



July 16, 2021

The Honorable Diana DeGette
Member of Congress
2111 Rayburn House Office Building
Washington, DC 20515-2206

The Honorable Fred Upton
Member of Congress
2183 Rayburn House Office Building
Washington, DC 20515-0601

Re: Cures 2.0 submitted electronically via Cures2@mail.house.gov

Dear Representatives DeGette and Upton:

The Alliance for Connected Care appreciates the opportunity to provide input into the development of Cures 2.0 that will build upon the important legacy of the 21st Century Cures Act. We look forward to working with you to achieve our mutual goals of advancing access to digital health technologies.

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.

As such, the Alliance has a strong interest and member expertise in the way digital health technologies can support and expand access to care while improving patient engagement. Unfortunately – as witnessed through the flexibilities afforded during the COVID-19 pandemic – the history of our delivery system, reimbursement, and governance structures are holding back this transformation. We believe the Cures 2.0 effort has the potential to modernize an antiquated reimbursement system to better serve patients in need and realize the potential of digital technologies through better integration into care patterns.

Telehealth and remote patient monitoring are important tools for bringing innovative services and treatments to those with the least access to it. The Health Resources and Services Administration found that there were roughly 7,200 designated Health Professional Shortage Areas lacking adequate primary care nationwide, affecting more than 81 million patients. Provider shortages are associated with delayed health care usage, reduced continuity of care, higher health care costs, worse prognoses, less adherence to care plans, and increased travel. In addition to being a tool to address barriers, telehealth services play an important role in supplementing and strengthening clinician networks available to patients. Telehealth can be leveraged to strengthen the delivery system by providing highly specialized services in areas where clinicians with these skills are not available to consumers.

For digital health technologies to truly transform the way Americans access innovative treatments and cures, we must reduce barriers to accessing that care. Many of these barriers are remnants of a time in which telehealth did not have the advanced capabilities available today.

As observed during the COVID-19 pandemic, public health emergency flexibilities have 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 public health emergency (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, demonstrating 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 peer-reviewed 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-income 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 percent in 2019. The same poll showed that 64 percent of those surveyed in June 2020 were comfortable with using videoconferencing technology for any purpose, up from 53 percent in May 2019.

Below we have summarized our support for the inclusion of the Telehealth Modernization Act – the most robust telehealth legislation introduced by Congress. Additionally, we provide recommendations for several additional telehealth priorities for future telehealth expansion that Congress should consider – including steps to ensure equitable access to telehealth:

Extending Medicare Telehealth Flexibilities

1. Move to replace outdated originating site and geographic requirements on telehealth. The Alliance strongly supports the Telehealth Modernization Act (H.R.1332), introduced by Representatives Carter and Blunt Rochester, which would eliminate the originating site construct



completely. We are pleased to see the inclusion of the Telehealth Modernization Act to ensure that all patients can access care where they are – and provide the HHS Secretary authority to expand the types of health care providers that can offer telehealth services and the types of services that can be reimbursed under Medicare. Section 1834(m) of the Social Security Act has long been a barrier to expanding Medicare beneficiaries’ access to telemedicine due to stringent originating site and geographic location restrictions. Evidence has shown that telemedicine is not only necessary in rural and underserved areas, but also in urban and suburban communities where health care may not be accessible, convenient, or affordable. While requiring specific sites of care for telehealth may have made sense when technology was new and unreliable, the commercial market today is effectively deploying telehealth nationwide. There is no reason for our most vulnerable populations to have less access to care.

2. 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. Again, the Alliance is pleased to see the inclusion of the Telehealth Modernization Act, that would provide the HHS Secretary authority to expand the types of health care providers that can offer telehealth services and the types of services that can be reimbursed under Medicare.
3. Ensure Federally Qualified Health Centers, Rural Health Clinics and Critical Access Hospitals can furnish telehealth in Medicare and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each. It is important to note that Critical Access Hospitals (CAHs) are sometimes omitted from this list, but are a crucial component of a health care system’s ability to reach all Medicare beneficiaries. As such, they must be able to directly bill for telehealth services as a distant site provider.

Additional Telehealth Priority Recommendations

4. Permanently remove obstructive in-person requirements. 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.
5. Drive greater flexibility for clinicians to provide care across state lines. State lines create artificial barriers to the delivery of care – complicating access for patients and creating additional burden on clinicians. These lines sometimes split major urban areas and hamper the ability of telemedicine providers to fill in gaps in the delivery system and provide high-value care directly



to consumers in rural or underserved areas. Current efforts to expand interstate licensure have been insufficient to meet the needs of patients and the clinicians seeking to better serve them. One of the most effective utilizers of telehealth networks to support the delivery of care, the U.S. Department of Veterans Affairs, supported 900,000 veterans through telemedicine visits in fiscal year 2019 – a majority of which were for mental health care. The program demonstrated growth of 17 percent over the prior fiscal year.

Telehealth video appointments using VA Video Connect increased by 1,000 percent between February and May 2020 at the onset of the pandemic. A major reason for this success is because the VA benefits from rules allowing it to bypass barriers like state licensing requirements, which remain a major barrier for other regional or national networks of care – often inhibiting any work across state lines. States across the U.S. used emergency authority during the pandemic to waive some aspect of licensure requirements to facilitate patients getting care, which has provided an unprecedented opportunity for patients, providers, and policymakers to explore the impact of cross-state care. This has benefited the delivery of health care in many ways, but perhaps most notably it has opened up many new avenues for patient choice and access to care. It is time to build on this momentum to address outdated, burdensome licensure requirements by creating a national compact that states may voluntarily join. HHS could develop a voluntary compact with stakeholder input, and notice and comment, with the patient at the center. It would set up a consistent national compact for licensure portability that any state could join, much like the federal government set up for adoption of children.

6. Move to address provider enrollment concerns and facilitate actions to reduce provider burdens
During the COVID-19 public health emergency, CMS moved to allow practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. Unfortunately, this policy is set to expire at the conclusion of the PHE. The current enrollment structure is outdated and does not support providers new operational and privacy concerns faced in a digital age. Furthermore, we encourage thoughtful consideration of the implications of telehealth on providers – not just patients. All of the conveniences that telehealth provides for patients, are also afforded to providers. First, care can be delivered dynamically and in many settings. A provider may not be just at their office, they can be at home, or at an off-site clinic, etc., and there are operational issues with how to list all of those various addresses. In addition, all providers (whether 0%, 51%, or 100% virtual care) are associated with a clinic that has a primary address. The associated address for that clinic represent the “operational structure.” Therefore, the infrastructure has little to do with where the provider is located physically during the virtual visits. Second, in addition to operational concerns, providers have personal privacy concerns with submitting their personal home addresses. Given that CMS declined to address this issue under rulemaking, we urge examination of these concerns and adoption of appropriate changes as described herein.



7. Advance progress toward the regulation of digital health and connected care technologies in a platform and technology agnostic manner. Specifically, as we move toward more care being delivered through outcome-based payment, the specific tools or methodologies used to deliver care become far less significant than the clinical services being delivered. This flexibility will promote further innovation in care delivery. 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.

Thank you for your consideration. We look forward to working with you on this important effort. Please contact Crystal Wallace at 301-742-5240 or crystal.wallace@connectwithcare.org with any questions.

Sincerely,

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

Krista Drobac
Executive Director
Alliance for Connected Care