of the acute hospital care at home waiver flexibilities. This legislation provides additional time to collect data and understand the benefits of the Hospital at Home model, enable hospitals and health systems nationwide to continue building out the logistics, supply chain, and workforce, and encourage multiple payers, include Medicare, to enter the Hospital at Home market. Moving Health Home recently co-led a letter, signed by over 65 organizations, urging Congress to extend this waiver. We urge the Subcommittee to push this legislation forward to ensure Medicare beneficiaries have continued access to this necessary program.

The value of Hospital at Home programs was demonstrated during the COVID-19 pandemic. As you know, the Centers for Medicare and Medicaid Services (CMS) established the Acute Hospital Care at Home (Hospital at Home) program, which provided hospitals with unprecedented regulatory flexibilities to treat eligible patients in their homes. The Hospital at Home waiver, as of March 2024, includes 321 hospitals across 133 systems, in 37 states. Hospital at Home programs have been studied for decades both in the United States and internationally.

Research overwhelmingly demonstrates that Hospital at Home programs are at least as safe as traditional in-patient care, improve clinical outcomes and patient satisfaction, and reduce the total cost of care. One research article found that the total cost of hospital at home was 32 percent less than traditional hospital care ($5,081 vs. $7,480), the mean length of stay for patients was shorter by one-third (3.2 days vs. 4.9 days), and the incidence of delirium (among other complications) was dramatically lower (9 percent vs. 24 percent). Another study found similar findings.

CMS also released initial findings from its congressionally mandated report on the Hospital at Home waiver and found, for Medicare patients, the median length of stay obtained from claims was 5 days. Another study found that early analysis of the waiver suggests rapid uptake, with the potential for significant capacity creation, but a slower uptake over time. This highlights the need for additional resources to launch this care model to address these barriers.

While MHH and its members are supportive of this three-year extension, we believe that once sufficient data is collected from the waiver, a long-term solution for broad adoption of inpatient services at home should be adopted. Temporary waivers are a bridge to enable care in the home to continue for a time-limited period post-pandemic, but do not fully leverage the promise of home-based care. They continue to rely on fee-for-service payment, while our goal would be to integrate a value-based mechanism into the program. Hospital at Home programs have realized savings of 30 percent or more per admission, while maintaining equivalent or better outcomes. The Subcommittee has an opportunity to consider authorizing a permanent model that allows hospitals to deliver inpatient hospital services to Medicare beneficiaries at home.

As telehealth and remote care continues to become more integrated into the health care delivery system, we also encourage the Subcommittee to consider legislation that furthers care in the home, which is the preferred site of care for patients, caregivers, and providers. This would include the Expanding Care in the Home (H.R. 2853), introduced by Representatives Dingell (D-MI) and Smith (R-NE). This legislation would ensure home-based care is a viable option for patient care and scalable for providers.

Additionally, we urge the Subcommittee to consider skilled nursing facility (SNF) at home as an option for eligible patients. The creation of a SNF-at-Home program would allow patients to access these services from the home using a mix of skilled care, personal care, and telehealth services. SNF-at-home provides opportunities for payers, health systems, and providers to lower costs, facility-associated infections, promote patient compliance, free up capacity in facilities, and address practitioner burnout. SNF-at-Home may not be a fit for every patient, but it is an important option for patients and providers to have. An integrated SNF-at-home program can bring services directly to the patient, allowing them to recover in a familiar environment.

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Moving Health Home greatly appreciates the House Energy & Commerce Committee's leadership in working to ensuring patients are able to continue receive care at home. We look forward to working with

you to develop and advance bipartisan legislation to enhance care in the home access, including hospital at home, for Medicare beneficiaries. If you have any questions or would like to hear from Moving Health Home member experts on these topics, please do not hesitate to contact Rikki Cheung at [redacted].

Sincerely,

Krista Drobac
Executive Director
Moving Health Home

AARP
STATEMENT FOR THE RECORD
for the

U.S. HOUSE OF REPRESENTATIVES
ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
on

LEGISLATIVE PROPOSALS TO SUPPORT PATIENT ACCESS TO TELEHEALTH SERVICES

April 10, 2024
Washington, DC

For further information contact:
Andrew Scholnick
Government Affairs Director
Health Access and Affordability
[redacted]

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the Energy & Commerce Committee's efforts to ensure Medicare beneficiaries and their family caregivers are able to maintain access to telehealth services.

Access to telehealth provides convenience, protects against exposure to infection, improves treatment adherence, enables chronic disease management, helps enable family caregiver participation in care, 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 and may have to travel further, or incur 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.

The COVID-19 pandemic forced Medicare to quickly adapt to an increased need for telehealth, often relying on waivers granting the flexibility to allow for otherwise impermissible care. AARP believes Medicare beneficiaries should continue to be able to access care via telehealth beyond the 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. We are heartened by the Committee's decision to hold this hearing to discuss and consider a variety of legislative proposals. Just because a telehealth service or provider was permitted during the public health emergency does not mean it should automatically continue without examination. We now have three 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 independent of their in-person counterpart, not writ large.

<u>Legislative Priorities</u>

As the Committee and Congress work on legislation 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 the use of telehealth by Medicare beneficiaries and facilities in urban and suburban areas and prevent people with Medicare from receiving care at home regardless of where they live. Similar restrictions placed on distant sites should also be permanently removed to allow patient engagement with Federally Qualified Health Centers and Rural Health Centers.

Telehealth Reimbursement

In general, payment for telehealth services should be sufficient to support telehealth use by providers and provide value for patients. Medicare and other payers should thoughtfully consider how to reimburse clinicians and other telehealth providers. Factors to consider include accounting for the cost of providing telehealth; the need to support patients' ongoing access to telehealth with compensation that fairly supports its use; the need to avoid unnecessary additional costs; and the efficiencies telehealth may produce. 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.

Access, 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, policymakers 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 often 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. For instance, the Medicare Diabetes Prevention Program can be effectively delivered without an in-person requirement. Virtual diabetes prevention programs, which are available to people outside of Medicare, would improve access and increase utilization for Medicare beneficiaries. Furthermore, many services, such as mental health services, can be safely and effectively delivered via audio-only, rather than audio-video. Requiring a live video link can be 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 may lack the 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 nuanced approach.

Family Caregiver Support

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 can result in better physical and mental health, improved caregiving knowledge and skills, and higher satisfaction in their caregiving roles.

The potential for telehealth to improve both patients and family caregivers' lives is well known by AARP member and volunteer Dr. Karla Abbott, DNP. Until recently, Karla was a cardiovascular specialty nurse and associate professor of nursing in South Dakota. She personally used telehealth to help treat her congestive heart failure patients and taught future nurses about the role of technology in care. Yet all her knowledge and experience did little to help Dr. Abbott and her father, Richard Zacher. Karla, a member of the Cheyenne River Sioux Tribe, struggled to care for her father following an illness about four years ago. Richard lived about 400 miles away from her on the reservation where he was born and raised, and received treatments many miles from his home. Moreover, Richard lost his vision and eventually needed someone to drive him to his appointments. This made every doctor's visit, consultation, and wellness check a whole-day affair, and required Karla to take considerable time away from her own family and miss work in order to ensure her father's needs were met.

While Richard is no longer with us, Dr. Abbott knows that telehealth could have made a huge difference in their lives. Telehealth would not have solved everything, but having that option for some parts of her father's care would have been wonderful, she says. As Karla puts it, "Living when he was sick like this was difficult. Ideally it would be great if we could [have] used telehealth in a way that would not only connect me with my dad, but also in a way that would connect me, my dad, and his health provider. I think what would make our lives a little easier is if we lived closer, but I also know that he [wanted] to be where he was born and raised and that's where he's happiest. I think telehealth would be not only convenient but it would be effective."

