



**Statement for the Record:
“Legislative Proposals to Support Patient Access to Telehealth Services”
U.S. House of Representatives
Energy and Commerce Committee**

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

April 10, 2024

The Alliance for Connected Care (the “Alliance”) appreciates the opportunity to submit testimony for this hearing on legislative proposals that will support patient’s access to telehealth services. 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.

Telehealth research continues to consistently show high patient satisfaction, no uptick in utilization, and strong clinical outcomes. We believe that 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.

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.



The Alliance has endorsed a range of telehealth legislation and urges the Subcommittee to advance bipartisan legislation including many of these proposals, as they would ensure continued access to permanent telehealth policies:

- **Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2023 (H.R. 4189)**, [introduced](#) by Rep. Thompson (D-CA) and 37 bipartisan cosponsors, would expand access to telehealth services.
- **Telehealth Modernization Act of 2024 (H.R. 7623)**, [introduced](#) by Rep. Carter (R-GA) and eight bipartisan cosponsors, would make permanent certain telehealth flexibilities under the Medicare program.
- **Telehealth Health Care Access Act (H.R. 3432)**, [introduced](#) by Rep. Matsui (D-CA), would ensure coverage of mental and behavioral health services furnished through telehealth.
- **Expanded Telehealth Access Act (H.R. 3875)**, [introduced](#) by Rep. Sherrill (D-NJ) and 52 bipartisan cosponsors, would expand the scope of practitioners eligible for payment for telehealth services under the Medicare program.
- **Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (H.R. 5541)**, [introduced](#) by Rep. Latta (R-OH), would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

Core Statutory Challenges in Medicare

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.

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. In addition to broader legislation, the Alliance is supportive of Rep. Buchanan’s (R-FL) and Steel’s (R-CA) legislation, H.R. 134, to remove geographic requirements and expand originating sites for telehealth services
- **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. The Alliance endorsed the Expanded Telehealth Access Act ([H.R. 3875](#)), [introduced](#) by Rep. Sherrill (D-NJ) and 52 bipartisan cosponsors, would expand the scope of practitioners eligible for payment for telehealth services under the Medicare program. 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.

2. **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. Current payment structures often do not capture the unique billing characteristics of telehealth and need to be updated to better align with the broader CMS payment environment. The Alliance for Connected believes the Equal Access to Specialty Care Everywhere Act of 2024 ([H.R. 7149](#)) would improve access to specialty health services, particularly in FQHCs, CAHs, and RHCs.
3. **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. A [recent study](#) found that “introducing in-person requirements for visits and prescribing could cause care interruptions.” The Alliance endorsed the **Telehealth Health Care Access Act ([H.R. 3432](#))**, [introduced](#) by Rep. Matsui (D-CA), would ensure coverage of mental and behavioral health services furnished through telehealth.
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.



5. **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.
6. **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.

Additional Telehealth Concerns

The Alliance for Connected Care also urges the Committee to consider other barriers to telehealth.

1. **Push the Drug Enforcement Administration (DEA) to Act on Regulations Continuing 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. 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. DEA must bring forward a revised final rule with enough time for stakeholder feedback prior to the end of patient access on December 31st. Like telehealth, there are huge logistical burdens around pharmacies and providers that will require time to implement.

Recently, the [Alliance for Connected Care co-led a letter](#), signed by 214 organizations, requesting the DEA to expedite the release of a revised proposed rule to permit and regulate the prescribing of controlled substances through telehealth. DEA’s national leadership is needed to set a clear path forward for the nation and to encourage more consistent definitions and aligned requirements from state regulatory bodies – to encourage care in our most underserved areas, without geographic barriers limiting access to care.

2. **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 Energy and Commerce Committee to ensure CMS prioritizes the needs of telehealth providers in addition to patients. We appreciate the Committee’s work on advancing the Medicare Telehealth Privacy Act of 2023 (H.R. 6364), but continue to remain concerned by the significant administrative burden of providers reporting their home address that would lessen access to virtual care.



