S. HRG. 117–546

COVID–19 HEALTH CARE FLEXIBILITIES: PERSPECTIVES, EXPERIENCES, AND LESSONS LEARNED

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

MAY 19, 2021

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

50–344—PDF WASHINGTON : 2023

COMMITTEE ON FINANCE

RON WYDEN, Oregon, *Chairman*

DEBBIE STABENOW, Michigan
MARIA CANTWELL, Washington
ROBERT MENENDEZ, New Jersey
THOMAS R. CARPER, Delaware
BENJAMIN L. CARDIN, Maryland
SHERROD BROWN, Ohio
MICHAEL F. BENNET, Colorado
ROBERT P. CASEY, JR., Pennsylvania
MARK R. WARNER, Virginia
SHELDON WHITEHOUSE, Rhode Island
MAGGIE HASSAN, New Hampshire
CATHERINE CORTEZ MASTO, Nevada
ELIZABETH WARREN, Massachusetts

MIKE CRAPO, Idaho
CHUCK GRASSLEY, Iowa
JOHN CORNYN, Texas
JOHN THUNE, South Dakota
RICHARD BURR, North Carolina
ROB PORTMAN, Ohio
PATRICK J. TOOMEY, Pennsylvania
TIM SCOTT, South Carolina
BILL CASSIDY, Louisiana
JAMES LANKFORD, Oklahoma
STEVE DAINES, Montana
TODD YOUNG, Indiana
BEN SASSE, Nebraska
JOHN BARRASSO, Wyoming

JOSHUA SHEINKMAN, *Staff Director*
GREGG RICHARD, *Republican Staff Director*

CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

COVID–19 HEALTH CARE FLEXIBILITIES: PERSPECTIVES, EXPERIENCES, AND LESSONS LEARNED

WEDNESDAY, MAY 19, 2021

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., via Webex, in the Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Casey, Warner, Whitehouse, Hassan, Cortez Masto, Warren, Crapo, Grassley, Cornyn, Thune, Portman, Cassidy, Lankford, Daines, Young, Sasse, and Barrasso.

Also present: Democratic staff: Joshua Sheinkman, Staff Director; and Beth Vrable, Deputy Chief Counsel and Senior Health Counsel. Republican staff: Brett Baker, Deputy Health Policy Director; and Gregg Richard, Staff Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order. And before we begin today's hearing, I particularly want to thank my colleagues on both sides of the aisle for the exceptional participation yesterday on the infrastructure hearing, because I thought we got a lot of good ideas out, hearing from Senators on both sides, and I want to thank my colleagues.

Today we are going to turn to another important area. And I particularly want to thank our Ranking Member Senator Crapo, because he and I have been talking about telehealth, talking about a variety of ideas that the committee could work on in a bipartisan way. And we thought in particular it made some sense as part of our duties, from time to time to step back and take a look at what happened during the pandemic, areas where we can do better, ideas where this committee can lead with bold changes, and particularly in the health-care area prevent dramatic disruptions of health care in our country.

We all understand that when COVID hit, it was no longer safe to meet face to face, take a bus to the doctor's office, even in many instances walk into a hospital for care. So when we talk about changes and what ought to stick around and what we ought to build on post-pandemic, Senator Crapo and I both thought telehealth was an ideal place to start.

Now the telehealth challenge has always been about balancing the speed and efficiency of new technologies with the need for health-care quality and accountability. During the pandemic, some patients have felt that they had to jump through too many hoops, too many bureaucratic challenges, in order to get access to telehealth.

My view, as a general proposition, is that patients ought to be able to have more accessible opportunities for telehealth. And particularly after they have seen a provider for the first time, we ought to be able to work together to clear out the bureaucratic hoops so that they can get access to telemedicine.

In some cases, the right approach may in fact be to give the green light to telehealth from the get-go, at the very beginning. So we are looking forward today to discussing how to go about striking that balance, after a year of experience during the pandemic.

Just so we get back to the question of the history here, the committee led the effort to shoehorn coverage for telehealth in Medicare as part of the CARES package. That was a particularly important part of CARES because it allows health-care providers in Medicare to offer telehealth services to all older people, regardless of whether they live in big cities or small rural towns.

And that particularly badly needed health-care measure provided care safely into the homes of tens of millions of seniors nationwide.

The CARES Act also allowed Federally Qualified Health Centers, including community health centers and Rural Health Clinics, to receive Medicare payment for telehealth services, which meant that still more health-care providers could be involved in stepping up, as they did, to provide assistance, particularly for health-care services that would otherwise be very remote, and possibly beyond the reach of millions.

Now again, for just a short bit of history, the Finance Committee actually paved the way for a lot of those changes in Medicare. Because for years we pressed the case on a bipartisan basis to update the Medicare guarantee, and to in effect say Medicare was not like it was in the days when I was director of the Gray Panthers. It is not primarily an acute care program any longer; it is a chronic care program. And so we led the effort to update the Medicare guarantee.

And for too many years, the Congress simply fell behind in terms of recognizing the transformation of the flagship health-care program at the Federal level. And telemedicine exists now largely because it was kicked off by work done by the Senate Finance Committee. Telehealth is going to be a big part of the transformation going forward, moving beyond acute care to dealing with chronic disease.

The CHRONIC Care Act, which was passed by the committee when Orrin Hatch was the chair, marked the very first time seniors, for example, could get telehealth in-home for kidney disease. The law also made it easier to use telehealth to diagnose and treat strokes. It allowed more flexibility for Medicare Advantage plans and Accountable Care Organizations.

So when the pandemic hit, because of the work of the Senate Finance Committee, the Centers for Medicare and Medicaid Services already had a head start for telehealth.

I would also like to mention, as Senator Crapo knows, we have had a number of colleagues in the Senate who have been interested in the telehealth issue, and I want to particularly commend Senator Schatz and Senator Wicker, who also have spent considerable time on this.

So Federal agencies have taken advantage of existing law to allow providers to care for their patients in fresh ways. For example, certain hospital doctors and nurses were able to travel out into their communities and provide services at home that would typically be reserved for inpatient care. Others could set up temporary spaces, like tents, near hospitals themselves. They were not allowed to do this prepandemic—in ordinary times. So these steps to increase capacity kept patients safe and helped maintain care.

Today we are going to hear from physicians and hospitals who have been on the front lines, and health-care experts who have seen how the fresh approaches I have just mentioned transformed care. And as we have indicated, there is bipartisan interest in building on these changes that work for seniors and providers, and that can allow us to use Medicare, and particularly the telehealth breakthroughs, as a model for other parts of the health-care system.

In the last year we also made progress on legislation that lets seniors on Medicare receive mental health services via telehealth, including at home. My view is, mental health services ought to be available via telehealth for all Americans. That provision was part of a bill that I authored that would also permit telehealth for routine health-care visits in Medicare, known as evaluation and management.

I believe the committee can work together on a bipartisan basis to make that and other changes a reality.

Let me recognize Senator Crapo, and I am again going to express my thanks for his partnership in making sure that we got this issue front and center, and we are starting to look at how to build on the lessons of the pandemic.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Mr. Chairman. Thanks for holding this important hearing.

Congress and the administration provided certain health-care flexibilities during the pandemic so that patients could continue to receive high-quality care. Making permanent changes based on these lessons learned is a top priority.

