



**Statement for the Record:
“Enhancing Access to Care at Home in Rural and Underserved Communities”**

**U.S. House of Representatives
Ways and Means Committee**

**Alliance for Connected Care
1100 G Street NW, Suite 420, Washington, DC 20005**

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The Alliance for Connected Care (the “Alliance”) appreciates the opportunity to submit testimony for this hearing on enhancing access to care at home in rural and underserved communities. 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 organizations from across the spectrum, representing health systems, healthy payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth and remote patient monitoring.

More than 60 million Americans live in rural areas. On average, rural residents are older and generally have worse health conditions than urban residents. Despite this, rural residents face [more barriers](#) to accessing health care like local hospital closures or traveling far for the nearest health care service. Telehealth can help reduce barriers to care by connecting rural Americans to health care services and specialists. Several [studies](#) reveal that telehealth decreases travel time, improves communication with providers, increases access to care, and empowers patients to manage their chronic conditions.

Urgent Action is Needed

It is first important to note that telehealth policy flexibilities granted during the pandemic, and subsequently extended in 2022, have supported telehealth access nationwide, including more than 30 million Americans in Medicare and many of the 33 million Americans with High-Deductible Health Plans and Health Savings Accounts.

While we deeply appreciate the Committee’s leadership in extending Medicare telehealth provisions through December 31, 2024, we encourage the Committee to act rapidly to provide certainty around the future of telehealth well in advance of December 2024. Recently, the Alliance convened [well over 200 organizations on a letter](#), urging congressional leaders to act on telehealth with enough notice for these services to be included in federal payment rules, employer and health plan benefit decisions, and health provider workforce decisions.

Clinicians need telehealth to expand access to care and support strong patient relationships, and they value the flexibility created by the option for remote care when clinically appropriate. Important safety net providers like community health centers and rural health clinics have depended on these flexibilities, as have clinicians such as physical therapists, speech therapists and occupational therapists to extend access to patients. Current telehealth flexibilities have played a critical role in promoting access to vital



health care services including advanced specialists (e.g. oncologists) and mental health services without a previous in-person appointment. This is particularly true for patients in rural and underserved areas, patients with mobility issues, and patients with transportation or other limitations that prevent them from accessing in-person care in a timely manner.

Virtual Care Helps Rural and Underserved Patients

Remote patient monitoring (RPM) helps improve the health of rural patients by allowing providers to monitor their patients' chronic conditions – and is a crucial capability due to these conditions being the [leading causes](#) of death and disability in rural America. [Better monitoring](#) can improve patients' quality of life and reduce hospital admissions and deaths from chronic diseases. While CMS has sufficient statutory authority to continue its expansion of RPM to meet these challenges, we believe Committee oversight to ensure these services meet the needs of Medicare beneficiaries is valuable and should be continued.

Specialty providers are less likely to practice in rural areas, making it more difficult for patients with chronic diseases to manage their conditions. [Less than 8 percent](#) of all providers, both specialty and subspecialty, choose to practice in rural settings. Audio-only and asynchronous care, like eConsults and eVisits, can help [connect rural patients](#) to a wider range of care options. These services improve access to care by supporting availability of specialty care services which are commonly limited or absent to rural patients.

Top 10 Telehealth and RPM Priorities

Below, we outline several recommendations that Committee should consider to permanently expand access to telehealth, particularly for those patients in rural and underserved areas.

- 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 eliminating 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 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. **Rural residents, in particular, have to travel 40 miles farther than their urban counterparts.** While requiring specific sites of care for telehealth may have made sense when technology was new and unreliable, clinicians today are 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. As you are aware, the United States currently faces unprecedented workforce challenges. The patient-to-primary care



physician [ratio](#) in rural areas is 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. Telehealth and RPM can help alleviate some of these workforce challenges. 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. The Committee should direct CMS to work to ensure that all 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.

