ALLIANCE for CONNECTED CARE

March 6, 2022

The Honorable Mariannette Miller-Meeks
Modernization Subcommittee
Healthy Future Task Force
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Mike Kelly
Modernization Subcommittee
Healthy Future Task Force
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Morgan Griffith
Modernization Subcommittee
Health Future Task Force
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Miller-Meeks, Kelly, and Griffith:

The Alliance for Connected Care appreciates the opportunity to provide input into the request for information from the Modernization Subcommittee of the Healthy Future Task Force regarding the utilization of wearable technologies, the expansion of telemedicine, and digital modernization efforts in the United States health care system. We look forward to working with you as you examine the benefits of telemedicine expansion and interstate licensure reform to further expand access to care and improve outcomes for patients across the country.

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 also works in partnership with an Advisory Board of more than 40 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

We believe telehealth has the potential to broaden access to care and improve patient engagement and outcomes, and we should catalyze on the progress made throughout the COVID-19 pandemic to ensure the telehealth flexibilities that have been utilized and enjoyed over the past two years can be maintained or expanded. Below, we provide recommendations that we believe should be considered when developing legislative solutions to expanding telehealth and addressing barriers to interstate licensure.

Telemedicine Expansion

Utilization of telehealth has proliferated throughout the pandemic and has significantly improved access to care, care coordination, medication adherence, patient engagement, post-operative

care, and more. Telehealth and remote patient monitoring are important tools for bringing innovative services and treatments to those with the least access to it, however there continue to be barriers in place that impede such access.

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. Below, we provide comments to several questions outlined under the "Employers, Payers, Providers, States, and other Stakeholders" subsection within the broader "Telemedicine Expansion" section of the request for comments.

Which flexibilities created under the COVID-19 public health emergency should be made permanent?

Congress took swift action during the COVID-19 pandemic to ensure patients could continue accessing vital health care services by implementing several telehealth flexibilities. As you know, telehealth has been a lifeline for millions of Americans, however we are concerned as we near the end of the Public Health Emergency (PHE) that we will approach a "telehealth cliff" unless Congress takes action to extend or make permanent certain COVID-era telehealth flexibilities.

The Alliance, along with more than 330 organizations, sent a letter to Congress in January 2022 urging leadership to facilitate a pathway to comprehensive, permanent telehealth reform. Below, we provide recommendations on which flexibilities we believe should be made permanent to ensure patients can continue to access critical health care services and providers can continue to utilize the telehealth infrastructure implemented throughout the pandemic:

- **Telehealth Safe Harbor for Individuals with HDHP-HSAs**. Section 3701 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 (P.L. 116-136) created a temporary safe harbor that allowed employers and health plans to provide pre-deductible coverage of telehealth services for individuals with a high-deductible health plan coupled with a health savings account (HDHP-HSAs). This safe harbor allowed individuals with these plans to access telehealth services before their annual deductible was met, ensuring that employers and plans could support patients that were leveraging virtual care to access a range of critical health care services during the pandemic. This provision increased health care access for the 32 million individuals with these plans that otherwise would have avoided care due to out-of-pocket costs. In fact, according to a survey by the Employee Benefit Research Institute (EBRI), about 96 percent of employers adopted pre-deductible coverage for telehealth services as a result of this provision.

  Unfortunately, Congress did not anticipate that the COVID-19 public health emergency would last this long, and only provided for this access until December 31, 2021. New action is needed to ensure Americans do not lose access to these important telehealth

benefits. We urge Congress to retroactively reinstate this vital telehealth provision, which has bicameral and bipartisan support and wide stakeholder support, via the next possible legislative vehicle to ensure Americans can access the telehealth coverage and virtual care they need.

- **Permanently Remove Obstructive In-Person Requirements for Telemental Health Services.** The *SUPPORT for Patients and Communities Act* (P.L 115-271) expanded Medicare coverage of telehealth services in the home for beneficiaries with substance use disorders. Then, at the end of December 2020, the Consolidated Appropriations Act, 2021 (P.L. 116-260) further expanded Medicare payment beyond substance use disorder treatment to include mental health disorders and waived the geographic restrictions typically placed on telehealth services. However, the expanded flexibility only applies when the physician or practitioner furnishes an item or service in-person, without the use of telehealth, within six months prior to the first time the physician or practitioner furnishes a telehealth service to the beneficiary. While this provision would not go into effect until after the PHE ends, it creates an unnecessary and burdensome in-person requirement for mental health services. The Alliance and its members strongly believe this is never the right approach for providing a telehealth service.