I shared my interest with President Biden's nominees for the key health-care positions that have come before this committee, and I appreciate their commitment to work with us on this committee. Republicans and Democrats often disagree on the best way to achieve our shared health-care goals. This hearing, however, highlights an area of common ground. In fact, Senator Wyden and I asked the majority and minority staff to jointly plan this hearing, demonstrating strong bipartisanship.

Acting on legislative changes and using administrative authority, the Centers for Medicare and Medicaid Services waived over 200 payment rules during the pandemic in Medicare alone. Needless to say, there is a lot we can learn. Today's witnesses will provide insight into our efforts that we need to take to evaluate these flexibilities.

Hearing firsthand about the patient experience during the pandemic from providers who overcame challenges to provide care will be invaluable. Understanding how the flexibilities are used in fee-for-service, Medicare Advantage, and alternative payment models will be insightful.

Much of the hearing will focus on care provided during the pandemic through telehealth. Telehealth has been a lifeline for patients and providers, especially in the early months of the pandemic. The reliance on telehealth increased in rural and urban areas alike, allowing patients to receive remote care from the safety of their own home.

Telehealth services have been especially useful for Idahoans. According to the Idaho Department of Insurance, telemedicine visits went from an average of about 200 appointments per month to 28,000 telehealth visits in April 2020 alone.

To ensure financial stability, providers have been paid at the same rate as if the service was furnished in person. This has facilitated care that otherwise would be risky or unavailable, and patients have appreciated the convenience. It has reduced the frequency of missed appointments and assisted provider investment in the infrastructure needed for remote care.

This long period of expanded telehealth will help us understand the impact on quality of care and program costs. This serves as a robust test project on a scale few could have imagined. The promise of telehealth is clear, but it is important that we gather evidence on its impact on access, quality, and cost.

There are approaches to providing care in the most efficient setting that go beyond telehealth. Some hospitals are using a waiver that provides flexibility to triage patients who present to the hospital to see if they can be best cared for in their home. Whether through telehealth, Hospital at Home, or other innovative care arrangements, it is important to find ways to get patients care that best meets their needs, and at the lowest cost possible.

Congress has taken permanent steps to do just that in recent years. Nephrologists can conduct remote evaluations of patients receiving home dialysis. Providers can administer certain drugs to vulnerable patients in their own homes. Hearing from our provider witnesses helps us to continue down this path.

The Government Accountability Office will supplement what we hear from our provider experts, offering a perspective on how to track and evaluate flexibilities in Medicare and Medicaid as we chart the right course forward.

I fully expect that we will take what we learn from this hearing to continue our bipartisan efforts to help providers give patients the best care possible. Permanent changes based on lessons learned from the pandemic can modernize our Medicare payments and systems and lend to the pressing need to address Medicare's financial struggles.

Identifying smart reforms that make Medicare more efficient will be better for patients and better for taxpayers. Such changes alone will not put Medicare on a sustainable path, but they should be a part of that broader conversation. Addressing Medicare solvency should be a bipartisan issue, with time best spent determining how to shore up the current system instead of expanding it to a broader population.

Finding the right path on these priority issues is important to patients and the health programs in the committee's jurisdiction. This hearing will help us to capitalize on that bipartisan opportunity.

Thank you again, Mr. Chairman. I yield back.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. Thank you, Senator Crapo. And I especially appreciate the focus on smart reform. And if we tie smart reforms to the whole notion of updating the Medicare guarantee, then I think we have really done a service in terms of the health-care debate, and I thank you for it.

We have virtually every member of the committee signed up to ask questions after we hear from the witnesses, so we are going to have a particularly busy morning. And we are just going to move ahead, our first witness being Ms. Jessica Farb, Director of Health Care at the Government Accountability Office. She has an extensive portfolio there.

Then we will hear from Dr. Kisha Davis, a family physician and a member of the American Academy of Family Physicians' Commission on Federal and State Policy. She is also a vice president of health equity for Aledade and cares for patients at a primary care clinic in Baltimore, MD. We thank her.

We then have Linda DeCherrie, M.D., a geriatrician and palliative medicine physician who serves as clinical director of Mount Sinai, part of the Mount Sinai Health System in New York.

After that, we will have Dr. Narayana Murali, a nephrologist and the executive director of the Marshfield Clinic in Wisconsin.

And finally, we will hear from Dr. Robert Berenson, whom we have had a chance to work with often over the years, an internal medicine physician and institute scholar at the Urban Institute, who is an expert on health policy, particularly Medicare.

So I would also like at this point—and I think we will not have any objection to this—to enter into the record, by unanimous consent, the statement of the Medicare Payment Advisory Commission, or MedPAC, on pandemic flexibilities in Medicare. Hearing no objection, we will make that part of the record.

[The statement appears in the appendix on p. 117.]

The CHAIRMAN. We will go right to our witnesses, and then today, colleagues, because we have so many Senators who are going to be asking questions, we are going to have to stick to the 5-minute rule pretty scrupulously or you will be eating your corn flakes tomorrow morning when everybody is still waiting to ask questions.

Ms. Farb?

STATEMENT OF JESSICA FARB, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. FARB. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to discuss GAO's ongoing work examining Medicare and Medicaid waivers and flexibilities implemented by CMS in response to COVID–19.

We undertook this work as part of GAO's broader responsibility to conduct monitoring and oversight under the CARES Act. To increase access to medical services during a public health emergency, the Secretary of HHS can use several different authorities to temporarily waive or modify certain Federal health-care program requirements.

Since the beginning of the pandemic, CMS has issued over 230 waivers related to the Medicare program and approved more than 600 different Medicaid waivers and other flexibilities. Many of the Medicare waivers offer flexibilities for providers, hospitals, nursing facilities, and hospices. They generally were intended to increase capacity at facilities, expand the available workforce and beneficiary access to care, and reduce administrative burdens.

As examples, CMS, one, allowed hospitals to provide patient care at non-hospital buildings or spaces, also known as "a hospital without walls;" two, created an expedited process for new provider enrollment, including waiving certain criminal background checks; and three, increased flexibility for providers to treat beneficiaries through telehealth.

Similarly, CMS approved Medicaid waivers and flexibilities aimed at addressing obstacles that affect beneficiary care, provider availability, and program enrollment. For example, CMS allowed out-of-State licensed providers to care for Medicaid patients across State lines, and permitted virtual patient assessments needed to qualify for long-term care services in Medicaid.

The full effects of most of these waivers and flexibilities are not yet known, but CMS has reported some data on the use of telehealth in both programs. For example, over the first 8 months of the pandemic, utilization of telehealth services by Medicare fee-for-service beneficiaries sharply increased from about 325,000 services per week at the start of the pandemic, to a peak of about 1.9 million about a month later. Since then, utilization has slowly declined, and as of mid-October was slightly over 700,000 services per week, still much higher than pre-pandemic levels.

This utilization varies in a number of ways, including by service type, provider specialty, and beneficiary demographics. For example, telehealth was used more frequently for mental health services and by beneficiaries under the age of 65, as well as those located in urban areas. CMS has also reported variation in the use of telehealth in the Medicaid program across the States and across age groups within the States.

