



**Statement for the Record:
“Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency”**

**U.S. Senate Finance Committee
Subcommittee on Health Care**

**Alliance for Connected Care
1100 H Street NW, Suite 740, Washington, DC 20005**

November 14, 2023

Dear Health Subcommittee Chair Cardin (D-MD), Health Subcommittee Ranking Member Daines (R-MT), and Members of the Senate Finance Health Subcommittee:

The Alliance for Connected Care (“the Alliance”) welcomes the opportunity to provide input to the Committee hearing on “*Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency.*” We applaud your continued leadership and critical role in ensuring continued telehealth access post-COVID-19 public health emergency. We look forward to working with you to ensuring permanent access to telehealth.

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 50 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 experience during COVID-19 has pushed forward a revolution in consumer attitudes toward virtual care. Polling data from the [University of Michigan](#) 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. A major [study of more than four million primary care encounters](#) from MedStar Health, Stanford Health Care, and Intermountain Health found that telehealth did not increase utilization, but rather served as a substitute for certain in-person encounters. In the same study, telehealth was mostly utilized for patients whose medical needs required multiple primary care visits during each year, suggesting that these telehealth encounters enabled follow-up for patients. A [study from Epic Research](#), also found similar results. A subsequent [study](#) found that a significant share of physicians continue to heavily rely on telehealth services amid the general decline in telemedicine use post-COVID. [Other studies](#) found similar results. These findings show us that fears about overutilization of telehealth in Medicare are unfounded, as usage rates have declined to a small, steady proportion of visits. Patients and health care practitioners have adopted telehealth as needed, and are using it appropriately. According to an [Alliance-commissioned Medicare claims data analysis](#), there is no evidence that telehealth is adding to the total volume of telehealth services being offered, and the average per service cost of an E&M telehealth visit to the Medicare program is less than in-person services by approximately 20%. The reason for this difference was that telehealth clinicians generally billed shorter visit codes than in-person providers.

Telehealth research continues to align in its findings and future telehealth research in the few years after the public health emergency will continue to demonstrate use for telehealth. Policymakers have more



than enough data to see the benefits of telehealth and consider a permanent pathway to ensure that telehealth continues to be available and accessible for Medicare beneficiaries.

The Alliance will focus comments on 1) recommendations for a permanent telehealth expansion that Congress should consider- including steps to ensure equitable access; 2) other non-Medicare recommendations that we believe Congress should prioritize, and 3) while we generally do not believe additional telehealth guardrails are needed, we offer some options here that would be operationally feasible for health care organization to implement without significantly disrupting patient access to care.

Top Telehealth Priorities

The Alliance believes that Congress should expand access of Medicare telehealth by permanently lifting the barriers of 1834(m). It is important to note that the removal of these broad statutory restrictions does not mean the removal of guardrails on Medicare services. Even without specific restrictions on telehealth, the full array of payment, cost, quality, and fraud prevention powers afforded to the Centers for Medicare and Medicaid Services (CMS) would be available to ensure Medicare only paid for high-quality, clinically appropriate telehealth care.

Below, we outline several recommendations that Congress should consider to permanently expand telehealth to Medicare beneficiaries.

Core Statutory Challenges in Medicare

- 1. Expand patient access to telehealth services by removing geographic and originating site limitations to enable patients to communicate remotely with their providers regardless of location.** 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 mental health care may not be accessible, convenient, or affordable. Furthermore, Medicare/Medicaid populations traditionally face significant transportation barriers such as affordability and physical impairments, making it more difficult to get to an in-person location. 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. In addition to patients, providers also request this flexibility.
- 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. Additionally, direct CMS 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 virtual care environment. An [Alliance 2022 survey](#) found that 8 in 10 practitioners say that retaining telehealth for health care practitioners would make them, *personally*, more likely to continue working in a role with such flexibility.



3. **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. Current payment structures often do not capture the unique billing characteristics of telehealth and remote patient monitoring services and need to be updated to better align with the broader CMS payment environment.
4. **Allow the Centers for Medicare and Medicaid Services to cover audio-only telehealth services where necessary to bridge gaps in access to care.** Audio-only telehealth visits should continue to be an option for patients who lack access to the resources needed to participate in video-based telehealth. The digital divide is well documented and congressional plans are in place to help narrow its impact over the next five years. We collectively acknowledge that patients across a wide range of demographic groups do not have sufficient internet access, device access, or digital skills to connect with their clinicians over a stable video connection. In these instances, patients and providers should have the flexibility to choose when an audio-only telehealth visit is both clinically appropriate and preferred by the patient. This would be consistent with prior CMS language emphasizing the importance of patient choice. We anticipate that CMS would also maintain a list of services that were appropriate for audio-only care, as it has done for the past several years.

Additional Medicare Challenges

5. **Allow providers rendering telehealth services from their home to offer services without reporting their home address on their Medicare enrollment or billing paperwork.** CMS allowance for practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment or billing paperwork will end on December 31, 2024. While these changes are within CMS's regulatory authority, we look forward to working with members of the Finance Committee to ensure CMS prioritizes the needs of telehealth providers in addition to patients.
6. **Drive better and more coordinated care for those with chronic disease through adequate reimbursement and flexibility supporting greater use of remote patient monitoring (RPM) technology.** Remote patient monitoring has a huge potential to reduce Medicare expenditures through better health and avoided hospital admissions. Geographic variation results in lower Medicare payments for remote patient monitoring in rural areas, despite many costs being higher in these areas where connectivity is more difficult. While these changes are within CMS's regulatory authority, we request that members of the Finance Committee prioritize work to expand rural access to remote patient monitoring.
7. **Facilitate the removal of remaining telehealth restrictions on alternative payment models,** 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] (1)(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. 1395jii(f) if directing the use of authority instead would keep the score down.

