



Testimony of Frederic Riccardi

President

Medicare Rights Center

“Legislative Proposals to Support Patient Access to Telehealth Services”

United States House of Representatives

Committee on Energy & Commerce

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**Summary Testimony of Fred Riccardi, President, Medicare Rights Center before
House Committee on Energy & Commerce, Health Subcommittee
April 10 hearing, “Legislative Proposals to Support Patient Access to Telehealth Services”**

The changes in Medicare telehealth spurred by the COVID-19 public health emergency (PHE) represent the biggest shift in policy and utilization since those services were created over 25 years ago. These flexibilities helped many beneficiaries safely and responsibly obtain needed care during the pandemic, likely leading to improved health outcomes. While we applaud these successes, not all beneficiary experiences have been positive—or studied. Telehealth service quality and the impact of these changes on health care disparities also remain largely unexamined, though research to date suggests inequities between in-person and remote care, as well as in accessing telemedicine across numerous demographic categories: age, race, ethnicity, preferred language, and income. Our own experiences counseling beneficiaries yield similar concerns. Since the PHE flexibilities have been in place, some callers to our national helpline have reported greater access to care, while others have faced new or heightened barriers and been left behind.

As a result, we are skeptical of calls to broadly extend the PHE telehealth system without needed updates, such as requirements for additional information gathering, service oversight, and beneficiary protections. To be clear, we do not support a return to the overly restrictive pre-pandemic treatment of Medicare telehealth services. We are, however, unconvinced that the flexibilities and lack of enforcement necessary during the PHE—a highly-specific time of crisis—will best serve beneficiaries and Medicare long term.

Congress has a generational opportunity to strengthen Medicare telehealth for millions of current and future beneficiaries. We encourage a deliberate approach that centers beneficiary needs, preferences, and experiences. In our testimony, we specifically recommend advancing policies that: (1) Meaningfully **increase access** to care; (2) Promote **health equity**; (3) Include robust **consumer protections and oversight**; and (4) Drive **high-quality** care.

Introduction

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

Medicare Telehealth Coverage

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

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

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

Original Medicare covers three types of virtual services: telehealth visits,¹ virtual check-ins,² and e-visits.³ Each has different eligibility standards, provider requirements, and payment rules—many of which were outdated prior to being put on hold in response to the COVID-19 public health emergency (PHE).⁴ This system has long been hard to understand, overly restrictive, and difficult to navigate, often leaving beneficiaries without meaningful access to remote care.

A main limitation of the pre-PHE rules is that most telehealth visits are only available in narrow circumstances. Medicare requires the beneficiary to live in a rural area and to travel to an “originating site”—such as a doctor’s office, hospital, or skilled nursing facility—for the service. There, they conference with a “distant site” provider via real-time audio-video technology. This usage helps connect people in rural areas with specialist care that is not within easy traveling distances, addressing a serious health care delivery challenge. But it does not contemplate the other promising uses of telemedicine technology, such as providing timely, acute care to beneficiaries in their homes, lowering barriers to mental health and substance use disorder treatment, reducing transportation burdens more broadly, and making it easier to manage chronic conditions.

Although these cumbersome geographic and originating site restrictions apply only to telehealth, virtual check-ins and e-visits have their own limitations: They are only for established patients; subject to strict frequency limits; and exclude certain types of providers and services. They are also, by design, less robust than a full telehealth visit, which can substitute, where appropriate, for an in-office visit. Virtual check-ins are brief telephone calls between providers and patients, and e-visits are non-synchronous care, relying on portals that allow patients to message their providers and receive an answer back within seven days.

Medicare Advantage plans are required to cover the same virtual services as Original Medicare and can offer additional benefits, including telehealth to people in their own homes and in non-rural areas.⁵ This imbalance creates an unequal system and further confusion.

¹ Centers for Medicare & Medicaid Services, “Telehealth” (last accessed April 7, 2024), <https://www.medicare.gov/coverage/telehealth>.

² Centers for Medicare & Medicaid Services, “Virtual check-ins” (last accessed April 7, 2024), <https://www.medicare.gov/coverage/virtual-check-ins>.

³ Centers for Medicare & Medicaid Services, “E-visits” (last accessed April 7, 2024), <https://www.medicare.gov/coverage/e-visits>.

⁴ Julia Shaver, “The State of Telehealth Before and After the COVID-19 Pandemic” (December 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/>.

⁵ Medicare.gov, “Medicare Advantage Plans Cover all Medicare Services” (last accessed April 7, 2024), <https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services>.

Medicare Telehealth Coverage During the COVID-19 Pandemic

The COVID-19 outbreak spurred significant changes in Medicare telehealth. Early into the pandemic, it was clear that Medicare beneficiaries—people over 65 and those with disabilities—were at high risk of infection, serious illness, and death.⁶ Congress responded quickly. In March 2020, lawmakers took steps to add telehealth flexibilities to the Medicare program. Such PHE-related legislative mandates, in addition to administrative actions, allowed the Centers for Medicare & Medicaid Services (CMS) to temporarily broaden Medicare telehealth coverage.

Under these authorities, the agency grew the list of reimbursable telehealth services and providers, waived geographic and originating site restrictions, loosened requirements about pre-established patient-provider relationships, and permitted services to be delivered via a wider array of devices and technologies, in order to respond to unprecedented circumstances.⁷ These flexibilities, which took effect amid broad lockdowns and pandemic-related precautions, allowed more beneficiaries to receive more services via telehealth, using more types of technology, and from more locations, including their own homes. Due to subsequent legislation and rulemaking,⁸ many of the PHE-era changes are still operational, some permanently so, with others expiring later this year.⁹

Below, we highlight some of the resulting trends in (1) **telehealth utilization**, as well as the (2) **beneficiary perspective** of these services and (3) the role of **beneficiary choice** in care delivery, drawing on recent research and (4) the experiences of callers to **Medicare Rights’ national helpline**.

Recent Telehealth Trends and Utilization

Once the initial PHE flexibilities were in place, beneficiary uptake was swift. Telemedicine use, particularly in Original Medicare, increased dramatically within a matter of weeks.¹⁰ Before the pandemic, approximately

⁶ Centers for Disease Control and Prevention, “COVID-19 Cases and Hospitalizations Among Medicare Beneficiaries With and Without Disabilities — United States, January 1, 2020–November 20, 2021” (June 17, 2022), <https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7124a3-h.pdf>.