The waivers and flexibilities implemented in Medicare and Medicaid during COVID–19 likely benefited providers and beneficiaries, yet determining whether and, if so, how to continue them post-pandemic warrants consideration.

Factors to consider include program spending, program integrity, beneficiary health and safety, and health equity. Both the Medicare

and Medicaid programs are on GAO's high-risk list in part due to concerns about fraud, waste, and abuse.

Telehealth and other waivers pose some risks of unnecessary program spending. The lower but stable telehealth utilization trend we saw last fall in Medicare suggests that demand for telehealth may continue after the pandemic.

Medicare currently pays the same for telehealth and in-person services, and one provider group we interviewed cautioned that this could create incentives for specialties that can provide and be paid for both in-person and additional telehealth services to generate telehealth visits without obvious clinical benefit.

In addition, the lack of complete data for oversight and suspension of some program safeguards may have increased program risks. For example, CMS lacks complete data to determine the telehealth modality being used, audio-only or audio-video, or where the services are originated—important information to consider, given payment incentives and the lack of evidence so far about the quality of telehealth services in Medicare.

Extending or ending waivers and flexibilities may affect beneficiary health and safety in unknown ways. For example, expedited processes for provider enrollment in both programs, including waivers of normal screening and criminal background checks, could affect the quality and safety of care provided to beneficiaries.

And finally, the health disparities we have observed during the pandemic also extend to beneficiaries' access to services and may be exacerbated by differences in access to things such as technology used to support telehealth in rural areas. Thus, health equity may be an important factor in decisions about the continuation of these flexibilities.

Careful contemplation of the benefits and risks of continuing these waivers and flexibilities will be key to determining the path forward. We look forward to working with Congress and this committee as we continue our oversight of the Federal response to the COVID–19 pandemic.

Chairman Wyden, Ranking Member Crapo, and members of the committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have.

[The prepared statement of Ms. Farb appears in the appendix.]

The CHAIRMAN. Thanks very much, Ms. Farb.

We go now to Dr. Davis.

STATEMENT OF KISHA DAVIS, M.D., MPH, FAAFP, MEMBER, COMMISSION ON FEDERAL AND STATE POLICY, AMERICAN ACADEMY OF FAMILY PHYSICIANS, LEAWOOD, KS

Dr. DAVIS. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. I am Dr. Kisha Davis, a member of the American Academy of Family Physicians' Commission on Federal and State Policy, and I am honored to be here today representing over 133,000 physician and student members of the AAFP.

I am a practicing family physician providing primary care to patients in Baltimore, MD, and I also serve as vice president of health equity at Aledade, working to reduce health disparities in physician-led ACOs across multiple States.

I have experienced the impact of COVID–19 and resulting Federal policy changes first-hand, as well as through the shared experiences of the physicians that I support. I am appreciative of the flexibilities granted due to the public health emergency. These have allowed all patients, especially some of the most vulnerable, isolated, elderly, and disadvantaged patients, to maintain their relationship with their trusted primary care physician, while many offices had to close or severely limit in-person visits due to social distancing restrictions.

They have also allowed these practices to remain financially solvent, whereas their mass closure would have been devastating at a time when medical care was needed most.

Lastly, the ability to connect with one's trusted primary care physician via telehealth helped to alleviate the burden on emergency rooms and hospitals.

As a physician myself, I want telehealth to be a tool in my toolbox that I can deploy based on a clinical judgment, not based on whether I get paid. As Congress considers whether to extend these flexibilities beyond the public health emergency and how to build upon recent advances, it is vital that Medicare and Medicaid policy changes are designed to advance health equity, protect patient safety, and enable clinicians to provide the right care at the right time.

To this end, I suggest the following four recommendations regarding telehealth flexibilities.

First, Congress should permanently remove the section 1834(m) geographic and originating site restrictions, to ensure that all Medicare beneficiaries can access care at home. Expanded access to telehealth visits has allowed me to observe my patient's home or work environment, identify factors that may be affecting their health, and develop more personalized treatment plans. While some worry that telehealth will cause patients to become disconnected from their doctor, I have seen just the opposite. For patients, telehealth enables timely first contact access to care, while building and maintaining long-term trusting relationships. I have numerous examples of physicians ensuring patients were still getting the preventive care they needed by conducting annual wellness visits via telehealth, the monitoring and treatment of chronic diseases such as diabetes and hypertension, addressing acute concerns, and most notably conducting transitional care management visits—visits done post-hospital discharge aimed at preventing readmission.

Prior to COVID, coming into the doctor's office after being hospitalized was often a barrier. Providing these services for patients in their home increases accessibility for patients who may be homebound or lack transportation, and creates opportunities to engage distant family and caregivers. Eliminating geographic and originating site requirements is essential and improves utilization of high-value care and patient outcomes.

Second, Congress should require Medicare to cover audio-only E&M services beyond the public health emergency. It is vital to ensure equitable access to telehealth services for patients who may lack broadband access or be uncomfortable with video visits. For many of our patients, especially rural, low-income, elderly, and

non-English speakers, voice calls are simply the most accessible option. Payments should support patients' and physicians' ability to choose the most appropriate modality of care, whether it be telephone, audio-video, or in-person, and ensure appropriate payment for care provided.

Third, Congress should ensure the permanent equitable coverage and payment of telehealth services provided by community health centers, and modify existing payment methodologies to provide timely, appropriate payment for telehealth. Community health centers have been stalwarts during the COVID–19 pandemic, providing testing services, remaining open during staffing shortages, and now leading in vaccine distribution, while ensuring quality of care for millions of low-income persons.

Fourth, policymakers should monitor the impact of telehealth on access and equity, and invest in infrastructure to promote digital health equity. While the rapid expansion of telehealth has yielded many benefits for patients and clinicians, not everyone has benefited equally. To achieve the full promise of telehealth, Congress must proactively address structural barriers to virtual care. Additional studies to inform the direction of permanent telehealth policies should include the collection and reporting of data stratified by race, ethnicity, gender, language, and other key factors.

Thank you for the opportunity to discuss with this committee the impact of these flexibilities on family physicians and the AAFP's recommendations for permanent policies to advance accessible, equitable, high-quality health care beyond the pandemic.

[The prepared statement of Dr. Davis appears in the appendix.]

The CHAIRMAN. Dr. Davis, thank you. You said so many sensible things, but I especially appreciate your bringing up and advocating for the voice calls, because I heard that repeatedly again and again. Thank you.

Our next witness will be Dr. Linda DeCherrie, a geriatrician.

STATEMENT OF LINDA V. DeCHERRIE, M.D., CLINICAL DIRECTOR, MOUNT SINAI AT HOME; AND PROFESSOR OF GERIATRICS AND PALLIATIVE MEDICINE, ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, MOUNT SINAI HEALTH SYSTEM, NEW YORK, NY

Dr. DECHERRIE. Thank you.

The CHAIRMAN. There she is. Good.

Dr. DECHERRIE. Chairman Wyden, Ranking Member Crapo, and the members of the Senate Finance Committee, it is my distinct pleasure on behalf of the Icahn School of Medicine at Mount Sinai, and the Hospital at Home Users Group, to be part of this panel to discuss Hospital at Home, specifically extending the current acute hospital care at home flexibilities being offered under the public health emergency.