Other Telehealth Challenges

1. **Encourage Additional Care Across State Lines** – While we recognize that licensure is a state, not federal authority, we believe there is much that Congress can do to incentivize the adoption of licensure reciprocity among states. We strongly encourage Congress to support legislation and funding that helps patients receive access to care, even when that care is not available in their state. One option would be to provide incentives for states to adopt the [Uniform Law Commission’s Telehealth Act](#). Simultaneously, there could be specific federal telehealth licensure carve outs similar to those successfully enacted by the Veterans Administration for VA patients, the Department of Defense for military spouses practicing medicine when deployed, and by Sports Medicine physicians to care for players even when they travel to another state. These telehealth licensure carve outs would allow for recognition of the providers home license when they virtually care for out of state patients under certain clinical scenarios such as organ donation, clinical trials, rare medical diseases, student health, and established patients. A multidisciplinary team of experts from leading national institutions developed a [consensus statement](#) outlining these and other possible licensure solutions.
2. **Continue Oversight of the Drug Enforcement Administration (DEA)’s Regulations Restricting the Prescribing of Controlled Substances via Telemedicine** - Special registration to prescribe controlled substances through telemedicine was originally called for in the [Ryan Haight Act of 2008](#). After 15 years of several congressional mandates to promulgate regulations related to a Special Registration for Telemedicine, the DEA has still not issued permanent policy. On October 6, 2023, the DEA extended temporary flexibility for telehealth prescribing through December 31, 2024. Its proposed rule, offered in the spring of 2023, would cut off access to care for millions of Americans and must not be finalized as proposed.
3. **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 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 has provided important virtual care for 32 million individuals with these plans. As such, we strongly urge the Finance Committee to pass *S. 1001- the Telehealth Expansion Act of 2023* as introduced by Senators Daines and Cortez-Masto.
4. **Allow employers to offer telehealth benefits for seasonal and part-time workers**. Increasing access to some telehealth benefits for part-time employees, seasonal workers, interns, new employees in a waiting period can be a meaningful way to support workers – as long as this access supplements health insurance purchased by that individual or a family member. We urge Congress to find a way to continue expanded access that has been experienced by workers over the past several years.



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 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.

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.

- **Develop restrictions to prevent the exploitation of telehealth services by soliciting telemarketers.** In combination with an enhanced Medicare provider enrollment process, we believe that a restriction on the solicitation would provide significant protection against durable medical equipment (DME) fraud actors exploiting telehealth services to drive improper DME sales. This restriction would not apply to patient outreach that: arises out of an established patient-provider relationship and is conducted for purposes of appropriate management of acute or chronic disease; arises out of a Medicare enrolled provider's referral to a new provider or supplier for appropriate items or services; or meets an otherwise applicable marketing exception under HIPAA or other federal or state consumer protection laws. We do not believe that this restriction would significantly hinder appropriate healthcare organization marketing or existing healthcare delivery models.
- **Strengthen the Medicare provider enrollment process for telehealth:**
 - Require new virtual-only providers to indicate their intent to bill only virtual services during the enrollment process. Subject these providers to enhanced scrutiny and/or audits.
 - Consider additional private-sector accountability tools for virtual-only providers, such as certifications. Such certifications could include education on billing and the avoidance of fraud and abuse in billing for telehealth services.



- To provide telehealth services to a Medicare beneficiary, all providers must indicate the intent to do so during enrollment. Phase in for currently enrolled providers. Establish clear billing guidelines for services arising out of telehealth service/CTBS.
- **In place of an in-person requirement prior to prescribing, consider alternate restrictions on DME.** While we recognize and support efforts to address DME fraud, including when it exploits virtual care tools, we believe there are better tools to address this concern:
 - Temporarily allow prescribing (for 2-3 years) with enhanced monitoring tools. At the end of this period leverage data collected to design any restrictions.
 - Enhanced monitoring tools should identify providers with unusual, high-volume DME prescribing patterns for audits or investigation. Initiate early communication with unusually high-volume providers that their volume is unusually high even before expending resources on an investigation.
 - Require that the prescribing of DME be tied to documented and auditable clinical criteria.
 - Require DME to be tied to a service code/submission (even if telehealth not billable) – making it easier for the Medicare program to track.
- **Strengthen existing HHS/OIG efforts to fight fraud and guide health care organizations.** The Office of the Inspector General at HHS has been effective in combating DME fraud that exploited virtual care tools. We should maintain and enhance that authority through additional resources. OIG must also issue telehealth compliance guidance, inviting input and opportunity to comment from the Alliance for Connected Care, the American Health Lawyers Association and other interested private sector groups before publication, to healthcare organizations to help prevent and mitigate unintentional mistakes related to Medicare telehealth billing.

The Alliance greatly appreciates the Senate Finance Committee’s leadership in working to ensuring permanent access to telehealth. We look forward to working with you to develop and advance bipartisan legislation to enhance telehealth access for Medicare beneficiaries. 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
Alliance for Connected Care