⁷ Centers for Medicare & Medicaid Services, “Information Related to Coronavirus Disease 2019—COVID-19” (March 10, 2020), <https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf>.

⁸ Lok Wong Samson, *et al.*, ASPE, “Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019–2021” (July 20, 2023), <https://aspe.hhs.gov/sites/default/files/documents/cb83f6f25c25c3a3529807f23cd2327d/medicare-telehealth-updated-trends-report.pdf>.

⁹ U.S. Department of Health and Human Services, “Telehealth policy changes after the COVID-19 public health emergency” (last accessed April 7, 2024), <https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency>.

¹⁰ See, e.g., Ateev Mehrotra, *et al.*, “The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices are Adapting to the New Normal” (June 25, 2020), <https://www.commonwealthfund.org/publications/2020/jun/impact-covid-19-pandemic-outpatient-visits-practices-adapting-new-normal>; and Assistant Secretary for Planning and Evaluation, “Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic” (July 28, 2020), https://connectwithcare.org/wp-content/uploads/2021/01/HP_IssueBrief_MedicareTelehealth_final7.28.20.pdf.

13,000 beneficiaries received telemedicine in any given week. By the end of April 2020, that number had skyrocketed to 1.7 million.¹¹ Compared to pre-pandemic levels (April to December 2019), beneficiary telehealth use rose from about 5 million services to more than 53 million (from April to December 2020).¹² Utilization peaked around this time, with roughly 47% of people with Original Medicare obtaining a telehealth service in early to mid 2020. That share has fallen steadily and is now around 12%.¹³ Despite this tapering, Medicare telehealth is still used more broadly today than before the pandemic.¹⁴

Amid declines in utilization, service trends have remained consistent over time. Behavioral health visits have seen the highest engagement, followed by primary care. In 2021, behavioral telehealth appointments accounted for 35% of all behavioral health specialist visits (down from a high of 56% in 2020) and 10% of primary care visits (down from 37% in 2020). Telehealth appointments for all other conditions comprised 5% of primary care visits (down from 23%) and 1% of non-behavioral health specialist visits (down from 10%).¹⁵

Research indicates that throughout the pandemic, telehealth usage was varied across demographic and geographic groups. Telehealth use varied by state, trending higher in the Northeast and West, and lower in the Midwest and South.¹⁶ Analysis of Medicare claims data shows that women, urban residents, and beneficiaries aged 65 – 84 had higher odds of Medicare telehealth usage than minorities, rural residents, beneficiaries with disabilities, and those over age 85. Researchers found substantial racial disparities, with White beneficiaries using telehealth far more than any other group. “These disparities by sex, race, rurality, and disability status persisted through 2021 and 2022, indicating telehealth usage divides [did] not improv[e] over time.”¹⁷

There were also noteworthy disparities in audio-only and video-based telehealth use. Across all insurance types, the likelihood of video telehealth use rose with household income and educational attainment.¹⁸ Hispanic,

¹¹ Seema Verma, “Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19” Health Affairs (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

¹² U.S. Government Accountability Office, “Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks” (September 26, 2022), <https://www.gao.gov/products/gao-22-104454>.

¹³ Centers for Medicare & Medicaid Services, “Medicare Telehealth Trends Report, Medicare FFS Part B Claims Data: January 1, 2020 to September 30, 2023” (March 7, 2024), https://data.cms.gov/sites/default/files/2024-03/Medicare%20Telehealth%20Trends%20Snapshot%2020240307_508.pdf.

¹⁴ See, e.g., Centers for Medicare & Medicaid Services, “Medicare Telehealth Trends Report, Medicare FFS Part B Claims Data: January 1, 2020 to September 30, 2023” (March 7, 2024), https://data.cms.gov/sites/default/files/2024-03/Medicare%20Telehealth%20Trends%20Snapshot%2020240307_508.pdf; and Kersten Bartelt, et al., “Telehealth Utilization Higher Than Pre-Pandemic Levels, but Down from Pandemic Highs” (November 21, 2023), <https://www.epicresearch.org/articles/telehealth-utilization-higher-than-pre-pandemic-levels-but-down-from-pandemic-highs>.

¹⁵ See, e.g., Lok Wong Samson, et al., ASPE, “Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019-2021” (July 20, 2023), <https://aspe.hhs.gov/sites/default/files/documents/cb83f6f25c25c3a3529807f23cd2327d/medicare-telehealth-updated-trends-report.pdf>; and Kersten Bartelt, et al., “Telehealth Utilization Higher Than Pre-Pandemic Levels, but Down from Pandemic Highs” (November 21, 2023), <https://www.epicresearch.org/articles/telehealth-utilization-higher-than-pre-pandemic-levels-but-down-from-pandemic-highs>.

¹⁶ Lok Wong Samson, et al., ASPE, “Medicare Beneficiaries’ Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location” (December 2021), <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf>.

¹⁷ Akshaya S. Bhagavathula, et al., “Building the Telehealth Divide: Racial and Ethnic Disparities in Medicare Telehealth Usage Highlights the Need for Equity-Focused Approaches” Telemedicine and e-Health (January 12, 2024), <https://pubmed.ncbi.nlm.nih.gov/38215268/>.

¹⁸ *Id.*

Black, and Asian individuals were much less likely to use video telehealth than White patients.¹⁹ Overall, Medicare beneficiaries had higher rates of video telehealth use than privately insured patients.²⁰

According to CMS, some of these differences may be driven by “access to broadband internet, varying state-level policies on the delivery of telehealth across state lines and the timing and degree to which the pandemic affected geographic areas differently.”²¹ Further, inadequate infrastructure factors, such as unreliable internet connections, lack of access to technology, and workflow issues, may impact a provider’s ability to offer video telehealth, potentially curtailing beneficiary access across a community or region.²² Other analysis proposes “barriers to digital access and literacy, lack of trust and previous negative health care experiences” as well as cultural and language incongruence and “lack of awareness about telehealth benefits coupled with insufficient outreach and promotion” may also play a part.²³

Further study is needed to confirm key reasons for these patterns, develop effective intervention strategies, and inform future policymaking. Alongside any telehealth service extensions, we urge comprehensive data collection, analysis, and publication, including on how provider readiness, patient preferences, adequate broadband and technologies, cultural and linguistic competence, digital literacy trainings, and community-level outreach can impact access to clinically appropriate, high-quality telehealth services.²⁴

The Beneficiary Perspective

Although the PHE expansions greatly loosened often burdensome care restrictions, the Medicare beneficiary experience with telehealth during the pandemic has been mixed.²⁵ Importantly for your work, many people, including those with positive views of telehealth, favor a return to in-person care, often citing personal

¹⁹ Euny C. Lee, *et al.*, ASPE, “Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)” (April 19, 2023), <https://aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf>.