Hospital at Home is patient-centered model of care which provides hospital-level care at home for patients with select acute illnesses who would otherwise be hospitalized. Multiple Hospital at Home studies have demonstrated improved patient safety, reduced mortality, enhanced quality, and reduced costs.

It was a model that many Medicare Advantage commercial and Medicaid Managed Care plans already covered before the pan-

demic. Adding the rest of the Medicare beneficiaries allows equitable care and has been extremely helpful since November 2020 when the Acute Hospital Care at Home waiver was approved.

I believe the coverage of Acute Hospital Care at Home should be covered beyond the pandemic, preferably as a 30-day bundle of care. In 2014, Mount Sinai applied and received a Center for Medicare and Medicaid Innovation award to develop and test Hospital at Home for the fee-for-service Medicare population. From this work, we submitted a proposal to the Physician-Focused Payment Model Technical Advisory Committee.

The PTAC recommended our proposal in 2018 to the Secretary of the Department of Health and Human Services for implementation. The Secretary expressed interest in testing home-based hospital-level care models, but no payment model was advanced for beneficiaries in fee-for-service Medicare.

In 2017, when our CMMI award was finished, our Hospital at Home program was no longer able to provide care for fee-for-service Medicare patients, as there was no reimbursement, and the program shifted to focus on Medicare Advantage commercial and Medicaid Managed Care plans.

We believe congressional action to extend the current waivers and flexibilities is necessary and particularly valuable for patient care. During the initial surge of COVID–19 in March of 2020, we were an important part of helping the Mount Sinai health system open up more capacity for patients needing higher levels of care, such as ICU, by completing Acute Hospital Care at Home for patients already hospitalized.

However, we were still unable to admit fee-for-service Medicare patients from the emergency departments. We were very excited to be part of the original group of hospitals approved for the Acute Hospital Care at Home waiver in November 2020. In addition, we formed a Hospital at Home Users Group with support from the John A. Hartford Foundation, which provides technical assistance and office hours to other hospitals seeking to respond to the waiver.

To date there have been 129 hospitals approved for the Acute Hospital Care at Home waiver, with 56 health systems in 30 States, all since November. This shows that there is great interest. However, it does take significant start-up resources and time, and many hospitals are not planning to launch until this summer.

I believe even more hospitals would implement Hospital at Home if they knew this program would be extended or made permanent.

Therefore, we request Congress and HHS to consider a permanent extension of Acute Hospital Care at Home waivers beyond the PHE to mitigate the residual impacts of COVID–19 on the public health, and to encourage broader adoption of providing patient-centered health-care services in the home.

Thank you for the opportunity to present today.

[The prepared statement of Dr. DeCherrie appears in the appendix.]

The CHAIRMAN. Thank you very much, Dr. DeCherrie.

Next will be Dr. Murali.

STATEMENT OF NARAYANA MURALI, M.D., BOARD MEMBER, AMERICA'S PHYSICIAN GROUPS; AND EXECUTIVE DIRECTOR, MARSHFIELD CLINIC, MARSHFIELD, WI

Dr. MURALI. Thank you, Chairman Wyden, Ranking Member Crapo, and members of the committee. I serve as the executive vice president of care delivery and chief strategy officer of the Marshfield Clinic Health System. I also serve as the executive director. What I am advocating for, and strongly believe, is that permanently supporting the flexibilities created in response to the COVID–19 pandemic, and broadband, particularly in middle America, will combat the rising cost of health care in America and its economic impact on both patients as well as their employers.

The potential that telehealth infrastructure has advanced in the American health-care system in enhanced equity, access to health care, as well as prosperity for all Americans, cannot be overstated.

It is my honor and privilege to testify on behalf of America's Physician Groups. APG is a national professional association representing 300 physician groups and their members with approximately 195,000 physicians who provide care to nearly 45 million patients from coast to coast.

Our vision is to transition from legacy transaction fee-for-service reimbursement to a capitated value-based system, where physician groups are held accountable for the total cost of care, the quality of care that they provide for their patients, and are incentivized to innovate to provide the best possible care.

Marshfield Clinic Health System is one of the Nation's largest fully integrated systems, serving a predominantly rural population in the State of Wisconsin. Our 1,400 primary care and specialty providers provide approximately 3.5 million encounters annually.

Our primary service area encompasses over 80 percent of Wisconsin's rural population. In fact, over half of our 60-plus facilities serve populations of less than 2,000 people. We have more cars than people. Our mission to provide health care for the large area greater than the State of Maine led to the genesis of our telehealth program in 1997, where we performed heart and lung exams over the Internet.

Today we use telehealth for Hospital at Home care, acute care, arterial care, dental screenings in schools, and much more. We were one of the first hospitals in the country granted a Hospitals Without Walls waiver by CMS; this, because we were already providing hospital-level care in the comfort of our patients' homes since 2016, using telehealth even when there was no formal incentive to do so. We knew that for a subset of our population, there is no place like home for inpatient recovery.

Compared to matched hospital cohorts, we saw our patient satisfaction increased by 22 percent, hospital readmission decreased by 44 percent, length of stay decreased by 37 percent, and ER visits halved.

Together, this created a 15-percent cost savings per episode per patient for the health plan. Since the onset of the pandemic, APG physicians have adopted a lifeline of telehealth, ensuring access to care for all patients who were terrified to leave their homes.

In 2020, MCH provided a quarter of a million telehealth and telephone encounters. Presently, they average about 15 percent of

all encounters. Telehealth is here to stay. It is convenient and economically beneficial for patients, as well as employers. Our patients are older, sicker, and poorer than average in the State of Wisconsin, as well as in the Nation.

Almost half our children are eligible for reduced or free lunches. Public transportation is virtually nonexistent. Our patients are geographically isolated, and travel 2 hours in treacherous winter weather to come and get essential care. Such obstacles deny care. Telehealth addresses these disparities, ensuring proactive care that reduces ER visits, as well as enhancing equity and access to health care and stabilizing the economy.

My heart tugs at the story of a 67-year-old diabetic woman whom I had managed for heart failure as well as kidney disease back in 2007. Since then, we managed her care virtually, except for one visit in a year. For the last 13 years, every year she has sent me a Christmas card.

Telehealth has the power to become the norm of this country. We are at a critical juncture at this point. Here are some obstacles.

First, given our experience with the current waivers, the site visit restrictions are no longer justifiable. The location for a physician or a patient should not deny care for a patient.

Second, the greatest obstacle for patient satisfaction is access to broadband or Internet that is stable. Our patient appointments are taken by patients at schools, as well as library parking lots. It would be important for us to focus, at least as a stopgap, on using phone care for increasing access for Medicare Advantage people. Our members agree with that, that restricting care denies care.

Finally, and most importantly, permanently reviewing and renewing the waivers, including acute care without walls, will trigger commercial investments to go faster. I thank you for your service, as well as your support.

I would like to share this in the historical context. The U.S. Congress has acted decisively in the past, creating great infrastructure like the Hoover Dam, the Tennessee Valley Authority, and the highway system. We look forward to working with you in advancing America's health care Thank you.

[The prepared statement of Dr. Murali appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Murali. I can tell you, millions of Americans would be clapping for your proposition that, with respect to health care, there is no place like home. So thank you very much for your valuable testimony.

