



January 4, 2020

The Senate Telehealth Working Group and House Telehealth Caucus
United States Congress
Washington, D.C. 20515

Re: Input for the CONNECT for Health Act of 2021

Dear Members and Staff of the Congressional Telehealth Caucus:

The Alliance for Connected Care (“the Alliance”) welcomes the opportunity to provide feedback on the Senate Telehealth Working Group and Congressional Telehealth Caucus’ request for information (RFI) on the 117th Congress’ iteration of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act. We applaud your continued leadership and critical role in ensuring Medicare beneficiaries were able to access connected care during the COVID-19 Public Health Emergency.

The Alliance is dedicated to improving access to care through the reduction of policy, legal and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of more than 30 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

The Alliance will provide 1) overarching comments about top priorities for telehealth legislation, 2) recommend new provisions for inclusion in the CONNECT package and 3) provide feedback on the continued relevancy of 2019 CONNECT provisions.

Critical Telehealth Priorities

These priorities were also outlined in the [July 2020 group letter](#) to Congress with 340 endorsing organizations. The following four items must be the core of CONNECT in 2021.

- Removal all geographic and originating site restrictions on telehealth in Medicare. The COVID-19 pandemic has clearly demonstrated the need for telehealth in rural areas, in urban areas, at work, at school, at home and many other locations. These provisions are obsolete and outdated and should be removed from statute entirely. The location of the patient should not matter for telehealth.
- 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.



- Ensure Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics can furnish telehealth in Medicare and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each.
- Make permanent the Health and Human Services (HHS) emergency waiver authority so that it can be quickly leveraged during future emergencies. Telehealth has maintained critical connections between patients and healthcare practitioners during the pandemic, and should be enabled for a future wildfire, flood, hurricane, or other emergency.

New Recommendations for Inclusion:

Given that the CONNECT Act is the centerpiece of telehealth policy, we encourage the Caucus to consider adding the following provisions:

- Enhance the ability of HHS to fight fraud in Medicare through new resources and capacity
 1. Provide additional funding for OIG to strengthen existing fraud, waste, and abuse mechanisms that have already been proven successful in fighting fraud perpetrated through virtual tools. The House Ways and Means minority staff has proposed workable text to this effect that we recommend the caucus adopt.
 2. Strengthen the *Public-Private Partnership for Health Care Waste, Fraud and Abuse Detection* created by the Consolidated Appropriations Act of 2021 (Section 1128C(a) of the Social Security Act (42 U.S.C. 1320a-7c(a)). This public-private partnership must be empowered with experts with experience in virtual care delivery and payment.
 - After – (6)(E)(i)(II) add “(III) *The executive board shall include no less than 3 individuals with significant expertise delivering and managing the delivery of virtual care, including practitioners, medical directors and individuals with oversight of telehealth programs, and virtual care experts with experience in corporate fraud prevention.*
- A comprehensive study of telehealth during the COVID-19 pandemic using claims data and qualitative interviews with providers and patients who used telehealth during the pandemic. The study should to answer specific questions critical to future telehealth decision-making by Congress and regulators at CMS. Priorities include:
 1. Is telehealth being adequately leveraged to address health disparities, and what policies could Congress or HHS enact to ensure telehealth is a tool to increase access to those most in need of healthcare?
 2. To what extent are Medicare telehealth services during the PHE replacing in-person care?
 - How often to telehealth services require a follow-up in person visit and how often are they fulfilling patient needs?
 - Is the availability of telehealth increasing utilization, and if so are they primary care or preventative services with the potential to prevent a more costly encounter downstream?



3. Are there specific, high-cost areas of the Medicare program that might lower long-term costs through telehealth utilization?
 - Are care coordination codes that have been shown to improve care such as 99495 and 99496 being used more frequently during virtual care?
 - Has the shift to using telehealth to manage lower acuity conditions in skilled nursing facilities prevented unnecessary transfers to hospitals?
 4. To what extent have CMS permissions for virtual/remote supervision of healthcare professionals been utilized during the COVID-19 pandemic? Have these permissions resulted in patient harm? How have healthcare providers expanded their capability and capacity using this tool during the PHE.
 5. In addition to HHS investigations of fraud and abuse, what has been the healthcare provider, patient, and health plan experience with fraud perpetrated through virtual tools during the PHE?
- Facilitate the removal of remaining telehealth restrictions on alternative payment models
 1. Accountable Care Organization's (ACO) telehealth flexibility is limited a narrow set of ACOs with downside risk and prospective assignment – even though other tools apply to all ACOs. Since all participants in the Medicare Shared Savings Program are being held accountable for quality, cost, and patient experience, all of them should have flexibility to use telehealth tools to deliver care. We recommend eliminating Sec. 1899. [42 U.S.C. 1395jjj] (l)(2) requirements limiting participation to a select set of ACOs. ⁱ (We believe CMS may already have the statutory authority to make these changes under 42 U.S.C. 1315a(d)(1) and 42 U.S.C. 1395jjj(f) if directing the use of authority instead would keep the score down)
 - Allow the Centers for Medicare and Medicaid Services to cover audio-only telehealth services when where necessary to bridge gaps in access to care. This would include, at a minimum, flexibility for areas with limited broadband service, for populations without telehealth-capable devices, or in necessary situations such as a future public health emergency. We anticipate that CMS would also maintain a list of services that were appropriate for this emergency audio-only care, as it has done during the PHE and that the clinician would document the reason.
 - Expand virtual chronic disease interventions with the potential to prevent downstream costs to the Medicare program.
 1. Virtual diabetes prevention programs (DPP) can produce transformative weight loss reducing the prevalence of obesity and comorbidities including prediabetes and type 2 diabetes. These programs can produce better outcomes for patients and would likely reduce downstream costs to the Medicare program, not only by expanding access to a broader set of beneficiaries but by keeping patients engaged and creating more