²⁰ Akshaya S. Bhagavathula, *et al.*, “Building the Telehealth Divide: Racial and Ethnic Disparities in Medicare Telehealth Usage Highlights the Need for Equity-Focused Approaches” *Telemedicine and e-Health* (January 12, 2024), <https://pubmed.ncbi.nlm.nih.gov/38215268/>.

²¹ Centers for Medicare & Medicaid Services, “Medicare Telehealth Trends Report, Medicare FFS Part B Claims Data: January 1, 2020 to September 30, 2023” (March 7, 2024), https://data.cms.gov/sites/default/files/2024-03/Medicare%20Telehealth%20Trends%20Snapshot%2020240307_508.pdf.

²² Euny C. Lee, *et al.*, ASPE, “Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)” (April 19, 2023), <https://aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf>.

²³ Akshaya S. Bhagavathula, *et al.*, “Building the Telehealth Divide: Racial and Ethnic Disparities in Medicare Telehealth Usage Highlights the Need for Equity-Focused Approaches” *Telemedicine and e-Health* (January 12, 2024), <https://pubmed.ncbi.nlm.nih.gov/38215268/>.

²⁴ *Id.*

²⁵ Rupa S. Valdez, *et al.*, “Ensuring full participation of people with disabilities in an era of telehealth” *Journal of the American Medical Informatics Association* (November 9, 2020), <https://academic.oup.com/jamia/article/28/2/389/5988542>.

preferences and quality concerns. As you consider legislative changes, we encourage a close examination of existing and emerging beneficiary feedback, and its incorporation into Medicare’s telehealth framework.

For example, in a nationally representative survey of primary care physician and patient views of PHE-era telemedicine, 90% of both groups reported favorable experiences with video telehealth visits. An overwhelming majority of physicians (86%) said video visits were important in reaching their patients during the pandemic, and half of patients (50%) said they would have delayed or skipped care without them.

Yet, few members of either cohort were satisfied with telehealth quality. Nearly two-thirds of physicians (61%) and one-third of patients (33%) said video telehealth was inferior to in-person care, largely due to the absence of a physical exam and face-to-face interaction, as well as technical and communication difficulties.²⁶ Only small shares of those surveyed—6% of physicians and 16% of patients—thought the quality of video visits was higher than that of in-person care.

Going forward, nearly all of the physicians (80%) said they would “prefer to provide only a small share of care or no care via telemedicine,” and only 36% of patients said they wanted “to seek care by video or phone” in the future (with 31% preferring video visits and 5% preferring telephone calls).²⁷ The clear majority of patients, 64%, wanted to return to in-person care. Patients who were older or less educated were more supportive of such a shift, as were Asian, Hispanic, and Black patients. The survey findings underscore that a one-size-fits-all approach to Medicare telehealth is not appropriate or desired.

Beneficiary Choice

In addition to recognizing the beneficiary perspective, as you contemplate how future Medicare telehealth policies could best meet beneficiary needs, we urge you to consider the important role of agency and choice.

Beneficiary choice is a cornerstone of person-centered care, a necessary component of shared decision-making, and a core element of health care quality.²⁸ By definition, it involves “providing care that is respectful of

²⁶ Gillian K. SteelFisher, *et al.*, “Video Telemedicine Experiences In COVID-19 Were Positive, But Physicians And Patients Prefer In-Person Care For The Future” Health Affairs (April 2023), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01027>.

²⁷ *Id.*

²⁸ Jessica Sousa, *et al.*, “Choosing Or Losing In Behavioral Health: A Study Of Patients’ Experiences Selecting Telehealth Versus In-Person Care” Health Affairs (September 2023), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00487>.

and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”²⁹

Despite its significance, details are scarce regarding patient choice in the PHE Medicare telehealth landscape, including on whether beneficiaries have access to both in-person and telehealth visits or an understanding of how providers decide to use or offer a particular modality.³⁰ The data that does exist suggests improvements are needed to strengthen patient involvement, provider responsiveness, and care delivery.

A 2023 survey of telehealth consumers found they were dissatisfied with the low levels of control and choice they had over how to receive their care. One-third of respondents said their provider did not offer both modalities (telehealth and in-person care), 32% reported they did not typically receive their preferred visit type, and 45% did not believe their provider considered their preferences when scheduling appointments. Although favorability of in-person care and telehealth varied, nearly all respondents wanted the choice. Achieving this, of course, requires program rules and provider behaviors that prioritize and accommodate beneficiary preferences.

At the community level, policymakers can advance these goals by building a beneficiary-centered system—setting payment rates that incentivize access to both modalities; imposing robust network adequacy standards that do not contemplate virtual-only care; and ensuring beneficiaries have the tools and resources they need (such as accurate and publicly posted provider directories and adequately funded SHIPs) to identify providers who offer their preferred modality in a person-centered way.

At the service delivery level, providers can increase beneficiary engagement and agency by discussing available modalities at the time of scheduling and as part of telehealth consent, and through ongoing conversations with patients about their needs, priorities, and preferences. Where providers cannot accommodate patient choices, they can explain why and, as appropriate, help them obtain more suitable care.

²⁹ Agency for Healthcare Research and Quality, “Six Domains of Healthcare Quality” (last accessed April 7, 2024), <https://www.ahrq.gov/talkingquality/measures/six-domains.html>.

³⁰ Jessica Sousa, *et al.*, “Choosing Or Losing In Behavioral Health: A Study Of Patients’ Experiences Selecting Telehealth Versus In-Person Care” Health Affairs (September 2023), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00487>.