Telehealth is used in Hospital at Home programs, where providers can engage with family caregivers both in-person and virtually. Although a small number of these programs have existed for decades, they have proliferated in recent years. During the COVID-19 pandemic, CMS created a temporary waiver, the Acute Hospital Care at Home (AHCaH) Waiver, that allowed hospitals to offer certain acute-level care in the home with the same inpatient designation as in a physical hospital. This has made these programs easier to administer and more financially viable for hospitals.

As Congress considers potential extension of the AHCaH waiver, we urge Congress to address considerations for family caregivers utilizing the programs, including:

- That Hospital at Home programs support the family caregiver by recognizing the role they play in making care successful, and understand the needs of the family caregiver in relation to what they are being asked to do. Recognizing these individual needs is done through intentional engagement with family caregivers and the person receiving the care. Services and supports should be available and provided to meet needs of both the patient and family caregiver.
- That Hospital at Home programs be clear and understandable to the patient and family caregiver about what the program involves and what is expected of participants.
- That Hospital at Home programs remain voluntary and receive consent from the patient and family caregiver, and the criteria for program eligibility is inclusive such that participants reflect the community which the hospital serves.
- That Hospital at Home programs capture and report data on caregiver experiences. It is important to understand the team who is in the home and providing assistance and technical tasks (including medical/nursing tasks) and what leads to positive health outcomes, as well as what happens when there is no family caregiver, in order to provide better communication and support.

Conclusion

The recent Medicare telehealth waivers and flexibilities have clearly demonstrated the usefulness and potential of health care delivered via telehealth. Without additional action by Congress, people with Medicare risk losing the access to care, 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. The proposals in the bills being discussed today 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.

American Association of Nurse Practitioners
Statement for the Record
Legislative Proposals to Support Patient Access to Telehealth Services
House Committee on Energy and Commerce, Health Subcommittee
April 10, 2024

The American Association of Nurse Practitioners (AANP), representing the 385,000 Nurse Practitioners (NPs) in the United States, appreciates the opportunity to provide a statement for the record for the Health Subcommittee of the House Committee on Energy and Commerce hearing entitled "Legislative Proposals to Support Patient Access to Telehealth Services." AANP is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).[1] We appreciate the Subcommittee's attention to the importance of telehealth in ensuring that patients across the country have access to health care. Telehealth was a vital lifeline throughout the COVID-19 Public Health Emergency (PHE) to reach patients who otherwise would not be able to receive care and it is essential to health care access moving forward. In particular, we would like to express our support for H.R. 4189, the *CONNECT for Health Act of 2023* and H.R. 7623, *the Telehealth Modernization Act of 2024,* and urge Congress to pass these important pieces of legislation.

This issue is of particular importance to our members, as NPs provide a substantial portion of the high-quality[2], cost-effective[3] care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[4] Approximately 42% of Medicare patients receive billable services from a nurse practitioner[5], and approximately 80% of NPs are seeing Medicare and Medicaid patients.[6] According to the Medicare Payment Advisory Commission (MedPAC), APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[7]

NPs also provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status. As such, they understand the barriers to care that face vulnerable populations on a daily basis.[8],[9],[10] They are also "significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are

[1] https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/strategic-focus,
[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[4] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021.
[5] *Ibid*.
[6] NP Fact Sheet (aanp.org)
[7] https://www medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[8] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. Journal of General Internal Medicine, 4–6. https://doi.org/10.1007/s11606-017-4287-4.
[9] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. Journal of the American Medical Association, 321(1), 102–105.
[10] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. https://doi.org/10.1177/1077558718793070

all more likely to receive primary care from NPs than from physicians."[11] NPs are also the second largest provider group in the National Health Services Corps[12] and the number of NPs practicing in community health centers has grown significantly over the past decade.[13] When rural communities experience hospital closures, it is often NPs who are filling the gaps and providing critical care to these communities. According to the Government Accountability Office (GAO), an exception to the pattern of clinicians leaving rural areas after rural hospital closures were APRNs, finding that "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[14]

We thank Congress for extending the Medicare telehealth flexibilities through the end of 2024 and urge the permanent adoption of those policies. In a 2020 AANP member survey on the impacts of COVID-19, 76% of nurse practitioners identified federal telehealth waivers as some of the most beneficial flexibilities throughout the COVID-19 PHE.[15] NPs have made a rapid transition to telehealth, with over half of AANP members reporting their practices have adopted, or increased the use of, telehealth and virtual platforms. According to the United States Health Resources and Services Administration (HRSA), there are 4,986 rural primary care HPSAs and 2,157 non-rural primary care HPSAs.[16] Adequate access to providers impacts patients in both rural and non-rural geographic settings. Permanently removing the restrictions that prevent Medicare patients in certain geographic areas from accessing telehealth is increasingly important.

The expanded coverage of certain services throughout the PHE, including audio-only care, have also enabled NPs and other clinicians to reach patients who otherwise may have been unable to receive medically necessary healthcare, particularly in rural and underserved communities and for patients with behavioral health needs. Coverage of audio-only telehealth has been critical for NPs and patients who do not have access to adequate broadband or technological devices capable of synchronous two-way audio video technology. In the survey previously noted, AANP members reported that the three most significant barriers to telehealth adoptions were patient connectivity issues, patient access to technology and the internet and patient comfort with technology.[17] For patients experiencing issues that prohibit them from utilizing synchronous two-way technology, the permanent coverage of audio-only visits will be an important component of telehealth moving forward.

As Congress further considers telehealth legislation, we respectfully request that increased coverage of telehealth removes barriers to care, and that policies intended to maintain program integrity are flexible and do not inadvertently inhibit patient access to care. Important policy changes include the permanent coverage of audio-only services, and removal of geographic and site restrictions for telehealth services for Medicare beneficiaries. Accordingly, we would like to reiterate our support for H.R. 4189 and H.R. 7623 and urge Congress to pass this legislation.

[11] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[12] https://www hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf
[13] https://www nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[14] https://www.gao.gov/assets/gao-21-93.pdf
[15] Nurse Practitioner COVID-19 Survey (aanp.org)
[16] Shortage Areas (hrsa.gov)
[17] Nurse Practitioner COVID-19 Survey (aanp.org)

Conclusion

We are deeply appreciative of the Subcommittee's recognition of the importance of telehealth services. We thank the Committee for focusing on improving our nation's health care system and look forward to working with the Committee on solutions that will expand access to care for patients.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

April 10, 2024

The Honorable Brett Guthrie
Chair
Committee on Energy and Commerce
Subcommittee on Health
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
272 Cannon House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Eshoo,

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's hearing entitled "Legislative Proposals to Support Patient Access to Telehealth Services." The flexibility to provide remote care is not just a matter of convenience; it is a critical component of modern health care delivery, ensuring that patients receive timely and effective treatment. We appreciate the committee's attention to ensuring that this important tool remains a viable part of health care delivery moving forward.

Emergency physicians are particularly well-positioned to provide excellent telehealth services. Triaging, diagnosing, and intervening in nearly any medical condition, and then connecting our patients with the follow-up care they need are skills that are naturally aligned with telehealth care delivery. As hospital emergency departments (EDs) are grappling with the issue of patient "boarding," where individuals wait for hours, often days, when there are no inpatient beds available, expanded utilization of telehealth services provides emergency physicians with another essential tool to help alleviate the strain of this growing public health crisis and potentially reduce ED congestion. By removing barriers to care through expanded telehealth flexibilities, physicians can meet patients in their homes, in other more appropriate or comfortable settings, or reach patients who might otherwise have limited access to the health care services they need and deserve. ACEP strongly supports the CONNECT for Health Act of 2023 (H.R. 4189), and we urge the committee to support this legislation and related efforts to secure a future where quality care is not confined by physical boundaries but is bolstered by technological advancement.

ACEP remains committed to advancing policies that promote access to telehealth for all patients and we look forward to working with the committee on this important issue. Once again, we appreciate your attention to these critical issues, and we are grateful for the opportunity to share our support. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP Congressional Affairs Director, at [redacted].