  Requiring an in-person visit constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, or face other challenges in receiving care. 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. This in-person requirement will only create an access barrier between patients and their clinicians – and will lead to harm for the most vulnerable and access-constrained Medicare beneficiaries. We strongly support *The Telemental Health Care Access Act (H.R. 4058),* which would repeal the in-person requirement for behavioral health services furnished via telehealth. This legislation is crucial to increasing access for Medicare beneficiaries needing behavioral health and substance use services.

- **Remove Outdated Geographic and Originating-Site Restrictions on Telehealth.** The Alliance supports legislation to eliminate the originating site construct completely – rather than just adding the "home." Section 1834(m) of the Social Security Act has long been a barrier to expanding Medicare beneficiaries' access to telemedicine due to stringent originating site and geographic location restrictions. Evidence has shown that telemedicine is not only necessary in rural and underserved areas, but also in urban and suburban communities where health care may not be easily accessible, convenient, or affordable. Furthermore, the Medicare and Medicaid populations traditionally face significant transportation barriers such as affordability and physical impairments, making it more difficult to get to an in-person location to receive care. 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.

- **Ensure FQHCs, CAHs, and RHCs Can Furnish Telehealth in Medicare.** We strongly support policies that would ensure Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and Rural Health Clinics (RHCs) can furnish telehealth in Medicare and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each. Prior to the pandemic, RHCs and FQHCs were limited to serving as an originating site for telehealth services, however Section 3704 of the CARES Act allowed both types of facilities to serve as distant sites for the duration of the PHE. The Alliance supports the continuation of this provision and believes it should be permanent policy.

  CAHs could not serve as distant sites prior to the pandemic unless the telehealth services were billed by the eligible provider rather than the hospital. Flexibilities under the Hospitals Without Walls (HWW) program allowed CAHs to deliver certain services to patients at home, and bill for those services at 101 percent of cost as though they were delivered in person. While this flexibility was not included under statutory changes to Sec. 1834(m) of the Social Security Act in the Coronavirus Preparedness and Response Supplemental Appropriations Act that allowed patients to receive services at home, the *Telehealth Extension Act (H.R.6202)* would ensure CAHs can continue to offer telehealth services after the HWW program expires at the end of the PHE. The Alliance strongly supports making these flexibilities permanent, and also supports the following legislation: *The Protecting Rural Telehealth Access Act (H.R.5425/S.1988)* which has strong provisions for both rural providers and audio-only telehealth; and the *Rural Behavioral Health Access Act (H.R.2228),* which would address specific telehealth changes to enable Critical Access Hospitals to take full advantage of telehealth to meet rural behavioral health needs.

- **Remove Distant Site Provider List Restrictions.** Removing distant site provider list restrictions would 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, we encourage Congress to 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 the virtual care environment.

- **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.

- **Allow CMS to Cover Audio-only Telehealth Services 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.

- **Facilitate the Removal of Remaining Telehealth Restrictions on Alternative Payment Models.** Accountable Care Organization's (ACO) telehealth flexibility is limited to 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.

- **Expand Virtual Chronic Disease Interventions with the Potential to Prevent Downstream Costs to the Medicare Program.** 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.

Employees and plans are often faced with provider shortages in certain geographic areas. Increased use of telemedicine may help alleviate these shortages, but barriers still exist that keep providers from practicing across state lines. Should Congress allow for health care providers who hold a valid license in good standing in at least one state to practice via telemedicine in all other states? Why or why not?

Background on the Issue

One of the most prominent barriers to virtual care are the antiquated state licensure laws that limit the ability of health care providers to give 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.

Health care professionals are prohibited from treating patients in states where they are not licensed, but the state-by-state licensing processes are burdensome and expensive. Uniform national standards across clinical practice areas are in place, but there is wide variation in state licensing processes. In the case of physician licensure, for example, all states require postgraduate training, proof of successful completion of all three steps of the U.S. Medical Licensing Examination, and training verification forms. However, some states add additional unique requirements for medical licensure such as background checks, fingerprinting, completing continuing medical education requirements, providing additional documents such as birth certificates, or even character witnesses. Another barrier is the expense. Licenses in a single state can cost upwards of $1,000, and application fees on top of the licensing fees can add up.