Medicare Rights Helpline Experiences

These survey perspectives align with what Medicare Rights hears on our national helpline. Since the PHE flexibilities have been in place, some callers have reported greater access to care, while others have faced new or heightened barriers and been left behind. We have heard from people who easily navigated the changes, as well as from patients and providers with worries about telehealth being used inappropriately. For example, one Medicare Rights client, Ms. N, reached out because she had a serious leg infection and was worried the treatment her provider offered through telehealth was substandard and ineffective. A primary care provider, Dr. D, told us one of her patients collapsed during a telehealth visit, requiring her to contact and rely on outside emergency services for swift, lifesaving intervention.

And asymmetric beneficiary experiences are not uncommon. Consider two Medicare Rights clients, Ms. S and Ms. L. They have never met but have much in common. They live in the same New York city neighborhood, are primary speakers of a non-English language, are in Medicare Advantage plans, and are dually eligible for Medicare and Medicaid. They were also both diagnosed with COVID in late 2020. During and after her diagnosis, Ms. S had access to her provider through virtual and in-person visits. She also received an iPad and training on relevant technologies. Ms. L, however, was not offered care via telehealth or in-person; her provider instructed her to go to the Emergency Room if she needed help. Despite similar circumstances, coverage, and diagnoses, their encounters with the PHE Medicare telehealth system could not have been more different. The mere existence of telehealth alone does not solve for inequity in treatment and care, and, without oversight and guardrails, could exacerbate it. Telehealth is a tool, and like others, it must be used prudently.

Post-Pandemic Medicare Telehealth Coverage

The PHE developments represent the biggest shift in Medicare telehealth policy and utilization since the services were created over 25 years ago. As discussed above, these flexibilities helped many beneficiaries safely and responsibly obtain needed care during the pandemic, likely leading to improved health outcomes.³¹

³¹ Khayreddine Bouabida, *et al.*, "Telehealth and COVID-19 Pandemic: An Overview of the Telehealth Use, Advantages, Challenges, and Opportunities during COVID-19 Pandemic" *Healthcare* 2022 (November 16, 2022), <https://pubmed.ncbi.nlm.nih.gov/36421617/>.

While we applaud these successes, not all beneficiary experiences have been positive—or studied.³² Telehealth service quality³³ and the impact of these changes on health care disparities also remain largely unexamined, though research to date reveals inequities between in-person and remote care,³⁴ as well as in accessing telemedicine across numerous demographic categories: age, race, ethnicity, preferred language, and income.³⁵ Our own experiences counseling beneficiaries yield similar conclusions.

As a result, we are skeptical of calls to broadly continue the PHE telehealth system without needed updates, such as requirements for additional information gathering, service oversight, and beneficiary protections. To be clear, we do not support a return to the overly restrictive pre-pandemic treatment of Medicare telehealth services. We are, however, unconvinced that the flexibilities and lack of enforcement necessary during the PHE—a highly-specific time of crisis—will best serve beneficiaries and Medicare long term.

Congress has a generational opportunity to strengthen Medicare telehealth for millions of current and future beneficiaries. We encourage a deliberate approach that centers beneficiary needs, preferences, and experiences. The following principles, drawn from collaborative partnerships and our 35 years of helping people understand and navigate Medicare, are intended to support those efforts.³⁶ When contemplating changes to Medicare telehealth, we recommend advancing policies that: (1) Meaningfully **increase access** to care, (2) promote **health equity** (3) include robust **consumer protections and oversight**, and (4) drive **high-quality** care.

Increase Access to Care

Telehealth should serve as an additional access point—supplementing, but not supplanting, in-person care. Some beneficiaries and their families may prefer telehealth for certain services, but not others. Virtual options can reduce caregiving burdens, require less time spent off work, and allow remote caregivers and loved ones more

³² U.S. Government Accountability Office, “Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks” (September 26, 2022), <https://www.gao.gov/products/gao-22-104454>.

³³ U.S. Government Accountability Office, Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks” (September 26, 2022), <https://www.gao.gov/products/gao-22-104454>.

³⁴ Gillian K. SteelFisher, *et al.*, “Video Telemedicine Experiences In COVID-19 Were Positive, But Physicians And Patients Prefer In-Person Care For The Future” Health Affairs (April 2023), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01027>.

³⁵ See, e.g., Lauren A. Eberly, *et al.*, “Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic” JAMA (December 29, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488>; Madjid Karimi, *et al.*, ASPE, “National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services” (February 1, 2022), <https://aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021>; Jen Lau, *et al.*, “Reducing Disparities In Telemedicine: An Equity-Focused, Public Health Approach” Health Affairs (May 2022), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00314>.

³⁶ See, e.g., Medicare Rights Center, “Comments for the Telehealth Taskforce” (July 13, 2020), <https://www.medicarerights.org/policy-documents/comments-for-the-telehealth-taskforce>; Medicare Rights Center and Center for Medicare Advocacy, Joint Principles from the Center for Medicare Advocacy and the Medicare Rights Center (July 2020), <https://www.medicarerights.org/pdf/072320-cma-joint-principles-telehealth.pdf>; LCAO, “Draft Telehealth Principles (May 5, 2021), https://www.lcao.org/wp-content/uploads/2022/01/LCAO-Telehealth-Principles_approved-by-full-LCAO-7.7.21_formatting-needed.pdf; and

The SCAN Foundation, “Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers” (January 2023), <https://www.thescanfoundation.org/media/2023/01/2023-01-PHE-Flexibilities-Roadmap-for-Policymakers.pdf>.

interaction with providers, as requested by the patient. But some people may find telemedicine to be unavailable, unworkable, or uncomfortable. Protecting that choice is critical. An effective Medicare program must support the full range of beneficiary needs and preferences. Specific recommendations include:

- **Remove Geographic and Site Restrictions.** Under current law, Original Medicare generally cannot pay for telehealth for beneficiaries in urban areas, or at all unless the beneficiary goes to a qualifying health care facility to connect with a doctor remotely. These restrictions may have been appropriate in 1997 when the services were created, but they no longer reflect the technology landscape or the beneficiary experience.³⁷ Medicare claims data bears this out—beneficiaries across the country have been successfully accessing telehealth, and uptake has consistently been higher among urban beneficiaries than rural dwellers.³⁸ Medicare Advantage and many commercial insurers can already reimburse for telehealth services without geographic or originating site limitations.³⁹ Congress must allow Original Medicare to do the same.
- **Pursue Appropriate Rate Setting.** During the PHE, CMS began paying providers the in-person rate for qualifying services furnished via Medicare telehealth. This means providers have been receiving higher reimbursements for virtual services than they did before the pandemic. Doing so on a permanent basis, for all modalities and all services, could create financial incentives that undermine access to in-person care, putting beneficiary health and agency at risk. We urge you to support Medicare telehealth payment rates that are sufficient, sustainable, and properly structured. This is a delicate but crucial balance: If payment for telehealth is too high, it could jeopardize access to in-person services, whereas if it is too low, it could jeopardize access to telehealth.
- **Safeguard Network Adequacy.** Medicare Advantage network adequacy rules exist to make sure enrollees can access needed care. Troublingly, starting with the 2021 Part C & D rule, CMS has given plans credit toward network adequacy when they contract with telehealth providers under certain circumstances,

³⁷ Centers for Medicare & Medicaid Services, “Information on Medicare Telehealth” (November 15, 2018), <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf>.