Sincerely,

Aisha T. Terry, MD, MPH, FACEP
ACEP President

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Statement for the Record
American College of Physicians
Hearing before the House Energy and Commerce Subcommittee on Health
"Supporting Patients Access to Telehealth"
April 10, 2024

The American College of Physicians (ACP) is grateful for the opportunity to submit this statement on the following legislative proposals that would maintain access to essential telehealth services for Medicare patients across the country. We appreciate Chairman Guthrie and Ranking Member Eshoo for holding this hearing to examine the importance of telehealth and its role in improving patients' access to care. We hope that this important discussion will provide a platform to act on bipartisan solutions to promote telehealth as an essential part of health care access and delivery and to improve the nation's capacity to confront future national public health emergencies and improve access to care more broadly.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

The College supports the expanded role of telehealth as a method of health care delivery that may enhance the patient-physician relationship, improve health outcomes, increase access to care from physicians and members of a patient's health care team, and reduce medical costs. Telehealth can serve as an alternative for patients who lack access to in-person primary or specialty care due to various social drivers of health such as lack of transportation or paid sick leave, or insufficient work schedule flexibility to seek in-person care during the day, among many others. Telehealth flexibilities from the pandemic-era public health emergency (PHE) have been instrumental in improving access to care for patients across the U.S. We were pleased that the Consolidated Appropriations Act of 2023 extended many of those flexibilities through the end of 2024, helping ensure access to care modalities that many physicians and patients rely on.

ACP believes that the following existing flexibilities should be continued – and not allowed to expire – to support making telehealth an ongoing and continued part of medical care now and in the future. We urge the subcommittee to make these existing flexibilities permanent or to provide long-term extensions for them.

- Expand originating sites and lift geographic requirements for telehealth services
- Allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to continue to provide and receive payment for telehealth services
- Allow the furnishing of audio-only telehealth services for evaluation and management services
- Remove the in-person visit requirement for behavioral/mental health furnished through telehealth services

Removing geographic requirements and expanding originating sites for telehealth

ACP has long-standing policy in support of lifting geographic site restrictions and expanding originating sites so that patients can receive virtual care at home based on their needs and clinical appropriateness. **Therefore, we support H.R. 134, which would remove geographic requirements and expand originating sites for telehealth services permanently. ACP has endorsed the CONNECT for Health Act in previous years and we continue to support it in this Congress.** H.R. 4189 would provide a comprehensive framework to permanently expand telehealth services in Medicare. We strongly support the provisions in the bill that would remove geographic restrictions on where a patient must be located in order to utilize telehealth services and expand eligible originating site locations to include patients' homes and other clinically appropriate sites. The bill would allow for FQHCs and RHCs to provide telehealth services and would also establish a permanent waiver authority for the Secretary of Health & Human Services for future PHEs.

Audio-only telehealth can help to address health inequities

While there are many benefits to telehealth, we remain concerned about the increasing inequities associated with it as there are disparities in access to this technology. A February 2022 HHS publication reported that telehealth utilization during the period of April to October 2021 varied by race, region, education, income, and insurance. For those in rural and underserved communities, the nearest clinic may be hours away. Unfortunately, rural and underserved communities also suffer from more limited access to broadband internet, which restricts the ability of many in these communities to access telemedicine. Additionally, research shows that Black and Hispanic Americans own laptops at lower rates than white Americans, further dividing access to telemedicine. Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. **As the subcommittee discusses legislative proposals to improve telehealth, we urge you to explore policies that would support further broadband deployment to reduce geographic and sociodemographic disparities and improve access to care.**

ACP strongly supports the use of audio-only telehealth as an effective modality to address gaps in health equity. Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to or knowledge of the technology necessary to conduct video visits. Continued access to audio-only services is instrumental for patients who do not have the requisite broadband/cellular phone networks or who have privacy concerns or limited digital literacy, and do not feel comfortable using video technology. **The College supports H.R. 7623, the Telehealth Modernization Act of 2024 that would allow for audio-only telehealth reimbursement in Medicare.** This legislation would also make certain telehealth flexibilities that ACP supports permanent, including removing geographic restrictions and expanding originating sites required for telehealth visits in Medicare. Further, it would implement a permanent payment system for telehealth services furnished by FQHCs and RHCs. **We also support H.R. 5611, the Helping Ensure Access to Local TeleHealth (HEALTH) Act of 2023.** This bill would allow FQHCs and RHCs to continue to serve as originating sites for telehealth and would lift geographic site restrictions. These centers and clinics provide comprehensive care, including primary and preventive care services, for millions of Americans in medically underserved communities. Additionally, it would allow FQHCs and RHCs to be reimbursed permanently by Medicare for audio-only services.

Enhancing access to behavioral and mental health care

ACP's policy supports increasing availability and coverage for mental and behavioral health services. **We urge the subcommittee to support the removal of Medicare's requirement that**

patients undergoing behavioral/mental health treatment must have an in-person visit within six months of being seen virtually. Further, we recommend that the subcommittee ensure that the guardrails specified for patients to access tele-mental health services without an in-person visit to a physician do not impart a distinction via differing documentation requirements between mental health services provided via telehealth and those in the in-person setting. Generally, the College believes that the intent to treat documentation requirements for telehealth services differently than for in-person visits is misguided. This is because telehealth services are not different in terms of providing longitudinal care to patients. In addition, CMS has recently alleviated the administrative burden of evaluation and management services (E/M) documentation in 2021, so additional documentation requirements for telehealth would be contradictory to CMS' ongoing efforts to minimize documentation and focus on medical decision-making. Since medical record documentation continues to be an incredibly burdensome task for clinicians, ACP would be disappointed – and it would be a disservice to patients – to include any requirements that further complicate the provision of these services.

The College supports three additional bills that will be up for discussion in the hearing, H.R. 3432, Telemental Health Care Access Act., H.R. 7711, the Advancing Access to Telehealth Act, and H.R. 5541, the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act. These bills aim to improve access to mental and behavioral health services. H.R. 3432 would eliminate the Medicare requirement for in-person visits, ensuring that patients will continue to receive access to mental and behavioral health services where they feel most comfortable. H.R. 7711 would allow patients seeking virtual care from FQHCs and RHCs to continue receiving access to tele-mental health services by eliminating Medicare's in-person visit requirement. Further, it includes other provisions that ACP supports such as removing geographic restrictions, expanding originating sites, and allowing for the use of audio-only telecommunications technology. And lastly, the TREAT Act would provide temporary licensing reciprocity for telehealth and interstate health care treatment during PHEs. This legislation would ensure that physicians will be able to treat patients who move across state lines during future national emergencies. This is especially critical for maintaining care for patients with long established relationships with their primary care physicians.

In conclusion, we appreciate this opportunity to offer our input and suggestions on evidence-based proposals to enhance telehealth's ability to reach patients in meaningful and effective ways. We stand ready to offer the perspective of internal medicine clinicians on future legislation or hearings, as they relate to the delivery of primary care and the patient-physician relationship. Should you have any questions, please contact Vy Oxman, Senior Associate of Legislative Affairs, at [redacted].

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

"Legislative Proposals to Support Patient Access to Telehealth Services"

April 10, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislative proposals for consideration before the Energy and Commerce Committee Health Subcommittee on April 10.

We share the committee's commitment in ensuring that essential telehealth flexibilities are extended so that patients continue to receive access to high-quality care. The expansion of telehealth services has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients, especially those with transportation or mobility limitations. Given current health care challenges, including major clinician shortages nationwide, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. **We urge Congress to make these key telehealth flexibilities permanent before they expire on Dec. 31, 2024, and extend waivers for the Hospital at Home program.**

EXTENDING CRITICAL TELEHEALTH FLEXIBILITIES

H.R. 4189, the CONNECT for Health Act of 2023

The AHA supports the CONNECT for Health Act of 2023[1], which will increase patient access to telehealth services, while removing barriers preventing adoption of telehealth for hospitals and other providers. This bill would make permanent many of the telehealth waivers, including the removal of geographic restrictions and expanding originating site locations to include the patient's home; the removal of arbitrary requirements for in person visits for behavioral health treatment; and allow rural health clinics (RHCs) and federally qualified health centers (FQHCs) to serve as distant sites.