3. **Ensure Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics can furnish telehealth and RPM 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. **Remove In-Person Requirements Under Medicare for Mental Health Services Furnished Through Telehealth and Telecommunications Technology.** The Alliance urges the Committee to advance legislation, such as H.R. 3432, the Telemental Health Care Access Act to remove in-person requirements for mental health services. Requirements for in-person visits prevent telehealth from helping those who often need it most – patients with transportation, mobility, frailty, or stigma barriers that prevent them from receiving in-person care.
5. **Continue Committee leadership to make permanent the HDHP/HSA Telehealth Safe Harbor created in Section 3701 of the CARES Act.** Congress must make permanent the 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-HSA), ensuring that employers and plans could support patients that were leveraging virtual care to access a range of critical health care services. This has provided important virtual care for 32 million individuals with these plans. We applaud the Ways & Means Committee for passing (H.R. 1843) – *the Telehealth Expansion Act of 2023* as introduced by Representatives Steel, Lee, Smith, and Schneider which would address this concern.
6. **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. Patients living in rural areas, 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.



7. **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.
8. **Extend the Medicare Acute Hospital at Home (AHCaH) Waiver for at least Five years.** Without timely and decisive action from Congress, many Medicare beneficiaries will lose access to AHCaH programs that have been demonstrated to provide excellent clinical outcomes and lower the costs of care. The AHCaH program is a care delivery model that allows some patients to receive acute, hospital-level care in their homes, as opposed to a traditional, in-patient hospital setting. Hospitals that have a Hospital at Home program evaluate patients to determine whether in-home care is appropriate, and while the structure of each program differs, only patients that are stable enough for in-home monitoring are admitted to the home. Monitoring may happen via in-person visits, as well as through remote patient monitoring and telehealth visits. Patients can receive clinically appropriate care in the home, including but not limited to diagnostic procedures, oxygen therapy, intravenous fluids and medicines, respiratory therapy, pharmacy services and skilled nursing.
9. **Drive better and more coordinated care for those with chronic disease by ensuring adequate reimbursement for 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. A payment floor should be set for RPM, given that there are generally fixed costs in providing major components of these services.
10. **Work with CMS to ensure providers rendering telehealth services from their home are able 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 Ways & Means Committee to ensure CMS prioritizes the needs of telehealth providers in addition to patients.

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 from fraud, waste, and abuse. This being said, we note that **the Office of the Inspector General at HHS recently released a [report, finding that telehealth provided to Medicare beneficiaries generally complied with Medicare requirements](#) and did not lead to fraud. **OIG had no policy recommendations for CMS.**** We look forward to seeing additional reports which



confirm this commonsense finding. We believe that, using the data we are currently collecting about the provision of telehealth services, the Medicare program and the Office of the Inspector General at HHS will be able to target and differentiate nearly all fraudulent behavior from legitimate telehealth. Congress must trust this capability and authority, rather than creating barriers to access between Medicare beneficiaries and critical health services. It is important to note that the removal of the broad statutory restrictions under 1834(m) 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) will remain to ensure Medicare only pays for high-quality, clinically appropriate telehealth care.

As noted above, 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 permanent 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** by requiring 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. These could include additional private-sector accountability tools for virtual-only providers, such as certifications that include education on billing and the avoidance of fraud and abuse in billing for telehealth services.



Additionally, CMS could require that all providers must indicate their intent to provide telehealth services to Medicare beneficiaries during enrollment and 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 prior to 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 Committee’s leadership in working to ensuring permanent access to telehealth, particularly for rural and underserved communities. We urge the Committee to act quickly to ensure the removal of originating site, distant site, in-person visit requirements, and billing restrictions that undermine the option for health care practitioner to provide care virtually. We look forward to working with you to develop and advance bipartisan legislation to enhance telehealth and RPM 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 me at cadamec@connectwithcare.org.

Sincerely,

A handwritten signature in cursive script that reads "Christopher Adamec".

Chris Adamec
Executive Director
Alliance for Connected Care