³⁸ Centers for Medicare & Medicaid Services, “Medicare Telehealth Trends Report, Medicare FFS Part B Claims Data: January 1, 2020 to September 30, 2023” (March 7, 2024), https://data.cms.gov/sites/default/files/2024-03/Medicare%20Telehealth%20Trends%20Snapshot%2020240307_508.pdf.

³⁹ MedPAC, “Mandated Report: Telehealth Services and the Medicare Program” (March 2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0.

diluting these consumer protections.⁴⁰ We urge you to correct this. Virtual-only care must not count toward meeting network adequacy standards. Those guardrails are intended—and must—be built to support beneficiary preferences and needs, which includes robust access to in-person, locally available care.

- **Examine Interactions with Other Systems.** All post-PHE changes, which should be promulgated through normal legislative or regulatory procedures, must ensure that interrelated protections are either sufficient or updated in a coordinated way. For example, access to telehealth must not create loopholes that allow offices or facilities to skirt Americans with Disabilities Act (ADA) compliance, and privacy laws may need to be revisited to address evolving threats and technologies and protect patient privacy and health care information.
- **Equalize Access in Original Medicare and Medicare Advantage.** Telehealth service expansions must be identical in Original Medicare and Medicare Advantage, so that all beneficiaries have equal access to care. We also support correcting imbalances that allow Medicare Advantage plans to offer telehealth services that Original Medicare cannot.
- **Center Beneficiary Needs and Preferences.** Changes to Medicare telehealth policy must expand, rather than contract, beneficiary choice, agency, and care options. This includes maintaining access to in-person care, otherwise ensuring beneficiaries have a choice between care modalities, and recognizing that beneficiary preferences vary and evolve.

Promote Health Equity

Older adults and people with disabilities, in particular those in underserved communities, can disproportionately lack access to the devices and internet services that are a necessary component of telemedicine.⁴¹ Some PHE

⁴⁰ Medicare Rights Center, “Comments on Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly” (April 6, 2020), <https://medicarerights.org/pdf/medicare-rights-2021-c-d-rule-comments.pdf>.

⁴¹ See, e.g., Yohualli Balderas-Medina Anaya, et al., UCLA, “Telehealth & COVID-19: Policy Considerations to Improve Access to Care” (May 2020), <https://latino.ucla.edu/wp-content/uploads/2020/05/Telehealth-COVID-19-Report.pdf>; and Pew Research, “Internet, Broad Band Fact Sheet” (January 31, 2024), <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?tabId=tab-480dace1-fd73-4f03-ad88-eae66e1f4217>.

flexibilities may be appropriate longer-term policies, but careful planning and evaluation is needed to make sure that any expansions or other changes advance health equity goals. Specific recommendations include:

- **Prioritize Underserved Communities.** The differences in access to broadband internet, technologies, and digital literacy across regions and demographics⁴² need to be stabilized to reduce disparities.⁴³

Community-based organizations and health care providers are often uniquely positioned to intervene, but lack the resources to do so.⁴⁴ Congress could support this work, directing funding and other aid to communities with lower rates of technology access and use—including Black Americans, Latino Americans, Indigenous people, other people of color, individuals with disabilities, and people with limited English proficiency—to improve utilization.⁴⁵ More broadly, we encourage a holistic approach:

Meaningfully advancing equity requires looking beyond telemedicine-specific gaps and supporting the other systems—such as safety-net programs and community health centers—that disproportionately serve marginalized populations.⁴⁶

- **Collect and Analyze Data.** Telehealth expansions must not exacerbate health, racial, or income disparities. To align current and future policies with these goals, federal agencies must be directed to purposefully collect and publicly report data on telehealth use and barriers, including detailed demographic data (e.g., race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socioeconomic status, insurance coverage, and geographic location). Data collection and analysis must be culturally competent and consistent with patient privacy laws.
- **Promote Digital Inclusion.** The use of technology among older adults and people with disabilities increased during the COVID-19 pandemic, with many using computers, smartphones, wearable devices, and other technologies to access telehealth.⁴⁷ Policymakers, health care professionals, and researchers

⁴² Pew Research, “Internet, Broad Band Fact Sheet” (January 31, 2024), <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?tabId=tab-480dace1-fd73-4f03-ad88-eae66e1f4217>.

⁴³ See, e.g., Andrew Sixsmith, *et al.*, “Older People’s Use of Digital Technology During the COVID-19 Pandemic” (June 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9038938/>; Yosselin Turicos, SAMHSA “Digital Access: A Super Determinant of Health” (March 22, 2023), <https://www.samhsa.gov/blog/digital-access-super-determinant-health>; and Pew Research, “Internet, Broad Band Fact Sheet” (January 31, 2024), <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?tabId=tab-480dace1-fd73-4f03-ad88-eae66e1f4217>.

⁴⁴ See, e.g., HHS, “Improving Access to Telehealth” <https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth>; Courtney R. Liles, *et al.*, California Health Care Foundation “Bridging the Digital Health Divide: How Providers and Plans Can Help Communities Better Adopt Digital Health Tools” (February 2022), <https://www.chcf.org/wp-content/uploads/2022/02/BridgingDigitalDivideProvidersPlans.pdf>; and Ryan A. Mace, *et al.*, “Older adults can use technology: why healthcare professionals must overcome ageism in digital health” *Translational Behavioral Medicine* (September 8, 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9494377/>.