H.R. 7623, the Telehealth Modernization Act of 2024 and H.R. 7711, To amend title XVIII of the Social Security Act to make permanent certain telehealth flexibilities under the Medicare program

The AHA supports both H.R. 7623 and H.R. 7711, which would make permanent many telehealth waivers, including the removal of geographic originating site restrictions; the expansion of the types of providers eligible to provide telehealth services; and extend coverage for audio-only telehealth. Virtual care represents a spectrum of ways that telecommunications technologies can be used in care delivery, ranging from synchronous real-time video visits and audio-only phone visits to remote monitoring of patient vitals. These bills would continue to provide patients with a much-needed access point, particularly for those with bandwidth constraints, where data plans or devices to support video-based visits are lacking, or who otherwise are not able to participate in audio-visual encounters.

H.R. 134, To amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services

The AHA supports this bill to remove geographic requirements and permanently expand originating sites for telehealth services. Previously, patients had to be located in a rural designated area or health provider shortage areas; they also had to be physically located in a designated facility (like a physician's office or skilled nursing facility) to participate in a telemedicine visit. The removal of these requirements will continue to allow patients to access telehealth across geographies and settings, including from their homes and rural and urban locations. We would encourage eliminating originating and geographic site restrictions altogether.

H.R. 3432, the Telemental Health Care Access Act

The AHA supports the Telemental Health Care Access Act, which removes originating site restrictions for mental and behavioral health patients. This legislation would ensure that these patients, particularly those in rural and underserved

[1] https://www.aha.org/lettercomment/2023-10-10-aha-letter-support-house-connect-health-act-2023-hr-4189

areas, have access to these critical telehealth services. Behavioral health is one area that has seen sustained growth in telehealth utilization. Geographically dispersed patients have benefited from increased access to behavioral health services provided through telehealth, especially in areas that may have provider shortages, and where in-person visits are not possible. We would encourage removal of originating site restrictions beyond behavioral health alone, and across all clinical areas.

H.R. 3875, the Expanded Telehealth Access Act

To allow more types of providers to participate in administering telehealth services**, the AHA supports the Expanded Telehealth Access Act, which would expand the list of eligible telehealth practitioners** to include: physical therapists; occupational therapists; speech language pathologists; and audiologists. Historically, Section 1834 of the Social Security Act limited the types of providers who were able to administer telehealth services. Given the improved access and high levels of satisfaction with telehealth services, we encourage permanent expansion of eligible provider types able to perform telehealth services.

H.R. 5611, Helping Ensure Access to Local Telehealth (HEALTH) Act of 2023

The AHA supports this legislation that focuses on providing telehealth coverage and reimbursement for FQHCs and RHCs, including audio-only services. Historically, restrictions have been made on allowed distant sites (the locations where providers administering telehealth could be located), which in some cases has limited patients' abilities to see their own provider. AHA supports allowing RHCs and FQHCs to serve as distant sites, so that these facilities may use the providers at their own sites to offer care to patients, ensuring patients remain connected to their primary providers. Furthermore, we support reimbursement at face-to-face rates and allocation of costs associated with administration of telehealth services to be considered allowable under FQHC prospective payment system and RHC All Inclusive Rate calculations.

H.R. ____, the Hospital Inpatient Services Modernization Act

The AHA supports the Hospital Inpatient Services Modernization Act, which would extend the hospital-at-home waiver for three years, through the end of 2027. The hospital-at-home (H@H) model — where patients receive acute-level care in their homes, rather than in a hospital — has emerged as a promising approach to provide high quality care to patients in the comfort of their home. Hospitals continue to see H@H programs as a safe and innovative way to care for patients in the comfort of their homes. A growing body of research shows that H@H is an effective strategy that improves all three components of the value equation — improve outcomes, enhance the patient experience and reduce cost.

EXPANDING TELEHEALTH ACCESS TO PATIENTS WITH LIMITED ENGLISH PROFICIENCY

H.R. 6033, Supporting Patient Education and Knowledge (SPEAK) Act of 2023

This legislation would require the Secretary of Health and Human Services (HHS) to convene a task force consisting of representatives from the Centers for Medicare & Medicaid Services (CMS), Office of the National Coordinator (ONC), HHS Office of Civil Rights (OCR), and other industry professionals to improve access to telehealth services for patients with limited English proficiency. **The AHA supports the SPEAK Act, to identify best practices to reduce disparities in access to telehealth services for patients with limited English proficiency and help bridge the "digital divide."**

H.R. 7863, To require the Secretary of Health and Human Services to issue guidance on furnishing behavioral health services via telehealth to individuals with limited English proficiency under Medicare program

This bill would require HHS to issue best practices for: integrating interpreters in telehealth encounters with behavioral health patients; teaching patients with limited English proficiency how to use technology; and providing patient materials in multiple languages. **The AHA supports this legislation, to identify best practices to reduce disparities in access to tele-behavioral health services.**

FRAMING TELEHEALTH FOR THE FUTURE

H.R. 1110, KEEP Telehealth Options Act of 2023

The KEEP Telehealth Options Act of 2023 would require HHS, MedPAC, and MACPAC to conduct studies to provide information about the expanded use of telehealth during the COVID-19 pandemic. **The AHA supports this bill, as additional data on telehealth uptake and usage is critical to help inform changes that will need to be addressed going forward to ensure patients can continue to access care through telehealth.**[2]

H.R. 5541, the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act

The AHA supports the TREAT Act, which would create a licensure reciprocity process for tele-behavioral health services during public health emergencies. This legislation will allow health care workers the flexibility to cross state lines virtually to provide care to patients in future public health emergencies.

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[2] https://www.aha.org/lettercomment/2023-02-22-aha-expresses-support-hr-1110-knowing-efficiency-and-efficacy-permanent-keep-telehealth-options-act

CONCLUSION

Thank you for your consideration of the AHA's comments on these telehealth legislative proposals. We look forward to continuing to work with you to form a permanent pathway for these vital telehealth flexibilities and the hospital-at-home program.

Federation of American Hospitals®

Charles N. Kahn III
President and CEO

STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Re: "Legislative Proposals to Support Patient Access to Telehealth Services"
April 10, 2024

The Federation of American Hospitals (FAH) is pleased to provide the following feedback to the Energy and Commerce Subcommittee on Health in response to the April 10th hearing entitled "Legislative Proposals to Support Patient Access to Telehealth Services." We commend the Subcommittee's leadership in examining legislative proposals to create a framework that maintains access to vital telehealth services in Medicare, while ensuring appropriate guardrails are in place to protect against fraud and abuse.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. Tax-paying hospitals account for approximately 20 percent of community hospitals nationally.

Telehealth has transformed our health care system by utilizing technology to modernize and redesign how care is delivered, and hospitals have been at the forefront of making telehealth an integral part of our operations. We thank Congress for its swift action and leadership in expanding access to telehealth during the COVID-19 public health emergency (PHE) and maintaining access to telehealth coverage through December 2024 in the *Consolidated Appropriation Act of 2023*. Now, Congress must build on this progress and advance permanent telehealth policies that provide certainty to providers and patients alike and meet America's future health care needs. The past four years of telehealth expansion has set in motion a large-scale transformation of our nation's health care system and demonstrated strong patient interest and demand for continued telehealth access.

The FAH supports legislation that would make permanent the Medicare flexibilities implemented during the COVID-19 PHE, such as H.R.7623, the *Telehealth Modernization Act* and H.R.4189, the *CONNECT for Health Act.* These bills would remove geographic and originating site restrictions to ensure that all patients can access care where they are, rural or

urban. These bills are a critical solution for improving access to care in rural areas, where many patients can travel for over an hour for a routine doctor's appointment, and often much further to seek specialty care. Additionally, in many cases (particularly in rural areas where it is difficult to recruit physicians and other highly trained staff), telehealth and other remote technologies can help make up for staffing shortfalls or staff burnout, aiding rural hospitals struggling with recruiting and retaining qualified staff.