Dr. Berenson?

STATEMENT OF ROBERT A. BERENSON, M.D., INSTITUTE FELLOW, URBAN INSTITUTE, WASHINGTON, DC

Dr. BERENSON. Thank you very much, Chairman Wyden, Ranking Member Crapo, and members of the committee.

Telehealth offers the promise of an important disruptive innovation in health-care delivery, improving access and quality, while reducing spending. However, decisions on how to pay for expanded use of telehealth will determine whether that promise is achieved.

As a practicing internist, the government official in charge of Medicare payment policy at CMS, and now as a policy researcher at the Urban Institute, I have spent much of my professional life

exploring better ways of paying health professionals. I have also worked on Medicare payment issues as the Vice Chair of MedPAC, and as an initial member of the PTAC, which was established under the MACRA legislation.

On PTAC, I often argued for a straightforward fee schedule change, rather than the proposed alternative payment model, to achieve the purpose sought. My objections to some alternative models are that they are not operationally feasible. The converse is the case for telehealth. Fee-for-service for telehealth is not operationally feasible as long-term payment policy. I will briefly outline three major reasons.

First, fee schedules function reasonably well when the code descriptions are concise and clinically relevant, producing reliable and accurate coding. Codes for telehealth services are anything but concise. Telehealth code descriptions specify the specific modality employed, the patient's location during the communication, which party initiated the service, the duration of the virtual encounter, and a range of other specifications for each code that was described as part of the telehealth expansion.

These coding parameters were established for payment purposes alone. They are not useful clinically. Using the standard fee schedule to pay for telehealth services would likely produce a quagmire of confusion, inadvertent or intentional miscoding, and lots of clinician and patient complaints about burden and counterproductive rules.

Second, for many telehealth services, fee-for-service payments generate high billing costs relative to the payment actually received. A recent study found that the cost for billing and related documentation for an office visit was more than $20. And that is just the billing cost for the first submitted claim from the practice. A typical claim bounces between the practice, the Medicare contractor, the supplemental insurer, back to the practice, and then to the patient for applicable cost-sharing. Proper and fair payment levels will often be lower than the billing cost. So they either will not be billed or, even worse, they will not be provided post-COVID.

Yet, raising the fee to make it financially worthwhile, as under pay parity, would ignore the 30-year process for setting relative values in Medicare. Paul Ginsburg, who is the current Vice Chair of MedPAC, and I wrote that that process needs to be changed, but it should not be changed on an ad hoc, one-off basis just for telehealth.

Third, patients face substantial time costs and inconvenience in traditional travel, waiting rooms, and actual time with the clinician. I recently waited 20 minutes after my annual wellness visit just to check out. My time commitment for the visit was 3 hours. Patients will often prefer virtual visits, but there should be brakes on demand and spending, especially if paying for fee-for-service at parity.

RAND researchers found in the pre-COVID period that 90 percent of telehealth services were additional services, rather than substitutes for in-person services. Used properly, telehealth services often should be add-ons, such as for chronic care managers but also for lots of other sound clinical reasons, and those communications can certainly be done by telephone calls in many cases. But

those add-on services need to be managed by the practice, within a spending constraint, to help assure that virtual visits are used appropriately.

CMMI has developed a primary care alternative payment model called "Primary Care First." The approach needs to be tested in an expedited fashion on a regional, mandatory basis, in my opinion. It has the potential to be the permanent payment model for primary care practices generally, while also addressing payment for telehealth services. My written testimony also provides initial thoughts on using lump sum payments to practices for specialists' use of telehealth, rather than fee-for-service.

So in conclusion, I would just suggest that this is an important time and a real opportunity to fundamentally examine how Medicare pays physicians and other health professionals, and it should not be just sort of a default "let's just continue the current payment flexibilities and high payment levels" without full consideration.

Thank you very much.

[The prepared statement of Dr. Berenson appears in the appendix.]

The CHAIRMAN. Doctor, thank you. And we have virtually every member participating, so we are going to have to stay pretty close to the 5-minute rule today, colleagues.

My first question really speaks to the question of balance. We love the speed and efficiency of new technologies like telehealth, and at the same time, as Dr. Berenson just mentioned, we have to ensure quality care and accountability. And he described this horror story of bills just bouncing from place to place to place. So we are going to have to move around.

In terms of questions, I think I will start with our GAO person, and Dr. Berenson, on this. What are the lessons learned from how we did telehealth during the pandemic in striking this balance that I described as speed and efficiency and quality and accountability? Why don't we start with the GAO person, and then we will go to you, Dr. Berenson.

Ms. FARB. Sure. Thank you, Chairman Wyden. I think what we have learned so far is that we do not have the complete information that we need to study what we need to study in order to make some determinations about some of the issues that Dr. Berenson was raising.

I believe that is why MedPAC actually recommended that some of these flexibilities continue with some guard rails in place so that we can study the effects of these issues on the quality of care, which is still not quite known in Medicare at this point, and on sort of program spending and provider and beneficiary behavior.

The CHAIRMAN. Dr. Berenson?

[Pause.]

The CHAIRMAN. You are muted, Doctor.

Dr. BERENSON. Okay, I am on. I will make two points. One is that we learned that if you simply pay what the sort of process is for generating relative values and fees that has been used in Medicare, you will not get the services you are desiring.

In 2019, Medicare, CMS, put into effect something called a check-in visit, which was a payment to physicians to call their patients to discuss whether they needed to come in for an in-person

visit. The payment by the traditional method was about $14 and change. And guess what? Nobody did the visits. It was less. The practices are not stupid, so they may have made the call but they sure did not bill for it, and I would suspect that many practices did not even do it because of the inadequate payment.

And within 2 weeks of announcing that there would be a whole new list of telehealth services, CMS raised that payment level from $14 and change to $56. And guess what? Doctors did it. And I think it was a very smart move by CMS to get money out the door to beleaguered practices that suddenly saw their revenues decrease dramatically and patients who could not get care. So the payment level matters a lot. And so that is one point.

The second point I want to make is that—actually I am blanking on what my second point is, and so I will move on.

The CHAIRMAN. Thank you.

Let's go to the equity question. And by the way, all of you can give us additional information for the record. I just felt that this question of striking a balance is what practitioners and patients are always asking me. They want the speed. They like the efficiency. But they want the quality, and they want answers to these kinds of questions. So apropos of what we heard from GAO, we will be interested in more information, for example, on your work apparently in the guard rail kind of area.

A question for you, Dr. Davis. We have said in our work on this committee, every single time out, we are going to focus on equity issues, because we know in America much of health care is really a desert for vulnerable people. If you are affluent, and you are white, and you are in the suburbs, you have the world in front of you. If you are in the BIPOC community, very often these options just pass you completely.

So our first work was on maternal mortality, but we want to make sure that the principles of fairness extend to new technology as well. Wave your wand and tell us a couple of things you think you would be doing if you were on the Finance Committee to promote racial equity in telehealth.

Dr. DAVIS. Thank you, Senator Wyden. That is a great question, and it is a concern that we have as well. What we have seen from the pandemic is that there has been unequal access, and the communities that have been most likely to access telehealth have been whiter, richer, more urban, and with more access.