COVID-19 has exposed the barriers posed by the fragmentation of state practice act laws and regulations. The ability for licensed, credentialed health care professionals to provide patient care across state lines via telehealth during the pandemic helped maintain continuity of care, promoted patient choice, helped address workforce shortages, and improved care coordination. Telehealth also helped improve patient access to primary and specialty care, boosted patient and caregiver engagement, reduced missed appointments, and improved post-operative care.

The federal government took action at the start of the pandemic to address care across state lines. CMS temporarily waived requirements that out-of-state Medicare practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS also released guidance stating that state Medicaid agencies could use Section 1135 waiver authority to permit providers located out of state to provide care to another state's Medicaid enrollee impacted by the COVID-19 emergency. Governors across the country also took action to address licensure laws to ensure access to care.

As state emergency declarations enacted at the start of COVID-19, including licensure and telehealth flexibilities, began to expire, providers had to go back to cumbersome and expensive state-by-state licensing requirements if they wanted to continue to help patients in other states. Without a glidepath or permanent policy measures to adjust to these changes, patients have to either travel long distances to see a provider in person or cancel appointments, which creates a barrier to accessing convenient care and to continuity of care.

Patients want to be able to access care from providers of their choice, both in the short- and long-term. In fact, more than 230 organizations sent a letter to all 50 governors in November 2021 urging them to maintain and expand licensure flexibilities enacted at the start of the pandemic for the duration of the federal public health emergency to better address patients' needs during the ongoing pandemic.

Federal Solution to Interstate Licensure Challenges

As evident from the above, there is a clear need for a federal solution to decrease the barriers to providing care across state lines in order to improve access to care for all Americans. As such, we urge Congress to consider addressing antiquated licensure laws that impede access to care.

One possible solution to this issue is for Congress to pass legislation that would instruct the U.S. Department of Health and Human Services (HHS) to convene experts and support the development of a voluntary, national framework for interstate licensure using a system of mutual recognition. This would allow patients to receive care beyond their state borders, and allow qualified health care providers who are already licensed in a U.S. state or territory to treat patients without the costly and time-consuming burden associated with purchasing and renewing multiple state licenses.

Key features of this interstate licensure framework would include:

- Allows multiple provider types to participate in the framework and practice via telehealth in order to expand access to care to patients across the country.
- Maintains state control over licensure and does not pre-empt state law or take away authority from the state licensing boards. State governments must authorize the State's decision to participate through legislation or gubernatorial action.
- Creates a consistent federal framework for cross-state licensure drafted with the patient at the center, so that the focus is on patient access to care, and that has true licensure reciprocity for providers licensed and in good standing in at least one participating state.
- Creates an Advisory Commission on Care Across State Lines to develop the framework and engage in a robust stakeholder engagement process to hear from a broad range of groups on this issue.
- Ensures that health care professionals: must register and be listed in a central database of those who have been deemed eligible to practice across state lines by their home state

licensing board; may not establish physical practices in states where they are not licensed; and will be disciplined by their home state licensing board.

- Prohibits health care professionals from practicing beyond the scope of practice authorized by any jurisdiction that adopts this framework, and from providing any service or subset of services prohibited by any such authority in the jurisdiction in which the patient receiving services is located.

Two prominent examples of a federal-state legal framework that created consistency across states and could be considered models for this type of effort include:

- **Department of Veterans Affairs**. The U.S. Department of Veterans Affairs (VA) is one of the most effective utilizers of telehealth networks to support the delivery of care across state lines, as a result of a 2018 final rule that allowed VA health care providers to offer services via telehealth across state lines, regardless of where in the U.S. the provider or veteran is located. This followed the VA announcing it would expand telehealth in August 2017 for veterans to provide telemedicine across state lines, and Congress passing the *Veterans E-Health & Telemedicine Supports (VETS) Act of 2017* which allowed VA health officials to practice telemedicine across state lines if they are qualified and practice within the scope of their authorized federal duties. The VA supported 900,000 veterans though 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. In November 2020, the VA issued an interim final rule that further confirmed its authority and practice of allowing VA health care professionals to deliver health care in a state other than their home state of licensure, registration, certification, or other state requirement.