Telehealth also has proven critical to improving access to mental and behavioral health care delivery, acting as a lifeline to close significant gaps in patient access to these scarce and much-needed services. The FAH supports H.R. 3432, the *Telemental Health Care Access Act,* which would expand access to underserved and at-risk populations by removing the statutory requirement that Medicare beneficiaries be seen in-person within six months of being treated for mental health services via telehealth. Removing these restrictions on mental and behavioral health is a solution to a currently unmet need in our health care ecosystem.

Without action from Congress, Medicare beneficiaries could abruptly lose access to expanded coverage of telehealth in January 2025. This would have a chilling effect on access to care across the entire health care system. Telehealth has brought our health care delivery system into the 21st century, and the foregoing permanent telehealth policies would foster further innovation and long-term investment in advanced technologies. Congress should provide certainty to providers and patients that access to care when and where they need it via telehealth will be a permanent part of our nations' health care delivery.

We commend the Subcommittee's interest in advancing telehealth legislation and look forward to working with the Subcommittee on this critical issue.

HEALTHCARE
LEADERSHIP COUNCIL

April 10, 2024

The Honorable Brett Guthrie
Chairman
Energy and Commerce Committee
Subcommittee on Health
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
Washington, D.C. 20515

RE: April 10th "Legislative Proposals to Support Patient Access to Telehealth Services" Subcommittee Hearing

Dear Chairman Guthrie and Ranking Member Eshoo:

The Healthcare Leadership Council (HLC) thanks you for holding today's hearing: "Legislative Proposals to Support Patient Access to Telehealth Services." Over the past several years, our country has seen the dramatic impact that telehealth has had in helping individuals access healthcare. The flexibilities in permitting telehealth as a means of delivering healthcare during COVID were and continue to be broadly supported by providers and payers alike. It is in the best interests of all patients to ensure these flexibilities are preserved so that access to care is maintained.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, group purchasing organizations, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC has prioritized, advocated, and commended the extension of Medicare telehealth waivers established during the COVID-19 pandemic through December 31, 2024. We continue to view these flexibilities as critical and now urges Congress to make these waivers permanent. Congress must build upon this critical foundation by removing the existing prohibitions under Section 1834(m) of the Social Security Act that prevent patients from receiving telehealth services where they are located. Limiting telehealth services to originating sites reduces patients' ability to receive important care in a setting they prefer. These care modalities mitigate the infrastructure challenges individuals in many rural communities face and ensure these patients are not left behind in future care innovations. We encourage the Committee to evaluate additional

legislative proposals to further alleviate hurdles facing patients receiving or trying to access care and services via telehealth.

HLC also recommends exploring further innovative options for patients to receive care at their place of residence, such as the Acute Hospital Care at Home waiver program. Extending this waiver program will similarly improve access and facilitate treatment by allowing patients to receive acute care in the home. Further, we believe consideration should be given to the value of expanding the types of care covered beyond acute needs.

HLC looks forward to working with you to ensure we do not move backwards in providing critical access to services for patients generally as well as seniors and other vulnerable populations through innovative telehealth delivery. If you have any questions, please do not hesitate to contact Katie Mahoney at [redacted] or [redacted].

Sincerely,

Maria Ghazal
President and CEO

April 10, 2024

The Honorable Brett Guthrie
Chairman
Subcommittee on Health
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2123 Rayburn House Office Building
Washington, DC 20215

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20215

Re: MGMA Statement for the Record — House Committee on Energy and Commerce Hearing, "Legislative Proposals to Support Patient Access to Telehealth Services"

Dear Chairman Guthrie and Ranking Member Eshoo:

The Medical Group Management Association (MGMA) thanks you for holding this important hearing examining legislative proposals to support patient access to telehealth services. The expansion of telehealth services over the past few years has provided a vital lifeline to patients across the nation. Permanently instituting many of the telehealth policies currently in place in a comprehensive fashion would help allow for appropriate access and continuity of care for patients no matter where they may be located.

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.

Maintaining access to telehealth services is essential to avoid instituting unnecessary barriers to medical care such as traveling significant distances. The Centers for Medicare and Medicaid Services (CMS) implemented numerous temporary telehealth polices in response to the COVID-19 Public Health Emergency (PHE). Prior to these policies, telehealth services in Medicare were rarely used given geographic, originating site, and other restrictions. This expansion has been a clear success and allowed medical groups to continue serving their communities through the appropriate utilization of telehealth services.

The *Consolidated Appropriations Act of 2023* thankfully extended many of these flexibilities through the end of calendar year 2024. It is essential to build upon this legislation, not allow these flexibilities to expire, and make permanent these policies as the value of telehealth to patients has been widely established.

While many of the bills in front of the Committee address specific policies related to telehealth, it is critical that a holistic approach is ultimately adopted to ensure there are no policy gaps in legislation that would prevent patient access to telehealth services moving forward. Many bills have overlapping policies

included in them — reconciling them into one vehicle would be helpful to avoid confusion and promote uniformity. MGMA offers the following policy recommendations for telehealth legislation:

Expand access to telehealth services under the Medicare program by permanently removing current geographic and originating site restrictions

Before the COVID-19 PHE, in 2016, only 0.25% of beneficiaries in fee-for service Medicare utilized telehealth services.[1] Without the removal of the geographic and originating site restrictions under section 1834(M), following the end of the extension of telehealth flexibilities, telehealth utilization will significantly drop.

Telehealth should not be limited to Medicare beneficiaries in facilities located in rural areas as required prior to the flexibilities afforded by the COVID-19 PHE waivers. Medical groups must have the ability to virtually treat patients, when appropriate, regardless of their location. Eliminating these barriers would allow Medicare beneficiaries with limited mobility to receive critical and necessary care. These patients may not have access to the transportation necessary to attend in-person visits, and those in rural locations may live hours from their providers and be unable to spend half a day traveling to appointments. We appreciate the Committee for including multiple bills that would remove these restrictions.

Permanently cover and reimburse audio-only visits at a rate that adequately covers the cost of delivering that care

Audio-only visits have proven to be a lifeline to patients who may not have access to broadband services and are unable to attend visits in person. During the COVID-19 PHE, a large majority of MGMA members reported billing audio-only services, and in some cases, these services were only means of treating certain patients virtually.[2]

The Federal Communications Commission (FCC) reported that more than 8.3 million homes and businesses do not have access to high-speed broadband, further exemplifying the need for audio-only services.[3] Permanently adding audio-only codes and removing unnecessary restrictions would go a long way to facilitating quality care as the need for these services will not disappear after 2024.

Appropriately reimburse medical practices for telehealth services to allow them to provide cost-effective, high-quality care

CMS extended payment parity for in-person and telehealth visits in the most recent Medicare Physician Fee Schedule through 2024 for practitioners using Place of Service Code 10. Under CMS policy prior to the COVID-19 PHE, telehealth visits were reimbursed at the "facility rate," which is a significant reduction in practice expense payments for overhead costs. MGMA has heard from members that the cost and administrative burden of providing care to patients is not commensurately reduced when care is furnished through telehealth.

There are many facets to providing high-quality telehealth care: practices must still schedule, facilitate, and document the visits, virtually check-in with patients, and schedule follow-up appointments; HIPAA-

[1] Centers for Medicare & Medicaid Services, "Information on Medicare Telehealth," Nov. 15, 2018.
[2] MGMA poll, Physician Fee Schedule Q&A, Aug. 26, 2020.
[3] Jessica Rosenworcel, Federal Communications Commission, "National Broadband Map: It Keeps Getting Better," May 30, 2023.

complaint IT infrastructure must be installed; and practices must troubleshoot technical problems while establishing multiple workflows for both virtual and in-person visits. Reimbursement must appropriately account for the myriad factors and costs associated with facilitating a telehealth visit in the long term.