⁴⁵ See, e.g., Older Adults Technology Services from AARP (OATS) & the Humana Foundation, “Aging Connected: Closing the Connectivity Gap for Older Americans” (January 2021), https://agingconnected.org/wp-content/uploads/2021/01/Aging-Connected_2021.pdf; and Pew Research, “Internet, Broad Band Fact Sheet” (January 31, 2024), <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?tabId=tab-480dace1-fd73-4f03-ad88-eae66e1f4217>.

⁴⁶ Elaine C. Khoong, “Policy Considerations to Ensure Telemedicine Equity” *Health Affairs* (May 2022), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00300>.

⁴⁷ Ryan A. Mace, *et al.*, “Older adults can use technology: why healthcare professionals must overcome ageism in digital health” *Translational Behavioral Medicine* (September 8, 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9494377/>.

must recognize and support these efforts, and avoid harmful, ageist assumptions about digital health literacy that can undermine beneficiary care, outcomes, and well-being.⁴⁸

- **Support Workforce and Infrastructure Development.** Advancing equitable access to telehealth will require investing in non-health care systems, like telecommunications and technology infrastructure, as well as reforming the health care workforce in ways that build capacity and economic security. We also recommend ensuring that digital health tools and solutions are designed inclusively, including by encouraging technology developers to adhere to user-centered design practices that take into consideration the unique needs of older adults and people with disabilities into consideration.⁴⁹
- **Protect Beneficiary Rights.** Policymakers must closely monitor the marketing and provision of Medicare telehealth services in general, and to guarantee compliance with anti-discrimination rules and guidelines, including requirements around the use of interpreters and the provision of materials in alternative formats and non-English languages.

Consumer Protections and Oversight

Some of the recent Medicare telehealth changes expanded coverage, but others suspended important beneficiary protections. As you consider next steps for many of these service-related flexibilities, we urge you to reinstate and fortify the beneficiary protections that undergird that care. Specific recommendations include:

- **Improve Outreach, Education, and Documentation.** We recommend adopting policies to reduce misunderstandings and misinformation about one's care options and costs. Specifically, providers must be required to accurately disclose beneficiary cost-sharing obligations and available clinical modalities prior to the service, and to fully document such disclosures. Where they cannot meet patient needs and preferences, providers should endeavor to help them obtain care elsewhere. CMS must invest in beneficiary decision-making tools and assistance, as well as in outreach to consumers and providers

⁴⁸ See, e.g., HHS, "Improving Access to Telehealth" <https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth>; Courtney R. Liles, et al., California Health Care Foundation "Bridging the Digital Health Divide: How Providers and Plans Can Help Communities Better Adopt Digital Health Tools" (February 2022), <https://www.chcf.org/wp-content/uploads/2022/02/BridgingDigitalDivideProvidersPlans.pdf>; and Ryan A. Mace, et al., "Older adults can use technology: why healthcare professionals must overcome ageism in digital health" *Translational Behavioral Medicine* (September 8, 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9494377/>.

⁴⁹ Courtney R. Liles, et al., California Health Care Foundation, "Bridging the Digital Health Divide: How Designers Can Create More Inclusive Digital Health Tools" (February 2022), <https://www.chcf.org/wp-content/uploads/2022/02/BridgingDigitalDivideDesigners.pdf>.

around financial responsibilities and rights to person-centered care. The agency must also ensure that plans and providers are not engaging in deceptive marketing, outreach, or billing practices, intentionally or unintentionally.

- **Strengthen Beneficiary Consent Safeguards.** The PHE flexibility for providers to obtain an established patient’s consent for virtual check-ins at the time the service is provided, rather than prior to it, was made permanent in the CY 2021 PFS Final Rule.⁵⁰ In our experience, when these events co-occur, beneficiaries are more likely to agree to the service without fully understanding their financial obligations. This can lead to confusion and billing surprises, as well as mistrust, disruptions in care continuity, and fraud reporting. The complexity and relative novelty of telehealth may make these outcomes even more likely.⁵¹ We support advance consent and written notification processes that are designed to facilitate informed decisions.
- **Maintain Important Face-to-Face and in-Person Requirements.** The temporarily waived face-to-face and in-person requirements for certain evaluations and certifications relating to hospice, inpatient rehabilitation facilities, and national and local coverage determinations, some of which are still in place, must not be made permanent. These in-person visits are important for proper care delivery and planning, as well as for patient safety and program integrity. As Medicare Rights’ helpline callers have observed, these benefits are not easily achieved via remote care: They often report the virtual assessments are of poor quality and little use.
- **Protect Patient Privacy.** Privacy laws and protections must apply to all telehealth interactions between beneficiaries and providers, and personal health data must also be kept secure. We appreciate the federal agency efforts to date to educate providers and patients about data privacy and security.⁵² We encourage ongoing outreach on these issues and, as mentioned above, endorse more systemic alterations, such as updating privacy laws to reflect new technologies.

⁵⁰ Centers for Medicare & Medicaid Services, “Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19” (November 6, 2023), <https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf>.

⁵¹ Gabriela Weigel, et al., KFF, “Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond” (May 11, 2020), <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>.

⁵² U.S. Government Accountability Office, “Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks” (September 26, 2022), <https://www.gao.gov/products/gao-22-104454>.

- **Strengthen Data Collection and Evaluation.** CMS and other federal agencies, as appropriate, must collect and publicly release data on all Medicare-covered telehealth services, including the type of services being provided; instances and patterns of fraud, waste, and abuse; program integrity vulnerabilities and safeguards; beneficiary use, experiences, and preferences; programmatic and beneficiary spending; health outcomes; and, as discussed below, telehealth quality. Such monitoring can inform future policymaking, as well as help verify people are receiving the care they want and need in a way that is affordable and sustainable for beneficiaries and the program.
- **Combat Fraud.** Financial and other scams targeting people with Medicare are, sadly, not new. But the rise of telehealth may put beneficiaries and the program at greater risk for certain schemes,⁵³ including efforts to trick patients into accessing services they neither want nor need, exaggerations about the level of care provided, claims that care was provided when it was not, or even completely fictional provider-patient relationships.⁵⁴ These potential problems should be one of the factors policymakers consider when contemplating permanent telehealth changes, as should mitigation strategies. Consumer protections (e.g., advance written notice and consent to services) and program safeguards (e.g., monitoring and preventing upcoding and gaming of the risk adjustment system, as well as provider and beneficiary education) should be adopted wherever possible, and additional funding provided to support enhanced reporting, analysis, data collection, and oversight. We also urge putting these and other program integrity concerns in the appropriate context: Most providers have good intentions and want to serve their patients as best they can. Indeed, according to the U.S. Department of Health and Human Services Office of Inspector General (OIG), a relatively small share of providers appear to be engaging in fraudulent telehealth billing practices under the PHE telehealth system.⁵⁵ While we agree with OIG that these bad actors “demonstrate the importance of strong, targeted oversight of telehealth services,” we urge Congress not to cut off access to care unnecessarily, punishing the many for the sins of the few.⁵⁶