- **Driver License Compact.** The Driver License Compact (DLC) compact allows member states to share driver's license information and traffic violation records with other states for legal purposes. Data is exchanged through the National Driver Register (NDR), a computerized database of information about drivers who have had their licenses revoked or suspended, or who have been convicted of serious traffic violations such as driving under the influence. The DLC establishes procedures for reporting traffic offenses, convictions, and license suspensions of persons from a DLC member state within its jurisdiction to the offending individual's home licensing state. The DLC allows drivers to be punished for an out-of-state offense so long as the driver's state has an equivalent statute of the out-of-state offense.

How should this legislation address any complaints, investigations, or disciplinary actions against a provider?

The aforementioned legislative proposal to develop an interstate licensure framework would instruct HHS, through the Health Resources and Services Administration (HRSA), to develop an information coordinating mechanism among state licensing boards using, to the maximum extent

possible, existing structures. The purpose of this information coordinating mechanism would be to provide a way for participating states to exchange information about the standing of a qualified health care professional's license, certification, or registration – to include the provider's license number, any significant investigatory information or adverse actions taken against them, fingerprint information, and other requirements. This coordinating mechanism would also allow participating states to report and coordinate action on patient complaints or safety issues that are raised about any provider practicing through this framework that may result in matters related to provider discipline, regulation, investigation, and/or adverse action. Participating states would be required to submit such information to this coordinating mechanism and notify the provider's principal state of licensure when such actions arise.

The state in which the provider is licensed would have the power to impose adverse action against a provider's license, certification, or registration issued by that state. A state in which the patient is located would have the power to take adverse action on a provider's privilege to practice telehealth as part of this national licensure framework. If adverse action occurs, the state in which the provider is licensed may coordinate with the state where the adverse action occurred to ensure proper disciplinary actions are taken against a provider's license, certification, or registration. In the event discipline is taken on a provider's license or privilege to practice, which would be reported through the information coordinating mechanism, the provider would not be eligible to practice telehealth as part of this national licensure framework. The provider's home state licensing authority would investigate and take appropriate action with respect to reported acts by a health care provider that occurred in a state where the patient is located, as it would if such conduct had occurred by a health care provider within that home state.

The HHS Secretary, through this legislation, would be instructed to convene an Advisory Commission on Care Across State Lines to develop the entirety of this legislative framework, which would include guidelines on facilitating the exchange of information about the standing of a qualified health care provider's license, patient complaints between participating states, disciplinary or investigative actions, or adverse actions taken against a health care provider. This commission would also develop guidelines around a process for cooperation and coordination between states where the patient is located and states where the providers are being disciplined (i.e., their principal state of licensure).

How should this legislation address interstate licensure compacts?

While existing state licensure compacts are currently active for six health profession categories, they do not always go far enough to ease provider burden associated with providing care across state lines. Some compacts like the Interstate Medical Licensure Compact still require a provider to hold a license in every state in which they treat patients through the compact. Compacts like the Nurse Licensure Compact use a policy of mutual recognition, meaning providers licensed and in good standing in one compact member state can practice in other compact members states without obtaining an additional license. This is the type of model to aspire to for easing burdens associated with patchwork licensure laws. Compacts utilizing this model typically use a multistate

license or privilege to practice to ensure providers participating in the compact can practice across state lines in other compact member states.

The Alliance believes that any legislation to address interstate licensure should develop a criteria to deem any existing licensure compact that uses a policy of mutual recognition to be compliant with this framework, and therefore carved out. However, we will note that there currently are no existing licensure compacts that include a broad range of health professions, therefore leaving health systems and provider groups to keep up with the many compacts in existence or in development for every health profession category they employ.

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Thank you for the opportunity to provide comments on this important initiative. The Alliance greatly appreciates the Modernization Subcommittee's commitment to examining legislative pathways forward to expand access to telemedicine, including through exploring ways to increase this access across state lines. We hope we can be a resource to you as you move forward in this work, and look forward to working with you to develop legislation around this important effort. Please contact Casey Osgood at casey.osgood@connectwithcare.org with any questions.

Sincerely,

Krista Drobac
Executive Director
Alliance for Connected Care