And so I think the first thing is—really as we are exploring and expanding telehealth—really being sure to make sure that the data that we collect is stratified by race, ethnicity, gender, language, and other key factors, making sure that we are taking customer and patient reviews into account as we are expanding outward. And then also, continuing to invest in infrastructure, in broadband for our rural communities, for our underserved communities, making sure that they continue to have access so that we are not inadvertently creating a two-tiered system where all have access to in-person and only some have access to telehealth.

The CHAIRMAN. Good. I am over my time.

Senator Crapo?

Senator CRAPO. Thank you very much, Mr. Chairman.

I will start with you, Ms. Farb. The waivers have clearly been successful in increasing patient access. The impact of telehealth on the quality and cost of care is more complicated to measure, as you have indicated.

Focusing on the quality part of the equation, what metrics do you use to measure the quality of telehealth services, including in comparison to in-person care?

Ms. FARB. Well, Chairman Crapo—Senator Crapo, sorry—thank you for that question. Organizations like the NCQA and AQF have been working during the past year to retool their quality measurement sets and the frameworks that they use to develop quality metrics specifically for telehealth.

The key areas that AQF has noted include things like the timeliness of care—and obviously, telehealth may have an advantage in that regard—how well it encourages care coordination, and patient empowerment and engagement.

So there are a number of different metrics and sort of categories of metrics along which the quality organizations are suggesting telehealth be measured. We at GAO have not yet looked into specific quality measures for telehealth yet. We have been asking about those as part of our ongoing work to try to understand how providers and others are viewing that.

Senator CRAPO. All right; thank you.

And, Dr. Murali, it seems the ideal way to deploy telehealth is for a physician working with the patient to decide which care modality works best for each patient visit. But payer policies related to billing, documentation, and payment play a large role in the extent to which providers offer telehealth.

Understanding that physicians provide the same level of patient care regardless of the type of insurance, is telehealth more feasible in a capitated payment arrangement?

[Pause.]

Senator CRAPO. You are muted. There you go.

Dr. MURALI. Senator Crapo, thank you very much. Absolutely. Transactional fee-for-service does not help people to innovate because it is transactional. If you need transformation, you need prospective payments. Capitated payments allow the physician groups to focus on what is important as well as invest in the infrastructure required to provide optimal telehealth that is integrated in the electronic medical records.

As I shared in my documentation, presently physicians have worked as heroes. They do the video chats, the e-coms, as well as all the transactions while they are doing telehealth, but the systems are not optimally designed to get at patient care. So if you want to get the efficient care and adoption at a much higher rate, that is absolutely necessary, and you are right on.

Senator CRAPO. Well, thank you.

And, Dr. Berenson, could you comment on the same question?

You are muted.

Dr. BERENSON. I don't know who is muting me. In any case, I agree very much with Dr. Murali. Capitation does not—the problems that I described in fee-for-service where you have all these rules and requirements as to the circumstances that you have to follow and on which you can bill, in my practice I have found often

a 2- or 3-minute phone call follow-up the week after I either made a tentative diagnosis or changed the medication, was the proper way to follow up with a patient. Yet, that would not qualify for payment under fee-for-service.

With capitation, you have essentially an account that can be deployed to appropriately use capitation without artificial rules and regulations, to use telehealth without artificial rules and regulations. So I think that is the way to go.

CMMI has actually developed a model which is sort of half fee-for-service and half capitation. It seems like with expedited testing it could, within a couple of years, become a national model for moving primary care practices. It is a little trickier to figure out how to pay specialists for their telehealth because, with capitation, it is not easily done for specialty services.

Senator CRAPO. All right; thank you.

And back to you, Dr. Murali. We have talked about broadband and some of the infrastructure aspects of getting this issue resolved. You stated that telehealth was a fundamental element of caring for patients in rural Wisconsin, even before the pandemic. And can you speak to how Marshfield Clinics made the necessary investment in infrastructure and physician training to make that possible?

Dr. MURALI. Yes; some before the pandemic, some during the pandemic. Before the pandemic, we invested in optic fiber cables, along with our community of three-quarters of a million in Marshfield, to expand the capacity to provide that service; invested in a stand-alone data warehouse; as well as focused on trying to get the intelligence required for providing good care with quality outcomes that are measured.

In addition to what needs to be done—so if you want to provide telestroke coverage or ER coverage, or you want to do Hospital at Home, you need to invest in equipment and platforms that translate to roughly about $4½ million a year for us as a health system.

And so we have been doing that without any concern, because there is no other way to optimize labor and recruit physicians to provide the care in populations that are less than 2,000 in a 45,000 square mile geography.

Senator CRAPO. Thank you very much.

The CHAIRMAN. Doctor, thank you.

With 26 Senators waiting to ask questions, we are going to move quickly.

Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman. And you know, I have been smiling this morning as I am thinking back to when so many of us pulled together before the CARES Act was put together. At the time, Senator Thune and I were charged with getting together to make some recommendations, bipartisan recommendations on Medicare. And we quickly came together around telehealth. And of course the committee embraced those recommendations.

And I am just so pleased that we were, all of us together, willing to move forward on telehealth. And I support yours and the ranking member's desires to make these things permanent, certainly dealing with the issues around accountability that we need to do.

So when we look at the issues around telehealth, I wanted to specifically ask about mental health and addiction services. We did include these areas for behavioral health clinics to be able to use telehealth, as well as community health centers and others.

And while we are seeing that there has been dramatically expanded access to telehealth—CMS reported a 2,700-percent increase in telehealth utilization for Medicaid and children's health insurance beneficiaries. That is amazing.

But in behavioral health treatment for Medicaid and for CHIP, actually at the same time, it dropped dramatically overall during the pandemic—22 percent for adults, and 34 percent for children. So we definitely want to move ahead and do what we need to do to strengthen all these policies. But I do want to ask, Dr. Davis, if you could speak to the mental health addiction services piece of this, and what we need to do to be able to make sure we are reaching out to everyone who needs help, because obviously in this space, we are not reaching people.

Dr. DAVIS. Thank you, Senator Stabenow. Yes, telehealth for mental health and behavioral care is so important, and it really can help remove barriers to access, to stigma in terms of patients who may be hesitant to get out and meet somebody in person—and being able to see them face to face makes a huge difference.

In the practice that I work in, we have a strong connection with mental health. And so it has been absolutely beneficial to our patients to be able to provide them with behavioral health services through telehealth.

We also provide addiction services. And so being able to provide substance use disorder and MAT treatment through telehealth has been essential for our patients. I cannot explain why we have not seen the increase that we might have expected, but I can tell from patient experience that it is an essential service.

Senator STABENOW. Thank you.

And let me take my last moments just to ask Dr. DeCherrie about home health, more about home health, because we know that as we were expanding eligibility for more people to get care at home during COVID–19, how important that was. And many Medicare beneficiaries can now receive that care at home that they would previously have had to travel, or risk exposure, to be able to receive. And we know that home health care helps in many different ways.

But, Dr. DeCherrie, could you discuss the benefit to meeting patients' needs in their communities, including at home, when medically appropriate? Just a little bit more about why you think it is important that we focus on that.

Dr. DECHERRIE. Yes. Thank you for that great question. So yes, I provide care both in Hospital at Home—home-based primary care, home-based palliative care—so I believe in multiple models of home-based care. They all have their place, and we have seen increased need during this pandemic, where patients want to be home and get that care at home.

