**Statement for the Record:**
**"Modernizing American Health Care: Creating Healthy Options and Better Incentives"**

**U.S. House of Representatives**
**Committee on Ways & Means (W&M), Subcommittee on Health**

**Alliance for Connected Care**
**1100 G Street NW, Suite 420, Washington, DC 20005**
**February 11, 2025**

The Alliance for Connected Care (the "Alliance") appreciates the opportunity to submit testimony for this hearing on modernizing American health care. 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 virtual care.

Telehealth has supported greater access to care nationwide, including for the more than 30 million Americans in Medicare and many of the 33 million Americans with High-Deductible Health Plans and Health Savings Accounts. While these services are important for all Americans, they are particularly crucial for the more than 60 million Americans who 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**

While we deeply appreciate Congressional action to extend Medicare telehealth provisions through March 31, 2025, this was unfortunately only part of the extension needed to preserve full access to telehealth services. It is imperative that Congress act quickly to restore telehealth access lost in December and avert a loss of access to Medicare telehealth in March.

Telehealth is a bipartisan policy, as demonstrated by the broadly supported 2022 legislation which extended telehealth flexibilities through 2024. While our priority is legislation that would establish permanent telehealth policies, we recognize achieving this goal could be a multi-year process. As such, we request your leadership in ensuring Americans are able to access the same telehealth that they were able to utilize in 2024 in the future. We urge you to act in in March to create permanent or long-term access to telehealth.

**Core Barriers to Virtual Care**

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. In addition to broader legislation, the Alliance was supportive of Rep. Buchanan's (R-FL) and Steel's (R-CA) legislation introduced last Congress which would remove geographic requirements and expand originating sites for telehealth services.

2. **Build on Committee leadership to restore and 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.

3. **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. We believe the distant site provider construct should be completely removed – it is a burdensome, unnecessary restriction with little purpose. The Alliance endorsed the Expanded Telehealth Access Act, introduced last Congress with 52 bipartisan cosponsors, would expand the scope of practitioners eligible for payment for telehealth services under the Medicare program.

4. **Remove In-Person Requirements Under Medicare for Mental Health Services Furnished Through Telehealth and Telecommunications Technology.** The Alliance supported the Telemental Health Care Access Act, introduced last Congress, 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 **Telemental Health Care Access Act** would ensure coverage of mental and behavioral health services furnished through telehealth.

5. **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, introduced last Congress, would improve access to specialty health services, particularly in FQHCs, CAHs, and RHCs.

6. **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 ACHaH 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.

7. **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. As outlined by an Alliance member before the Committee last year, a payment floor should be set for RPM, given that there are generally fixed costs in providing major components of these services.

8. **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, 2025. While these changes are within CMS's regulatory authority, we look forward to working with members of Congress to ensure CMS prioritizes the needs of telehealth providers in addition to patients. We appreciate last Congress' work on advancing the Medicare Telehealth Privacy Act of 2023, but continue to remain concerned by the significant administrative burden of providers reporting their home address that would lessen access to virtual care.

**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. With this understanding we welcome a dialogue around what protections may be needed for virtual care in order to protect legitimate telehealth providers and the Medicare program.

Importantly, after the 2024 hearing on care in the home, the Alliance issued a statement related to inaccurate statements made around fraud, overutilization, and spending. While fraud does exist in Medicare, there is no evidence that telehealth is a key contributing factor to this behavior. In 2024, the Office of the Inspector General at HHS 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 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 telehealth problems. 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 approaches 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 such as – 1) enhanced

monitoring tools that 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 2) Requirements that the prescribing of DME be tied to documented and auditable clinical criteria. 3) Requirements that 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. We look forward to working with you to advance legislation extending Medicare telehealth, restoring commercial market telehealth flexibility, and strengthening access to RPM 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,

Chris Adamec
Executive Director
Alliance for Connected Care