Written Testimony of the Alliance for Connected Care
Senate Finance Committee
Hearing on: "COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"
May 19, 2021

The Alliance for Connected Care appreciates the opportunity to submit testimony for this hearing examining COVID-19 health care flexibilities. The Alliance for Connected Care (the Alliance) is an advocacy organization dedicated to facilitating the delivery of high-quality care using connected care technology. Our members are leading health care and technology companies from across the health care spectrum, representing insurers, health systems, and technology innovators. Our Advisory Board includes 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 focus comments on 1) Research and evidence we have gathered thus far; 2) recommendations for future telehealth expansion that Congress should consider – including steps to ensure equitable access; and 3) Recommendations for telehealth "guardrail" provisions that Congress should consider to prevent fraud, waste and abuse in the health care system.

While we prefer the implementation of permanent policies described in our recommendations below, the Alliance supports a two-year clean extension of telehealth flexibilities exercised during the COVID-19 pandemic, including 1834(m) Medicare telehealth waivers, a safe harbor for employer-subsidized telehealth for people with Health Savings Account eligible High-Deductible Health Plans, and the flexibility for Critical Access Hospitals to continue to bill telehealth as they have during the pandemic. We want policymakers to feel comfortable that access to telehealth services in Medicare will not negatively impact health care quality, or the federal budget. Therefore, we recommend Congress wait to make permanent policy until more peer-reviewed research has been published, government studies – such as the study underway by AHRQ – have been completed, the Office of the Inspector General has examined the level of fraud in telehealth during the Public Health Emergency, and when we have observed what the use of telehealth during "normal times."

Telehealth Research and Evidence

We have a unique opportunity afforded by the PHE to understand the effects of telehealth on clinical practice – and to make direct apples-to-apples comparisons across service modality. The sudden shift to virtual services generated fee-for-service (FFS) data and empirical provider and patient experience that didn't exist prior to the pandemic. This data is just now being understood, and peer-reviewed studies and reports are forthcoming. We believe it is essential to take this new evidence into account when writing permanent laws especially given that pre-pandemic telehealth studies were either narrowly-focused or relied on inferences on the impact of Medicare using commercial or Veterans Affairs data.

The COVID-19 pandemic has resulted in drastic increases in telemedicine utilization, introducing millions of Americans to a new way to access health care. Data from the Centers for Disease Control and Prevention (CDC) finds that during the period of June 26 – November 6, 2020, 30.2 percent of weekly health center visits occurred via telehealth. In addition, preliminary data from the Centers for Medicare & Medicaid Services (CMS) show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE.

Finally, an HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicare fee-for-service (FFS) telehealth report found that from mid-March through early July more than 10.1 million traditional Medicare beneficiaries used telehealth, including nearly 50 percent of primary care visits conducted via telehealth in April vs. less than 1 percent before the COVID-19 pandemic. In addition to providing a lifeline to continuity of care, it is important to note that the net number of Medicare FFS primary care in-person and telehealth visits combined remained below pre-pandemic levels. As in-person care began to resume in May, telehealth visits dropped to 30 percent but there was still no net visit increase. We infer this and other data showing that as in-person visits increased, telehealth visits decreased, that there was a substitution effect. A claims-based analysis suggests that approximately $250 billion in health care spend could be shifted to virtual care in the long term – roughly 20 percent of all Medicare, Medicaid and commercial outpatient, office and home health spend. The effects of the COVID-19 pandemic on patients seeking or avoiding care still need further analysis, but these data suggest that telehealth substituted for in-person care without increasing utilization.

In addition to telehealth largely substituting for in-person care, policymakers should consider telehealth's ability to increase efficiencies and improve access where barriers to care exist. COVID-19 has dramatically heightened awareness of existing health disparities and made the call to address these longstanding issues more urgent. Transportation is just one example of a barrier to care that telehealth can alleviate. Transportation barriers are regularly cited as barriers to access, particularly for low-incomes or under/uninsured populations – leading to missed appointments, delayed care, and poor health outcomes. In a 2018 proposed rule, CMS estimated that telemedicine is saving Medicare patients $60 million in travel time, with a projected estimate of $100 million by 2024 and $170 million by 2029. CMS also noted that these estimates tend to underestimate the impacts of telemedicine. Higher projections estimate $540 million in savings by 2029.

The experience during COVID-19 has pushed forward a revolution in consumer attitudes toward virtual care. Polling data from the University of Michigan showed that one in four older adults had used telemedicine during the first three months of the pandemic, compared to just 4% in 2019. The same poll showed that 64% of those surveyed in June 2020 were comfortable with using videoconferencing technology for any purpose, up from 53% in May 2019.

Top Telehealth Priorities

- Remove 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 – only the quality of the care being delivered.
    - Please note that the removal of the originating site construct, a relic from an era in which telehealth was an office-to-office interaction, is better policy that the addition of the home as a site for telehealth services or a waiver of these restrictions.[1]

[1] The Alliance strongly supports the *Telehealth Modernization Act (H.R.1332)*, introduced by Senators Tim Scott and Brian Schatz, which would eliminate the originating site construct completely.

- 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. Additionally, work to ensure that in-person 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.

- 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. Please note that Critical Access Hospitals (CAHs) are sometimes omitted from this list, but are a crucial component of a healthcare system able to reach all Medicare beneficiaries and must be able to directly bill for telehealth services as a distant site provider.

- Make permanent the Health and Human Services (HHS) emergency waiver authority for virtual care 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.