So yes, I think all of those are things that we should think about how to expand.

Senator STABENOW. Thank you. Thank you, Mr. Chairman. I am going to yield back 30 seconds, for the good of order.

The CHAIRMAN. Thank you for your good work.

Senator Grassley is next.

Senator GRASSLEY. Thank you, Mr. Chairman. I am glad to be with you for a very important issue of lessons learned from the pandemic, but we are still going to continue to learn a lot. Thank you very much.

So I am going to ask questions of all the panelists, pretty much, so if you can save some time by not repeating each other, I would appreciate it.

So my first question to the panel is, while the pandemic has shown many flexibilities in health care take place without compromising patient safety and quality, there are still areas in health care that are restricted by Federal laws and regulations. I sponsored the Pharmacy and Medically Underserved Areas Enhancement Act with Senators Casey and Brown. This bill would let pharmacists operate in a medically underserved area, offer health services like wellness screening in diabetes management, and be paid by Medicare.

For each of the panelists, which additional flexibilities should Congress consider, to improve patient access and remove Federal red tape?

Dr. MURALI. Senator Grassley, if I may, at this point in time in the Marshfield Clinic Health System, we do about 53,000 to 55,000 telepharmacy visits using the pharmacist at one center to help with respect to mixing in a sterile environment all the medications that are required across the large geography. So promoting programs that will help, like you have, is going to be very, very valuable in this space.

Senator GRASSLEY. Is there anybody else who wants to add, although you do not all have to speak if you do not have something to add.

Dr. DAVIS. Sure. This is Dr. Davis. I will say, I appreciate the extension of pharmacy, and as long as that is done as part of the medical home, I think that is important.

Speaking of other flexibilities beyond telehealth that should be considered, one is Medicare and Medicaid coverage for all AAFP- and also ACIP-required recommendations, not just the COVID–19 vaccines, but access without cost sharing beyond the public health emergency.

In addition, allowing physicians to provide direct supervision and teaching services via real-time two-way audio/video communication, which would expand access to primary care and increase training opportunities. This is already being done in rural areas, but extending that to all communities.

And then permanently removing or reducing the volume of prior authorizations, step therapy, and other administrative requirements, and allowing those to be done via telehealth or in person.

Senator GRASSLEY. Okay. Since you brought up telehealth, I am going to go to my next question. It is really a positive thing, I think, that has resulted from the pandemic, if you want to say anything good can come out of a pandemic. The public health emergency permitted more than 140 services to be administered through telehealth. Last Congress, we made mental services by telehealth a permanent Medicare benefit.

For each of the panelists who are physicians, telehealth was widely adopted throughout the pandemic, with its current utilization greater than pre-pandemic but less than its peak last spring. What type of medical services are most utilized today through telehealth? And which ones are most effective for patients and providers? And maybe the last half of that question is the most important part of it.

Dr. MURALI. Senator Grassley, so from the standpoint—I heard Senator Stabenow's comment. In the Marshfield Clinic Health System, the number of behavioral and psychological consults that go through telehealth has more than doubled compared to the average.

So more than 30 to 40 percent of home visits are actually for behavioral visits, for substance abuse, as well as with other elements. So that is an important factor from the standpoint of telehealth. I leave it to the others to comment.

Dr. BERENSON. I will just make a brief comment on that as well. I am going to agree again with Dr. Murali about the role of behavioral health by telehealth. I was involved with interviewing primary care physicians, nearly 20, and they all said, even though they are not specifically behavioral health physicians, that that has been the biggest uptake and the most valuable thing that has occurred.

The only issue that I can raise there is that, in some families there may be a confidentiality issue, where we are doing the telehealth when the patient is at their home. But that can usually be worked around.

I do not think there is a comprehensive analysis yet of which services—we heard anecdotally, for example, that hypertension was good to manage by telehealth because patients had their own blood pressure machines and could take their blood pressure, whereas for diabetes the patient needed to come in for a blood test to check the hemoglobin A1C. And this will evolve over time.

I think, however, that for the most part virtually all, sort of general medical and—not surgical, which needs a procedure in many cases—but general medical issues can be dealt with with telehealth being a central part of the management strategy.

Senator GRASSLEY. Thank you, Mr. Chairman. I am going to submit other questions for answers in writing.

The CHAIRMAN. That will be fine.

Senator Cantwell, chair of the Commerce Committee, and an expert, is next.

Senator CANTWELL. Thank you, Mr. Chairman. Thanks for having this hearing.

If I could just get a quick "yes" or "no" answer from all the witnesses, do you think we need more affordable health-care options for people in America?

Dr. DAVIS. Yes.

Dr. DECHERRIE. Yes.

Ms. FARB. Yes.

Dr. MURALI. Yes.

Dr. BERENSON. Yes.

Senator CANTWELL. Thank you.

Ms. Farb, one plan that is out there that could help reduce the cost is the Essential Plan in New York, or better known as the Basic Health Program from the legislation. It has allowed people under 200 percent of the Federal poverty line to see a huge savings in their costs.

Should we be doing more to drive the value of expansion of this program to other States?

Ms. FARB. Senator Cantwell, thank you for the question. We have not done any work looking at that plan in New York at GAO, so I cannot really comment on whether or not it should be expanded. I defer to my colleagues.

Senator CANTWELL. Yes, Dr. DeCherrie, you are a New Yorker. What do you think?

Dr. DECHERRIE. That is also not in my area of expertise, so I do not have anything to add to that.

Senator CANTWELL. Okay. Anybody else?

[No response.]

Senator CANTWELL. Okay, so I guess we have a mystery here that maybe I can try to illuminate for the future. But I can tell you this. My constituents are tired of subsidizing expensive health insurance plans when we do not have to. If there are ways to buy in bulk, which New York and Minnesota have done, and bundle up a large percentage of the population, then, yes, they believe they should get discounts. That is what is happening.

So, Mr. Chairman, mark me down as someone who is not going to go along, even if it is a Democratic proposal, not going to go along until we do something about lowering the investments we are making in expensive subsidies to insurance companies for health care.

This plan has worked in two States, and we should be using it as a way to save dollars and expand coverage to more people. Americans cannot, even with our tax subsidies, continue to have expensive health insurance costs.

Okay, great discussion on telehealth. I really appreciate all of that. The University of Washington has gone from doing about 20,000 people a year to 20,000 a month. And I am curious, Dr. DeCherrie or Dr. Berenson, what do you think that—what else do we need to do to change the actual reimbursement rate? Does it have to be on exact parity? Can it be a little off of parity? What do we need to do to make sure the reimbursement rate is fair? Or is there something else we need to do to differentiate?

Dr. DECHERRIE. I think that is probably Dr. Berenson's field to answer.

Dr. BERENSON. Again, my compulsion would be that we continue fee-for-service as an interim strategy. I do not have the magic number for you. If we pay based on the traditional resource-based relative value scale approach, the payments for the low end of telehealth would be too low to actually have them perform.