3. [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](#). The Alliance also endorsed the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act ([H.R. 5541](#)), [introduced](#) by Rep. Latta (R-OH), would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

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.

Recommendations for Fraud, Waste, and Abuse

A number of already disproven myths about telehealth have continued to persist. While broader understanding of the benefits and use of telehealth have come [a long way](#), these [outdated misconceptions](#) continue to undermine policymaking and must be corrected.

Importantly, the Alliance and its members believe that [an in-person visit requirement is never the right guardrail for a telehealth service](#) – because these requirements harm patients with access challenges, such those who are frail or homebound, have transportation issues, or live in rural or underserved areas. Similarly, we believe that [a clinician’s time has the same value, no matter if they are supporting a patient virtually or in-person](#). 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.

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.

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.



– ADDENDUM –

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In addition to its statement submitted in advance of the hearing, the Alliance for Connected Care submits this additional information in response to statements made during the hearing.

The following studies suggest that during the COVID-19 pandemic, minorities utilized telehealth services at **higher rates** than white individuals.

1. [HHS OIG](#): Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic
2. **Study Published in JAMA Network Open (2020)**: This study found that during the COVID-19 pandemic, Black, Hispanic, and Asian patients were more likely to have telehealth visits than white patients. The study analyzed data from over 148,000 patients and found that Black patients had the highest proportion of telehealth visits compared to other racial/ethnic groups.
3. **Survey by the COVID-19 Healthcare Coalition (2020)**: A survey conducted by the COVID-19 Healthcare Coalition found that Black and Hispanic respondents were more likely to report using telehealth services compared to white respondents during the COVID-19 pandemic. This survey included responses from over 36,000 individuals across various demographic groups.
4. **Research by the Urban Institute (2021)**: This study found that Black and Hispanic adults were more likely than white adults to have used telehealth services during the pandemic, particularly for mental health and substance use services. The study analyzed data from the December 2020 Coronavirus Tracking Survey, which included responses from over 9,000 adults in the United States.

Patients and Provider Preferences:

[Research conducted](#) by the Alliance for Connected Care shows that patients and providers do not want to go back to solely in-person care. A summary of the findings can be found [on our website](#). There is also variation based on the nature of the visit. A follow up appointment is different from an initial visit or a specialty consultation. At least [one study](#) shows that people prefer telehealth for follow up appointments.

Patient Choice

The [Telehealth Impact Study](#), an initiative of the COVID-19 Healthcare Coalition, surveyed patients on experiences and attitudes around telehealth. This graph shows results from the following question: *“What was the nature of your relationship to the individual who provided the telehealth service for your most recent visit?”*



That study found that an overwhelming majority of people received their telehealth visits from their own provider. On average, **78% of respondents** indicated that they received telehealth services from their own provider during the COVID-19 pandemic. For those ages 65 or older, **82.9%** indicated they had seen their own provider via telehealth (chart attached).

If their provider doesn't offer telehealth, and a patient wants it, they can switch providers or talk to their doctor about offering it.

It is also notable that, when Congress added telehealth to the Medicare Advantage basic benefit, they required in the law that there be beneficiary choice. Anytime telehealth is offered, there needs to be corresponding in person services also offered.