Ensure continuity of care between a practice and its patients through telehealth

Promoting high-quality care in the patient-physician relationship is essential, and legislation instituting permanent policies should bolster care continuity within a medical practice setting so that telehealth is able to support care for beneficiaries. Installing guardrails to discourage fragmented care from patients seeking services from outside vendors is important to sustain a strong telehealth system. Coverage could be improved by removing administratively burdensome billing requirements, like the requirement to collect co-pays for virtual check-ins.

The *Consolidated Appropriations Act of 2021* implemented flexibilities in Medicare allowing practitioners to provide telehealth services to patients in non-rural areas and in their homes for the purposes of diagnosis, evaluation, or treatment of a mental health disorder other than for treatment of a diagnosed substance use disorder (SUD) or cooccurring mental health disorder. Initially, upon conclusion of the PHE, continued Medicare coverage would have been contingent on there being an initial in-person visit within six months of the telehealth service and an in-person visit within 12 months of each mental telehealth service furnished. Subsequent legislation provided additional clarity by implementing the in-person visit requirements on Jan. 1, 2025. MGMA believes permanently eliminating the six month in-person visit requirement would promote equitable access to care for patients without creating unnecessary barriers.

Allow practitioners offering telehealth services from their home to continue reporting their work address on their Medicare enrollment to avoid privacy and security concerns

During COVID-19, CMS allowed practitioners to offer telehealth services from their homes while maintaining Medicare enrollment from their work addresses. This policy was extended through the end of this year in the 2024 Medicare Physician Fee Schedule. MGMA believes that home reporting requirements for practitioners offering telehealth services from home should be eliminated so they may continue to report from their work address.

CMS' current policy mitigates significant privacy and security concerns as this information may be available to the public. It also alleviates the undue administrative burden of having to update Medicare enrollments for every practitioner that would divert critical medical group resources away from clinical care. Should CMS not permanently address the home reporting issue this year, we urge Congress to enact legislation to protect practitioners' privacy.

H.R. 4189, *CONNECT for Health Act of 2023*

The *CONNECT for Health Act of 2023* would accomplish many of our priorities such as permanently removing geographic and originating site restrictions, eliminating the six-month in-person requirement for telemental health services, and more. Enacting this bipartisan legislation would be a great step to advancing patients' access to care.

Conclusion

MGMA looks forward to working with the Committee to support legislation that will help ensure medical groups can continue offering telehealth services to patients across this country. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at [redacted] or [redacted].

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

April 9, 2024

The Honorable Brett Guthrie
Chairman
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The Honorable Anna Eshoo
Ranking Member
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The Honorable Larry Bucshon, M.D.
Vice Chairman
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Re: Subcommittee Hearing: "Legislative Proposals to Support Patient Access to Telehealth Services"

Dear Chairman Guthrie, Ranking Member Eshoo, and Vice-Chairman Bucshon:

On behalf of the American Psychological Association Services, Inc. (APA Services), I want to thank the Subcommittee for convening this hearing concerning the future of access to behavioral health treatment via telehealth. APA Services is the companion organization of the American Psychological Association, which is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

While the COVID-19 pandemic represented a source of stress for many,[1] paradoxically it also helped facilitate an unprecedented expansion of access to behavioral health services through increased coverage of telehealth as a modality of treatment.[2] In December 2020, Congress encouraged the continued expansion of telehealth by enacting reforms that permanently allowed Medicare enrollees to receive mental health services via telehealth from their own homes.[3] However, the new law also required a periodic in-person exam for continued coverage of their telehealth services, a requirement that is currently set to go into effect after the end of 2024. This

[1] American Psychological Association (October 2020). Stress in America 2020: A National Mental Health Crisis, available at https://www.apa.org/news/press/releases/stress/2020/report-october.
[2] J. Lo, M. Rae, K. Amin, et. al. (Mar. 15, 2022). Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic, available at https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/.
[3] Consolidated Appropriations Act of 2021, Pub. L. 116-260 (Dec. 27, 2020).

in-person visit requirement is an unnecessary and arbitrary barrier to treatment, which will disproportionately impact patients in rural and underserved areas whom the law was meant to assist in the first place.

Additionally, the current statute prevents Medicare beneficiaries receiving health behavior services via telehealth from doing so in their own homes. The distinction between "mental health" and "health behavior" services is critical for psychologists, who often provide services such as health behavior assessment and intervention (HBAI) services that are furnished to individuals with a medical condition—such as diabetes or pain. A treatment team will bring in a health behavior specialist like a psychologist to help patients manage physical health problems. Health behavior assessment includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Health behavior interventions includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. Because the patient does not have a primary mental health diagnosis, the services are not classified as "mental health" services.

To address these issues, APA Services commends the Subcommittee for including the **Telemental Health Care Access Act (H.R. 3432)** and the **CONNECT for Health Act (H.R. 4189)** in its April 10th hearing. We appreciate the Subcommittee's consideration of a variety of proposals to ensure that any gains in access to behavioral health services via telehealth are not undone after the end of the year. To the extent that our psychologists can serve as a resource to the Subcommittee on this issue, please feel free to reach out to Andrew Strickland, Senior Legislative and Regulatory Counsel, at any time ([redacted]).

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer
American Psychological Association Services, Inc.

STATEMENT

of the

American Medical Association

U.S. House of Representatives

Energy and Commerce Subcommittee on Health

Re: Legislative Proposals to Support Patient Access to Telehealth Services

April 10, 2024

Division of Legislative Counsel

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Statement for the Record

of the

American Medical Association

to the

U.S. House of Representatives

Energy and Commerce Subcommittee on Health

Re: Legislative Proposals to Support Patient Access to Telehealth Services

April 10, 2024

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House Energy and Commerce Subcommittee on Health as part of the hearing entitled, "Legislative Proposals to Support Patient Access to Telehealth Services." The AMA commends the Subcommittee for its consideration of this critically important issue aimed at, among other things, ensuring the continuation of certain programs and policy flexibilities granted as part of the response to the COVID-19 pandemic that help ensure patients retain access to at-home care. The COVID-19 pandemic made clear that rural and underserved areas that have historically lacked adequate access to health care services can greatly benefit from permanent legislative and regulatory flexibilities. As a result, we applaud the Subcommittee for recognizing the importance of promoting health equity as it considers which COVID-19 policies to retain to facilitate continued access to home-based care. In addition, we urge Congress to consider how making many of these existing flexibilities permanent will provide the necessary assurances that physicians, health care organizations, and patients may need before investing additional resources into policies such as telehealth and the Hospital at Home program. Long-term or permanent extensions of policies that promote and enable at-home care will bring further value to the American health care system.

Improving and expanding access to telehealth services by removing antiquated statutory restrictions and requirements.

The AMA strongly recommends that Congress permanently lift the restrictions on access to telehealth services for Medicare patients by passing S. 2016/H.R. 4189, the "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act," H.R. 7623, the "Telehealth Modernization Act," H.R. 134, to amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services, H.R. 5611, the "Helping Ensure Access to Local TeleHealth (HEALTH) Act of 2023," H.R. 3432, the "Telemental Health Care Access Act," and H.R. 7711, the Advancing Access to Telehealth Act."