⁵³ See, e.g., Joan Stephenson, “Report Dissects Fraud Risk in Telehealth Services Billed to Medicare” JAMA Health Forum (September 13, 2022), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2796512>; and Nilpa D. Shah, et al., “Exploring Fraud, Waste, and Abuse within Telehealth” The Healthcare Fraud Prevention Partnership (May 2023), <https://www.cms.gov/files/document/hfpp-white-paper-exploring-fraud-waste-abuse-within-telehealth.pdf-0>.

⁵⁴ Alicia Diaz, “Federal watchdog raises concerns about increasing telehealth fraud during pandemic” STAT (February 21, 2021), <https://www.statnews.com/2021/02/22/federal-watchdog-raises-concerns-about-increasing-telehealth-fraud-during-pandemic/>.

⁵⁵ HHS OIG, “Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks” (September 2, 2022), <https://oig.hhs.gov/oei/reports/OEI-02-20-00720.asp>.

⁵⁶ *Id.*

High-Quality Care

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

- **Update Service and Provider Coverage as Clinically Appropriate and Supported by Evidence.** All covered telehealth services and providers must be clinically appropriate, as determined through CMS processes. Changes to the list of allowable telehealth services and providers should be made through notice-and-comment rulemaking—rather than through sub-regulatory guidance or statute—to maximize policy responsiveness, program nimbleness, and public engagement. Any coverages that are found to not meet clinical or other standards should be addressed quickly and seamlessly, to avoid breaks in or inappropriate care.
- **Ensure Equitable Access to Telehealth Modalities.** Seldom reimbursed prior to the pandemic, audio-only visits can make telehealth available to people who lack the technology or strong internet signals needed for useful video communications, potentially reducing disparities, and improving health. Indeed, many people with Medicare have relied on such devices for care during the PHE: Audio-only visits comprised about one-quarter of Medicare telehealth visits in both 2020 and 2021.⁵⁷ However, research suggests the use of audio-only telemedicine is only partially related to patient access to technology: Of Medicare beneficiaries who were exclusively offered audio-only visits in 2020, 66% had access to telehealth-compatible devices and the internet.⁵⁸ Hispanic, dually eligible, non-primary English speaking, and rural beneficiaries were more likely to be offered audio-only,⁵⁹ while video telehealth utilization was found to rise with income and education levels.⁶⁰ Though data on audio-only quality is limited, findings indicate

⁵⁷ Lok Wong Samson, *et al.*, ASPE, “Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019-2021” (July 20, 2023), <https://aspe.hhs.gov/sites/default/files/documents/cb83f6f25c25c3a3529807f23cd2327d/medicare-telehealth-updated-trends-report.pdf>.

⁵⁸ Ivy Benjenk, *et al.*, “Disparities in Audio-only Telemedicine Use Among Medicare Beneficiaries During the Coronavirus Disease 2019 Pandemic” *Medical Care* (November 1, 2021), <https://pubmed.ncbi.nlm.nih.gov/34534186/>.

⁵⁹ *Id.*

⁶⁰ Euny C. Lee, *et al.*, ASPE, “Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)” (April 19, 2023), <https://aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf>.

these services may exacerbate the disparities they are purported to reduce.⁶¹ Additional study is needed, and Medicare must not promote a two-tiered system of care. We urge that any extensions of audio-only telehealth be accompanied by strictly enforced safeguards. For example, practices offering audio-only visits should, ideally, also offer video visits, and check in with patients ongoingly to ensure they feel that telehealth is meeting their needs. When patient modality preferences cannot be met, providers should help them obtain care elsewhere, as appropriate. We also support the system-wide implementation of digital equity strategies to help patients who face technology access or literacy barriers obtain care in accordance with their preferences.

- **Update Modality, Device, and Technology Coverage as Clinically Appropriate and Supported by Evidence.** Decisions about what kind of care can be delivered safely and effectively using different modalities, including through audio-only interfaces and other non-broadband technologies, should rely on clinical determinations and outcomes and be subject to rigorous and ongoing oversight and data collection. Policymakers must balance the potential gains with the potential harms and establish robust consumer protections.
- **Ensure Appropriate Provider Relationship Requirements.** Where appropriate clinical and evidentiary support is present, telehealth services should be available to both new and established patients. However, this flexibility must be accompanied by robust oversight to ensure that beneficiaries are receiving the care they need, and that clinicians are providing the care they claim to be.
- **Advance Data Collection and Measures.** Actionable information on telehealth quality is lacking. A 2022 U.S. Government Accountability Office (GAO) study found that CMS does not have complete data on the use of audio-only technology or telehealth visits furnished in beneficiaries' homes, making it impossible to know if the quality of these services is equivalent to in-person care.⁶² Though some coding and billing practices have been updated to address this, those adjustments are too little, too late—they neither

⁶¹ See, e.g., Lori Uscher-Pines, et al., "Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic" JAMA (February 2, 2021), <https://jamanetwork.com/journals/jama/fullarticle/2776166>; Madjid Karimi, et al., ASPE, "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services" (February 1, 2022), <https://aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021>; and Lori Uscher-Pines, et al., "Many Clinicians Implement Digital Equity Strategies To Treat Opioid Use Disorder" Health Affairs (February 2023), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00803>.