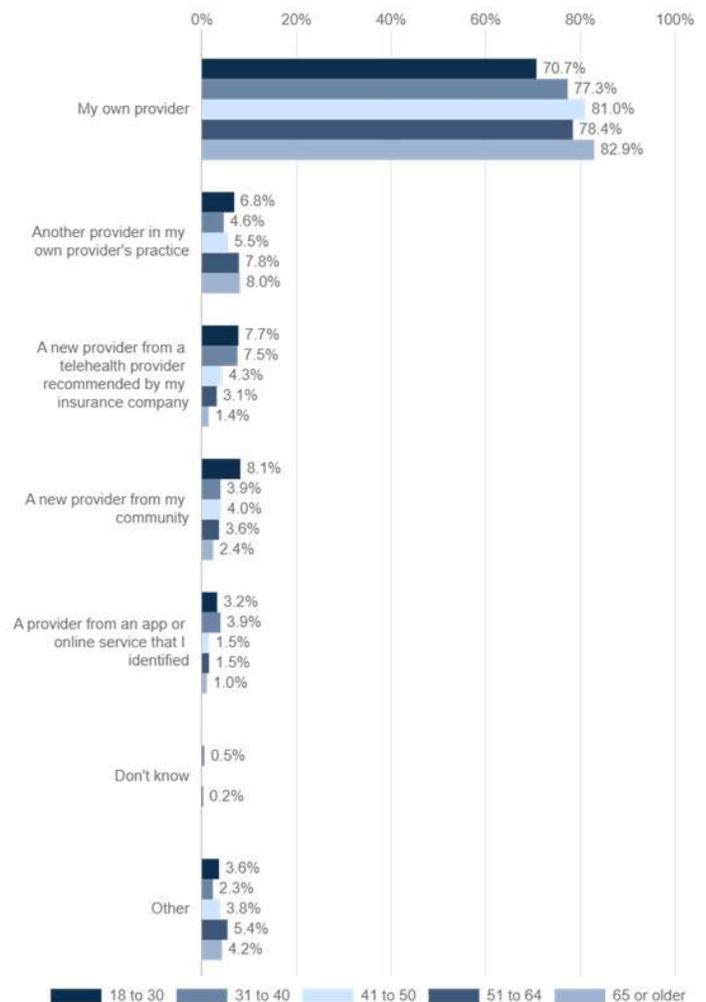
Payment rates

The vast majority of seniors are receiving telehealth from existing providers, not telehealth-only vendors, which are rate in Medicare. Alliance for Connected Care providers have both brick and mortar plus telehealth. It would not make sense to pay less for telehealth because the providers still have to maintain their offices for in-person appointments, and the incentive would be to simply quit offering telehealth and make patients come in person.

Network Adequacy

Telehealth does not count toward network adequacy in Medicare Advantage. Plans are given bonus points to encourage the availability of telehealth, which increases access to care. CMS declined to allow telehealth to count toward network adequacy because they interpreted the "Beneficiary Choice: language in the Bipartisan Budget Act to limit their ability to use telehealth to supplant in person visits for purposes of network adequacy. The choice language is explicit that if telehealth is offered, a corresponding in person benefit must also be offered.

"ENROLLEE CHOICE.—If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2))— "(A) the MA plan shall also provide access to such benefit through an in-person visit (and not only as an additional telehealth benefit); and "(B) an individual enrollee shall have discretion as to whether to receive such service through the in-person visit or as an additional telehealth benefit."





Equalizing Benefits across MA and FFS

When Congress enacted the Bipartisan Budget Act in 2018, they declined to cover telehealth in FFS, but put telehealth in the basic benefit of MA. This marked the first time the basic benefit in MA was different than in FFS. Advocates tried to get Congress to “equalize” the benefits by also including telehealth in FFS. That didn’t happen, but the pandemic brought telehealth to FFS. The pandemic equalizes patient access to telehealth across MA and FFS, and we should continue to ensure access for all patients.

In-Person vs. Face-to-Face Visits

An in-person medical visit and a face-to-face medical visit are not the same thing. Both the American Medical Association and the Federation of State Medical Boards have said that a relationship can be established via a face-to-face visit virtually. Making a person who is eligible for inpatient rehabilitation or hospice have an in-person visit is not necessary.

Fraud

[Linked here](#) is a statement that the Alliance for Connected Care issued after the discussion of fraud waste and abuse during the recent Ways and Means Hearing. Most notable in this statement is the recent study by the Office of the Inspector General at HHS showing that [there was not additional fraud in Medicare telehealth](#). OIG had no policy recommendations for CMS to consider, given that there were no problems identified.