Introduced by Representatives Mike Thompson (D-CA) and David Schweikert (R-AZ), the "CONNECT for Health Act" is bipartisan legislation that would permanently extend many important COVID-19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. More specifically, the bill repeals the existing Medicare geographic site restrictions and

permanently modifies the originating site requirements to allow patients to receive telehealth services wherever the patient can access a telecommunications system, including, but not limited, to the home. These COVID-19 policies have allowed patients to obtain telehealth services at home instead of having to travel to a medical facility to receive virtual care from a distant site. They have also allowed Medicare patients located in urban and suburban areas to have access to telehealth services for the first time. COVID-19 flexibilities also enabled patients to access health care services through audio-only visits when they do not have reliable access to two-way audio-video telecommunications technology. Therefore, passage of the "Telehealth Modernization Act" (S. 3967/H.R. 7623), introduced by Senators Tim Scott (R-SC) and Brian Schatz (D-HI) in the Senate, and Reps. Buddy Carter (R-GA), Lisa Blunt Rochester (D-DE), Greg Steube (R-FL), Terri Sewell (D-AL), Mariannette Miller-Meeks (R-IA), Jeff Van Drew (R-NJ), and Joe Morelle (D-NY) in the House, is crucial because in addition to eliminating the Medicare geographic and originating site restrictions on telehealth coverage, it permanently continues the ability to use audio-only telehealth services beyond the current statutory deadline of December 31, 2024. Access to two-way audio-visual telehealth and audio-only services has lowered or eliminated barriers that many patients in rural and underserved areas face when trying to obtain in-person care, such as functional limitations that make it difficult to travel to physician offices, long travel times, workforce shortages, the need for a caregiver to accompany the patient, and patients experiencing unstable housing and lack of transportation and childcare.

Permanently removing the antiquated geographic restrictions and modifying the originating site requirements means patients will no longer have to travel, counterintuitively, to a limited set of brick-and-mortar medical sites to access virtual care. In an effort to boost access to virtual mental health services, The Connect for Health Act also repeals the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within six months of an initial telehealth visit for a mental health condition. Federal lawmakers have also introduced stand-alone bills, specifically H.R. 3432/S. 3651, the "Telemental Health Care Access Act," to remove these in-person visit requirements that will only stifle access to mental health services. While federal lawmakers have, thus far, passed legislation delaying the mandate for patients to receive an in-person visit within six months of receiving an initial telemental health service from taking effect, it is crucial this policy is permanently removed to ensure patients retain ample access to virtual mental health services. Absent Congressional intervention, the in-person telemental health requirements will go into effect on January 1, 2025, so it is crucial legislative action occurs expeditiously.

The dramatic increase in the availability of telehealth services has catalyzed the development and diffusion of innovative hybrid models of care delivery utilizing in-person, telehealth, and remote monitoring services so that patients can obtain the optimal mix of service modalities to meet their health care needs. These models can also reduce fragmentation in care by allowing patients to obtain telehealth services from their regular physicians instead of having to utilize separate telehealth-only companies that may not coordinate care with patients' medical home. Now, all Americans, including rural, underserved, minoritized and marginalized patients, can receive a combination of in-person and virtual care, which is crucial for patients with chronic diseases. Congress should not permit these flexibilities to expire as it will run counter to its goals of promoting more home-based care.

Addressing fraud, waste, and abuse concerns associated with expanded access to telehealth.

In general, the AMA urges members of the Subcommittee to reject any inclination to establish additional guardrails, including in-person visits or mandatory audits, in the name of rooting out fraud, waste, and

abuse. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication of services are of particular concern for telehealth services.

The AMA believes existing HHS and OIG fraud capabilities and authorities are more than adequate to police telehealth services in the same way they oversee in-person Medicare services. A February 2024 HHS OIG report confirms this conclusion.[1] For 105 out of the 110 sampled Evaluation and Management (E/M) services provided via telehealth during the early parts of the pandemic, providers appropriately complied with Medicare requirements. As a result, OIG did not provide any policy recommendations to CMS because, "…providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records." Medicare fraud is still Medicare fraud, irrespective of whether it involved telehealth services. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare & Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority, or other technologies such as phone, text, or remote patient monitoring.

In February 2021, HHS's Principal Deputy Inspector General (OIG) released a statement dispelling any concerns with OIG's authority or ability to address concerns of fraud and abuse. Instead, HHS OIG's statement highlights concerns stem from "telefraud" schemes, rather than "telehealth fraud," in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the telehealth visit but instead use the sham telehealth visit to induce a patient to agree to receive unneeded items and gather their info. In other words, whether the telehealth service itself is covered has no impact on these kinds of fraudulent schemes.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. CMS has also implemented Place of Service (POS) indicators for this purpose, including POS 02 when the originating site is someplace other than the patient's home and POS 10 when the patient is in their home. Additional indicators may be used for asynchronous services and home health services provided via telehealth. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via Modifier 95 and other CMS indicators. 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. Modifier 95 and the POS indicators are applicable for telemedicine services rendered through December 31, 2024. The requirement to code with Modifier 95 and POS enables CMS to properly decipher and track telemedicine services, thus improving the chances of identifying and rooting out fraud, waste, and abuse.

[1] https://oig.hhs.gov/oas/reports/region1/12100501.asp.

Extending the Acute Hospital Care at Home Waiver Program.

In addition to telehealth, the Subcommittee should consider extending flexibilities that permit the continuation of the hospital-at-home program. Introduced by Representatives Brad Wenstrup (R-OH) and Earl Blumenauer (D-OR), the "Hospital Inpatient Services Modernization Act" achieves this goal by extending acute hospital care at home waiver flexibilities until September 2027. On March 11, 2023, the AMA along with other organizations, including medical groups participating in the Acute Hospital Care at Home (AHCaH) waiver program, submitted a request to Congress asking for at least a five-year extension of AHCaH before its expiration at the end of 2024. Without an extension, Medicare beneficiaries will lose access to AHCaH programs that have demonstrated excellent clinical outcomes and lower costs of care. With an expiration set for the end of this year, medical groups and health systems nationwide need assurance that this waiver program will be extended if they are going to invest their resources into logistics, supply chain, and workforce for AHCaH. A five-year extension can also help ensure hospital inpatient unit care is available for the patients who need it while enabling patients who can and want to be treated in their home to have the opportunity to do so, creating needed capacity for hospitals without increasing health system costs.

The State of Health at Home Models: Key Considerations and Opportunities

Building on existing playbooks and resources supporting digitally enabled care, the American Medical Association conducted research to explore the different ways health care is and can be provided in the home. The AMA report titled, "The State of Health at Home Models: Key Considerations and Opportunities" offers a comprehensive guide that outlines the concept and benefits of delivering care to patients in their home environments.[2] These include recommendations to:

- Determine whether your practice or organization should build your health at home program internally or partner with another organization.
- Consider required training to strengthen your mobile workforce, which is a core component of health at home programs.
- Ensure you understand the unique and varied circumstances of each home environment and plan for the patient and caregiver experience in detail.
- Develop the infrastructure up front that will provide the necessary tools to appropriately handle the flow of resources and information to provide patient care as required by your specific program.

Future of Health Case Study: Atrium Health

This case study highlights how this vision is being accomplished through a strategic partnership between a traditional brick-and-mortar health system and a technology company, with a common goal to build and scale a program that enables patients to continue their care and recovery at home. Each organization brings its expertise to the partnership, enabling thoughtful development and implementation of a complex, digitally enabled clinical initiative.

Creating a permanent Medicare Diabetes Prevention Program benefit that allows services to be delivered virtually.

[2] https://www.ama-assn.org/system/files/health-at-home-models.pdf.

The AMA supports H.R. 786, the "PREVENT DIABETES Act," introduced by Representatives DeGette (D-CO), and Bilirakis (R-FL). This important legislation would broaden access to diabetes prevention services by aligning the Medicare Diabetes Prevention Program (MDPP) with the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (DPP), make MDPP a permanent benefit in Medicare, ensure seniors can participate in the program more than once, and expand access to all CDC-recognized delivery modalities including virtual diabetes prevention platforms in the program. We, among other stakeholders, believe that one of the most significant factors contributing to current low enrollment in MDPP includes restrictions with respect to eligible suppliers and limiting the benefit to in-person programs. The consequence of this limitation prevents Medicare beneficiaries from taking advantage of the same virtual DPP programs that have greatly expanded access to DPP services under the CDC Diabetes Prevention Recognition Program. This legislation would expand access to life-changing preventative services while keeping important oversight, accountability, and program integrity protections in place.