⁶² U.S. Government Accountability Office, "Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks" (September 26, 2022), <https://www.gao.gov/products/gao-22-104454>.

capture prior year experiences nor constitute a comprehensive assessment of telehealth quality. Absent this information, “CMS may not be able to fully ensure that [telehealth] services lead to improved health outcomes”—potentially widening gaps in public and policymaker understanding and worsening beneficiary care.⁶³ We agree with GAO that CMS must examine telehealth quality to ensure services are appropriate, equitable, and effective. As of March 2024, however, CMS continued to disagree with this recommendation, saying they do not have any such assessment measures or the funding to develop them.⁶⁴ We strongly urge that any telehealth service extensions include funding for necessary measure development, as well as data collection, evaluation, and publication.

- **Promote Continuous Quality Improvement.** Similarly, policymakers must continuously study, evaluate, and adjust Medicare telehealth, to make sure it keeps pace with evolving technologies and beneficiary needs. This includes using and developing telehealth-specific quality measures that capture beneficiary satisfaction and outcomes. When service components are found to be clinically ineffective, or to worsen health, reduce access to care, or widen disparities, they must be swiftly corrected or curtailed.

Conclusion

Through our work with people with Medicare and their families, including our national helpline, we frequently hear from beneficiaries who are struggling.⁶⁵ Many have limited financial resources, face systemic inequities, and are confused and overwhelmed by complex Medicare rules and requirements. In addition to these longstanding barriers, older adults and people with disabilities, particularly those of color, were among those hit hardest by the COVID-19 pandemic and its economic fallout.⁶⁶

Given the confluence of these risks and circumstances, we greatly appreciate efforts to widen Medicare telehealth coverage during the PHE. And, since a system developed for and during a crisis may not be well suited beyond it, we similarly appreciate your thoughtful consideration regarding the post-PHE landscape.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ See, e.g., Medicare Rights Center, “2018-2019 Medicare Trends and Recommendations” (October 9, 2020), <https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations>; “2020 – 2021 Medicare Trends and Recommendations” (May 24, 2022), <https://www.medicarerights.org/policy-documents/2020-2021-medicare-trends-and-recommendations>; and “2022 Medicare Trends and Recommendations” (October 3, 2023), <https://www.medicarerights.org/policy-documents/2022-medicare-trends-and-recommendations>.

⁶⁶ See, e.g., Hannah R. Abrams, et al., “Characteristics of U.S. Nursing Homes with COVID-19 Cases” *Journal of the American Geriatrics Society* (June 2, 2020), <https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.16661>; Robert Gebeloff, et al., “The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes” *New York Times* (September 10, 2020), <https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html>; and Samantha Artiga, et al., KFF, “Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19” (April 7, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/>.

Looking ahead, as you consider various proposals to update Medicare’s telehealth policies in the coming months, we ask you to weigh not only the experiences of the past four years, but also the promises and perils of telehealth going forward. Legislation should anticipate and allow for nimble regulatory adjustments to ensure high-quality care, promote value, protect program integrity, manage participation rates, account for utilization barriers, maximize affordability and sustainability, and reduce disparities.

We note that additional reforms could complement any telehealth advancements by ensuring all who need such care can get it. Medicare services, be they delivered in-person or via telehealth, only help those who can access and afford them. Far too many older adults and people with disabilities have trouble connecting with and paying for their earned coverage.⁶⁷ Modernizing low-income assistance programs,⁶⁸ easing Medicare enrollment,⁶⁹ and decreasing barriers to care—including by curbing inappropriate denials,⁷⁰ boosting enrollment decision-making and notifications,⁷¹ and streamlining Medicare’s appeals processes⁷²—would more comprehensively beneficiary health and well-being.

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

⁶⁷ Medicare Rights Center, “2022 Medicare Trends and Recommendations” (October 2023), <https://www.medicarerights.org/pdf/2022-helpline-trends-report.pdf>.

⁶⁸ See, e.g., Medicare Rights Center, “Improving Access to Extra Help for Prescription Drugs” (March 1, 2023), <https://www.medicarerights.org/policy-documents/improving-access-to-extra-help-for-prescription-drugs>; “Improving the Effectiveness of Extra Help for Prescription Drugs” (March 1, 2023), <https://www.medicarerights.org/policy-documents/improving-the-effectiveness-of-extra-help-for-prescription-drugs>; “Improving Medicare Savings Programs” (March 1, 2023), <https://www.medicarerights.org/policy-documents/improving-medicare-savings-programs>; and “Increasing Access to Medicare Savings Programs: Lessons Learned and Policy Recommendations from New York” (June 27, 2023), <https://www.medicarerights.org/policy-documents/increasing-access-to-medicare-savings-programs>.

⁶⁹ See, e.g., Medicare Rights Center, “Simplifying Medicare Advantage Enrollment” (March 1, 2023), <https://www.medicarerights.org/policy-documents/simplifying-medicare-advantage-enrollment>; Medicare Part B Enrollment: Pitfalls and Solutions” (March 1, 2023), <https://www.medicarerights.org/policy-documents/medicare-part-b-enrollment-pitfalls-and-solutions>; and “The Beneficiary Experience with Medicare Advantage Enrollment and Access” (July 17, 2023), <https://www.medicarerights.org/policy-documents/the-beneficiary-experience-with-enrollment-and-access>.

⁷⁰ See, e.g., Medicare Rights Center, “The Beneficiary Experience with Medicare Advantage Enrollment and Access” (July 17, 2023), <https://www.medicarerights.org/policy-documents/the-beneficiary-experience-with-enrollment-and-access>

⁷¹ Medicare Rights Center, “Congress Must Streamline and Simplify Medicare Enrollment” (May 25, 2023), <https://www.medicarerights.org/policy-documents/congress-must-streamline-and-simplify-medicare-enrollment> and 2022 Medicare Trends and Recommendations” (October 2023), <https://www.medicarerights.org/pdf/2022-helpline-trends-report.pdf>.

⁷² See, e.g., Medicare Rights Center “Congress Must Streamline the Medicare Part D Prescription Drug Appeals Process” (July 31, 2019), <https://www.medicarerights.org/policy-documents/congress-must-streamline-the-medicare-part-d-prescription-drug-appeals-process>; “Case Study: Streamlining Part D Appeals Process Act” (July 31, 2019), <https://www.medicarerights.org/policy-documents/case-study-streamlining-part-d-appeals-process-act>; and “Medicare Part D Appeals Problems and Options to Correct Them” (March 1, 2023), <https://www.medicarerights.org/policy-documents/medicare-part-d-appeals-problems-and-options-to-correct-them>.