sustainable lifestyle changes. During the COVID-19 PHE, CMS has allowed DPP providers to practice virtually, but it has not created a long-term pathway for virtual DPP programs. As much of the commercial market has already moved to virtual care and app-driven interventions, the DPP program must be able to adapt to meet patients where they are and expand access to services for individuals not near a physical DPP provider.

- Expand the mandate of the Office for the Advancement of Telehealth at HRSA and require it to develop tools and resources on telehealth services that can be distributed to small healthcare practices, patients, and consumer organizations. Additionally, explore partnerships with leading consumer and patient organizations to educate seniors about telehealth services, including the use of technology and how to verify the identity of a healthcare provider.
- Encourage CMS to continue facilitating greater use of remote patient monitoring (RPM) technology through policy, including ongoing flexibility for allowing acceptance of patient-reported data for scales up to meet connected device requirements.

Feedback on Existing CONNECT for Health Text

Sec. 2. Findings and sense of Congress.

- The pandemic has provided new experiences and observations that should be incorporated into the Congressional findings. Given how the COVID pandemic has helped people with previously limited access to care, these findings should emphasize the importance of allowing for virtual visits with new patients, particularly for individuals who have experienced barriers to in-person care.

Sec. 3. Expanding the use of telehealth through the waiver of certain requirements.

- This section will not be necessary in legislation that removes geographic and originating site restrictions.

Sec. 4. Expanding the use of telehealth for mental health services.

- A future version of this section should be **devoted to modifying the language passed in the FY2021 appropriations bill** to strike the in-person relationship requirement. Adding an in-person requirement prevents people that are homebound, transient, or have existing healthcare access challenges from using telehealth – really negating so much of the value that telehealth creates in helping people that NEED access to care. The Alliance is happy to work with caucus leads and Committee staff to come up with an alternate approach to telehealth “guardrails” that do not create an in-person requirement.

Sec. 5. Use of telehealth in emergency medical care.

- This section will not be necessary in legislation that removes geographic and originating site restrictions.



Sec. 6. Improvements to the process for adding telehealth services.

- Update language instructing the Secretary to review the annual process to add new telehealth services to the list and improve as needed to also allow the Secretary to use a subregulatory process to expand and modify covered services.

Sec. 7. Rural health clinics and federally qualified health centers.

- Critical Access Hospitals are a critical part of rural health infrastructure. They have been left out of previous drafts. We urge you to include language in this section that pertains to critical access hospitals. Please see endnote I for proposed language. Similar language is supported by the National Rural Health Association, National Association of County Behavioral Health and Developmental Disability Directors, National Association for Rural Mental Health, and the National Organization of State Offices of Rural Health. Please note that while the Alliance does not consider an in-person relationship requirement appropriate for telehealth broadly, we were willing to support in this instance because a CAH is a geographically targeted provider with different payment rates.

Sec. 8. Native American health facilities.

- No feedback.

Sec. 9. Waiver of telehealth restrictions during national emergencies.

- As indicated above, we continue to support this language. We suggest you consider aligning with language in HR 7663.

Sec. 10. Use of telehealth in recertification for hospice care.

- No feedback

Sec. 11. Clarification for fraud and abuse laws regarding technologies provided to beneficiaries.

- While OIG has made progress in this area, we believe this provision would still be beneficial.

Sec. 12. Study and report on increasing access to telehealth services in the home.

- Should be replaced by the more comprehensive and impactful study outlined above.

Sec. 13. Analysis of telehealth waivers in alternative payment models.

- Allowing telehealth in APMs is literally the lowest telehealth bar to clear – MedPAC and others are comfortable with telehealth in APMs (and still evaluating broader). We should just go ahead and give the Secretary clear authority to waive all telehealth restrictions in all alternative payment models.



Sec. 14. Model to allow additional health professionals to furnish telehealth services.

- As recommended above, this should not be a model and should just create flexibility for more healthcare professionals to deliver telehealth services, as long as they are providing appropriate care.

Sec. 15. Testing of models to examine the use of telehealth under the Medicare program.

- No longer necessary due to our experience during COVID-19.

The Alliance greatly appreciates the Working Group and Caucus' leadership in working to ensure that seniors are able to realize the benefits of telehealth and remote patient monitoring. We are hopeful and confident that the telehealth provisions included in the upcoming iteration of the CONNECT for Health Act will usher in a new era in virtual care.

We appreciate the opportunity to provide feedback to the Caucus and look forward to continuing to work with Congress to increase access to high quality connected care. If you have any questions or would like to hear from Alliance member experts on these topics, please do not hesitate to contact Chris Adamec at cadamec@connectwithcare.org.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac".

Krista Drobac
Executive Director