Improving maternal and infant health outcomes for pregnant and postpartum women with the support of telehealth and remote patient monitoring solutions.

Telehealth and technology enabled devices have proven to be key assets in the physician's toolbox for prevention and improved health outcomes for a number of conditions. The AMA recognizes the same technology is critical to addressing maternal mortality and morbidity by helping screen new mothers for high blood pressure and related treatable and preventable conditions, such as preeclampsia, that lead to unnecessary and avoidable maternal deaths and adverse health outcomes. AMA supports the Connected Maternal Online Monitoring (MOM) Act. This bill would require CMS to send a report to Congress identifying barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity. The AMA strongly supports this legislation which would make a meaningful difference in addressing the unacceptably high rate of maternal mortality in the U.S., especially for women from marginalized populations.

CONCLUSION

The AMA is committed to working with Congress to find permanent solutions that ensure Medicare beneficiaries have uninterrupted continued access to high quality, affordable health care, including virtual care and care delivered in the home setting. We must build on the gains achieved during the pandemic so that all patients regardless of their zip code have access to the care they need.

Children's Hospital Association Statement for the Record

U.S. House Energy and Commerce Subcommittee on Health Hearing, "Legislative Proposals to Support Patient Access to Telehealth Services"

April 10, 2024

On behalf of the nation's children's hospitals and the children and families we serve, thank you for holding this hearing, "Legislative Proposals to Support Patient Access to Telehealth Services." We applaud your efforts to ensure that telehealth services are expanded and encourage you to prioritize the distinct needs of children, who represent some 25% of the total U.S. population.

Children's hospitals are increasingly the only places in their region with the breadth of pediatric specialists and subspecialists, equipment and other resources required to treat children, particularly those with rare and complex clinical conditions. Furthermore, teams of pediatric specialists are typically concentrated near large children's hospitals, underscoring the regional nature of pediatric specialty care for high-acuity conditions.

As a result, it is not uncommon for children, particularly those with medical complexity or specialized health care needs, to travel out of their communities, regions or states to receive care that can only be provided at a children's hospital. For these children, the children's hospital is the focal point of care, as pediatric specialists are frequently needed to provide expertise in treating their rare and complex clinical conditions. Additionally, many children, especially those in rural areas or residing far from specialized medical centers in their home state, face significant challenges in accessing care. Telehealth plays a crucial role in addressing these challenges by enabling children to connect with healthcare providers remotely, reducing the need for extensive travel and ensuring timely access to specialized care when appropriate.

Congress should examine opportunities to encourage and incentivize states to promote telehealth access and advance national Medicaid policies that level the telehealth playing field across the country for children. We encourage you to work with states to sustain telehealth policies implemented during the COVID-19 pandemic by advancing information about state Medicaid supports, incentives and learnings to encourage more widespread and high-quality use and adoption of telehealth for children. In particular, policies that allow for parity of telehealth coverage and reimbursement, including telehealth facility fees for clinical support services and infrastructure will help sustain telehealth access moving forward.

Telehealth has played a critical role in addressing some of the constraints that children and their families face accessing care due to geography—particularly in rural and other underserved areas. It also has allowed children with special health care needs or complex conditions, including technology-dependent children, to forgo long and complicated trips to one or more facilities and to connect with providers located outside of their home state. As a result, patient and family satisfaction has increased, and they can engage in care more efficiently.

Telehealth and PHE

The temporary expansions in telehealth regulations during the PHE have greatly facilitated access to care for children, especially those with chronic or complex conditions and those residing in remote areas. These flexibilities, including broader coverage and reimbursement policies, have proven instrumental in ensuring continuity of care and improving patient outcomes. However, to sustain these benefits beyond the emergency period, it is crucial to prioritize legislative actions that solidify telehealth's role in pediatric care delivery.

Telebehavioral Health

Anecdotal experience during the pandemic indicates patients may be more comfortable seeking behavioral health services using video or audio-only modalities, and no-show rates for these types of appointments have declined. Children and youth with access to telemental behavioral services seem to feel more comfortable seeing their mental health care provider in their own homes, and the provider is able to see their home environment, which can have implications for their care and outcomes. However, there is significant variation across states regarding telehealth policies and regulations, which is concerning because children with special needs or medical complexity, such as those who are dependent on technology, benefit from expanded access to telehealth services.

Originating Site/Distant Site

States chose to expand the originating site, or the site where the patient is located, to allow for the patient's home to be considered an eligible originating site during the pandemic. Before the pandemic, patients might have been required to travel to a health care facility for care via telehealth. Similarly, the distant site was expanded to include the clinician's home, allowing these clinicians to provide care while required to self-isolate or socially distance due to exposure to the coronavirus or increased risk. We also support removing geographic restrictions to allow broader access to telehealth. Congress should advance policies that continue these site expansions.

Congressional Action Needed

As the landscape of healthcare delivery evolves, it imperative for legislative actions to keep pace with the needs of patients, particularly vulnerable populations such as children. The following bills present tangible opportunities for Congress to enact meaningful reforms that support patient access to telehealth services:

H.R. 4189, CONNECT for Health Act: Sponsored by Representatives Thompson, D-Calif., Schweikert, R-Ariz., and Matsui, D-Calif., this legislation aims to enhance Medicare coverage and reimbursement for telehealth services. Recognizing the interconnectedness of Medicare and Medicaid policies, the CONNECT for Health Act sets a precedent that could impact Medicaid coverage and reimbursement structures. By addressing barriers to telehealth adoption in Medicare, such as licensure restrictions and originating site requirements, this bill paves the way for similar reforms in Medicaid. We encourage incentivizing states to align their Medicaid programs with the principles outlined in the CONNECT for Health Act, particularly by reconsidering the six-month in-person requirement. Removing this barrier would notably improve access to telehealth services for children and youth, especially for telemental health services, ensuring equitable healthcare access regardless of location. As advocates for children and

families, we call for the alignment of Medicaid policies with the CONNECT for Health Act to promote universal access to telehealth services.

H.R. 1110, KEEP Telehealth Options Act: Sponsored by Representatives Balderson, R-Ohio, Lee, D-Nev., Hinson, R-Iowa, and Neguse, D-Colo., this bill requires the Department of Health and Human Services, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment and Access Commission to conduct studies to provide information about the expanded use of telehealth during the COVID-19 pandemic. Additional data on telehealth uptake and usage is critical to help inform changes that will need to be addressed going forward to ensure patients, including children, can continue to benefit from the convenience and accessibility of telehealth. We endorse this effort and anticipate collaborating on next steps, particularly in advancing telehealth support within Medicaid.

H.R. 5541, Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act: Introduced by Representatives Latta, R-Ohio and Dingell, D-Mich., the TREAT Act addresses interstate licensure barriers, facilitating the provision of telehealth services across state lines during a PHE. This measure is crucial for children with specialized healthcare needs who may require access to out-of-state pediatric specialists during a national emergency. By promoting temporary licensure reciprocity, the TREAT Act enhances access to high-quality care for children regardless of geographical constraints.

In light of the invaluable role telehealth plays in pediatric care delivery, we urge Congress to prioritize the passage of these critical pieces of legislation. By supporting these bills, lawmakers can ensure that children and families have continued access to telehealth services, promoting equitable healthcare access and improved health outcomes nationwide.

In closing, we extend our sincere gratitude to the House Energy and Commerce Committee Chair Cathy McMorris Rodgers, R-Wash., Subcommittee on Health Chair Brett Guthrie, R-Ky., and all members of the committee for their commitment to advancing legislation that supports patient access to telehealth services, including children. As representatives of the nation's children's hospitals and the children and families we serve, we commend your dedication to ensuring that telehealth remains a viable option for all patients, particularly those in rural areas or facing unique healthcare challenges. We stand ready to collaborate with you in achieving these critical goals and look forward to a future where telehealth continues to play a central role in delivering high-quality, patient-centered healthcare. Thank you for your unwavering commitment to the well-being of our nation's children.