- Make permanent the HDHP/HSA Telehealth Safe Harbor created in Section 3701 of the CARES Act. This provision allows Americans with health savings account (HSA) eligible high deductible health plans (HDHP) to receive cost-free or discounted telehealth and remote care services prior to the patient reaching their deductible. According to the Bureau of Labor Statistics (BLS), only 15 percent of workers employed in the private sector participated in an HDHP in 2010. By 2018, that number had risen to 45 percent. With significant numbers of American workers now relying on coverage through account-based plans, policymakers can meaningfully expand access to care by permanently allowing first-dollar coverage of virtual care under HDHPs.

- Allow employers to offer telehealth benefits for seasonal and part-time workers. Congress should designate standalone telehealth as an excepted benefit so that this service can be offered to part-time employees, seasonal workers, interns, new employees in a waiting period, etc. Currently, standalone telehealth benefits are considered a "health plan" under Affordable Care Act (ACA) rules. That means they must be paired with a full medical benefit that meets all of the different ACA requirements. In June 2020, the Department of Labor created flexibility for large employers to offer telehealth to non-eligible employees but this access will end with the PHE.

- Enable the Centers for Medicare and Medicaid Services (CMS) to investigate and retain some "Hospital Without Walls" authorities after the end of the public health emergency and encourage that these authorities be used to maintain site of care flexibility whenever the services provided are clinically appropriate for virtual delivery. We believe that expanded capability for hospitals to remotely monitor and care for patients could lead to shorter or avoided hospital stays and lower costs – a potential benefit for both seniors and the Medicare program.

- Fund 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. Suggested 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?

- <u>Facilitate the removal of remaining telehealth restrictions on alternative payment models</u>
    - 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] (I)(2) requirements limiting participation to a select set of ACOs. *(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)*

- <u>Allow the Centers for Medicare and Medicaid Services to cover audio-only telehealth services where necessary to bridge gaps in access to care.</u> 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.

- <u>Expand virtual chronic disease interventions with the potential to prevent downstream costs to the Medicare program</u>. The most obvious example are virtual diabetes prevention programs (DPP), which 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.

Recommendations for Fraud, Waste, and Abuse

The Alliance understands that with change sometimes comes risk, and that Congress holds ultimate authority for protecting the Medicare program. We understand and respect this responsibility. We also believe that, using the data we are collecting about the provision of telehealth services during the PHE, the Medicare program and the Office of the Inspector General at HHS will be able to target and differentiate nearly all fraudulent behavior. Congress must trust this capability and authority, rather than creating barriers to access between Medicare beneficiaries and critical health services.

The Alliance and its members strongly believe that an in-person requirement, as Congress created in the Consolidated Appropriations Act, 2021 (P.L. 116-260) is never the right guardrail for a telehealth service. 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.

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.

We are pleased to note that on February 26, 2021, OIG Principal Deputy Inspector General Grimm issued a statement to this effect – differentiating between fraud perpetrated through virtual tools and telehealth fraud.

> *"We are aware of concerns raised regarding enforcement actions related to "telefraud" schemes, and it is important to distinguish those schemes from telehealth fraud. In the last few years, OIG has*

conducted several large investigations of fraud schemes that inappropriately leveraged the reach of telemarketing schemes in combination with unscrupulous doctors conducting sham remote visits to increase the size and scale of the perpetrator's criminal operations. In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. We will continue to vigilantly pursue these "telefraud" schemes and monitor the evolution of scams that may relate to telehealth."

Recommendations

With the understanding the Congress may still want to pursue additional guardrails against fraud, waste, and abuse as part of 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.

- Enhance the ability of HHS to fight fraud in Medicare through new resources and capacity
    - 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 support.
    - We also support the development of OIG telehealth compliance guidance to healthcare organizations to help prevent and mitigate unintentional mistakes related to Medicare telehealth billing.
    - 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.*

- Work with CMS to develop restrictions on the solicitation of Medicare Fee-For-Service telehealth services**.** It is our understanding that one of the primary ways in which fraudulent actors exploit virtual services is by calling Medicare beneficiaries to solicit their interested in high-value DME products. We believe a restriction on marketing, as currently exists for DME, would significantly hinder situations in which DME fraud actors exploit telehealth services to drive DME sales. As long as there was a significant allowance for legitimate marketing practices, we do not believe this restriction would hinder legitimate telehealth providers.

- Work with CMS to strengthen the Medicare provider enrollment process. The provider enrollment process is the best tool to prevent fraudulent actors from billing the Medicare program. Rather than placing barriers between patients and telehealth services, the enrollment process should be strengthened to identify and screen higher risk entrants.

- Encourage CMS to advantage of the enhanced data capabilities present in most telehealth platforms. Technology platforms that provide telehealth are often capable of automatically recording times, dates, patient information, prescribing, and other details which can be used to

enhance compliance. These technologies should allow for the greater use of audits and other forms of retroactive monitoring approaches on providers. As9 long as data capture requirements are very clear, and that compliance with any requirements do not impose a significant regulatory burden they could be a compliance tool. (Please note that very small-providers should likely be exempted from these burdens.)

- Work with CMS to develop targeted restrictions on high-value, high-risk DME prescribing through a telehealth. While we continue to believe that there are some appropriate circumstances for this prescribing, a step like this could significantly lower risk to the Medicare program.

Thank you for your consideration of these recommendations. Some combination of these recommendations could protect the Medicare program while aligning with the recommendations of the Task Force on Telehealth Policy, which stated "*we should not hold telehealth to higher standards than other care sites, and we should trust clinicians providing telehealth services to triage patients needing a higher level or care or in-patient care, as we do in other care settings. As is done in other care settings, patients' preference for obtaining care in-person or via telehealth should be respected.*"

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Thank you for your consideration – we look forward to working with you on this important effort. Please contact Chris Adamec at cadamec@connecwithcare.org with any questions.

Sincerely,

Krista Drobac

Krista Drobac
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