Pay parity, where we are now paying three times what that sort of proper amount should be, is too high. So I think some smart people could get into a room and come up with some middle ground so that it was high enough that physicians and practices would actually bill it. But RAND has pretty well demonstrated in a prior study, and I have not seen it challenged, that the costs for tele-

health are less than the costs for in-person. It just makes sense. And telehealth becomes sort of standard in most practices. They will—practices will reduce some of their infrastructure, and maybe work with less space, and their costs may come down. But in the interim, I think we can find some middle ground. But it should be in the context that we are moving to something different at some date, if not certain——

Senator CANTWELL. Thank you for that honest answer. Do you think that is rocket science? Or do you think that is just coming to terms on numbers—and yes, people will obviously have strong opinions. But do you think that is something we could achieve in the next several weeks?

Dr. BERENSON. The next several months. I think we have seen surveys of practices to get some answers.

Senator CANTWELL. Thank you so much. I do not know if I have any time left, Mr. Chairman. I cannot see the clock here, so——

The CHAIRMAN. You are pretty much on the line, but do you have one other one you want to ask?

Senator CANTWELL. I just want to say that I hope that Dr. DeCherrie could answer some questions in writing about—MultiCare got a CMS waiver on helping integrate doctor care and home care. So it is basically better ways for the home health-care programs to work with health-care providers, and I hope that we could look at that also as a cost savings in keeping patients in their homes longer.

So thank you very much, and we will write something for the record on that.

The CHAIRMAN. Great. And, Senator Cantwell, I want everybody to know I am with you all the way on this proposition that States ought to be given the opportunity to be able to do more to hold down health-care costs. And I think you said it very well.

Senator CANTWELL. Thank you.

The CHAIRMAN. Senator Cornyn is next.

Senator CORNYN. Well, thank you, Mr. Chairman. We all know that in an effort to maintain adequate capacity in our hospitals and doctors' offices, we limited the amount of elective procedures that were performed to deal with the potential surge of COVID–19 patients. And as a result, a lot of health-care screenings, colonoscopies, other life-saving diagnostics, dropped dramatically.

We know that about a third of adults have not received recommended screenings for age-associated risks during the pandemic, and 43 percent of patients have missed routine preventative health appointments as a consequence of these precautions.

Fortunately, now that more people are being vaccinated, hopefully those numbers will improve. But I want to add my voice to the chorus, I guess, here today of advocating the enhanced use of telehealth. I tell my friends and constituents back in Texas there are only two good things that came out of COVID–19. One is telehealth, and the second is margueritas to go. Those are the only two good things I can think of.

So let me ask. We are all very familiar with the digital divide. And this is very true, particularly of big States like mine, and we are working on that diligently. Senator Manchin and I have a Digital Divide Act which would provide grants to Governors to help

them work with Internet service providers to connect underserved areas.

But I want to ask the panel about audio telehealth. It seems to me that this could be an interim solution to make sure that low-income earners could get access to a doctor or health-care advice over the telephone. So maybe starting with Ms. Farb and Dr. Davis, could you explain how telehealth services furnished by audio-only communications could increase access to care, particularly in rural and underserved areas?

Ms. FARB. Sure. I'll start, and then I think Dr. Davis can speak more fully to this. But what we have observed—and even talking to some of the provider groups you have spoken with—is not only the beneficiaries not having access, but providers not having access is also an issue. And so a lot of providers initially started off using audio-only telehealth services, especially for the office visits, the evaluation and management codes. And that has probably continued throughout the pandemic.

But in the early days, that was definitely a source of modality that really was working for a number of groups that we have spoken to.

Senator CORNYN. Dr. Davis?

Dr. DAVIS. Thanks for that question. I would also echo that the need for audio-only is essential, both for our under-represented communities and under-serviced. We realize that sometimes broadband is just not there, and we will try and try to connect with patients via video, and the resource is just not there. The patient is not comfortable with it. They cannot get their smartphone or device to work, or they just do not have one. And as we build infrastructure, we should build it in a way that is mindful of that.

I also want to call out specifically around translation services for our non-English-speaking patients. And being able to get that language translation is often easier through an audio-only visit than it is through an audio-video visit.

Senator CORNYN. So, Dr. Murali, I saw you nodding when I asked about audio-only telehealth. What is your view?

Dr. MURALI. Well, out of the quarter-million or so encounters that we have in Wisconsin, more than 50 percent of the visits are by audio only. Unfortunately, even Medicare Advantage does not consider it for risk evaluation or adjudication, and that is a bad deal for patients because it increases disparities. And I think when you think about the digital divide, as well as racial disparities, we also need to think about the fact that even white people in rural America are poor. They basically do not have access to care. And there is also the question of literacy that needs to increase.

So all of those are disparities that we have to keep in mind. So, right on.

Senator CORNYN. I have time for one more question. You know, one of the concerns we have is about security of, specifically, personal health information. Obviously HIPAA provides that generally speaking, but as we continue to provide more telehealth, I am worried about the protection of the privacy of the doctor/patient relationship.

In closing here, do any of you have any particular observations or experience about how we can make sure that that is preserved?

Dr. MURALI. Yes. So I think it is important to invest in the infrastructure for security breaches. What is happening in Ireland right now with Conti is a good example of a security breach. And that can be addressed by infrastructure.

And then from the psychiatric care side, patients actually prefer to do that from home because it gives them the psychological safety of having that discussion in the comfort of the home, as opposed to sitting in a public health waiting room.

So those are all factors that should be factored in, and that is why payment parity is necessary to get us moving forward on this.

Senator CORNYN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cornyn. And we are with you on the audio question, particularly if the take-up rate is as low as Dr. Murali said; it is probably even worse when you are talking about traditional Medicare. If the take-up rate is low on MA, think about what it is like on traditional Medicare. So we are going to follow that up. Thank you.

Our next questioner is Senator Menendez.

Senator MENENDEZ. Thank you, Mr. Chairman.

Dr. Davis and Dr. Murali, in your testimony you both highlight the importance of audio-only telehealth. Can you tell the committee a little bit more about why coverage of audio-only telehealth services is so critical to ensure that we do not further fall behind on health-care equity?

Dr. MURALI. Senator Menendez, I would like to invite you to visit us in Marshfield. You can go from one location to any of our 60 locations for 2 hours without having access to the Internet. And the only thing that works is the old-fashioned telephone network.

So if we are really trying to address geographic isolation, that phone call is the most critical piece. In the Hospital at Home program that we started, we were trying to work those pieces back in 2016, and we were looking for one bar out of five to make sure that we could provide some kind of virtual help.

So it is not just the access to broadband, it is also the degree to which broadband is available in these rural areas that causes the disparity. So I hope that answers your question.

Senator MENENDEZ. Dr. Davis?

Dr. DAVIS. And I would second everything that Dr. Murali just said. The extension to rural areas is so important, and really investment in primary care is helpful in bridging that digital divide so that patients have timely access to in-person care and audio-video telehealth.

But the audio-only is really just essential for getting past some of those barriers. And we do not want to create a two-tiered system, so we need to make sure that payment is adequate to support the flexibility and modalities of care.

Senator MENENDEZ. Thank you.

Dr. DeCherrie, building on the previous question, the COVID–19 pandemic did not create inequity in our health-care system. Inequity is in fact a hallmark of American health care.

What role can telehealth play in addressing longstanding health disparities in our health-care system?

Dr. DECHERRIE. Yes. I mean, I witnessed this firsthand in my home-based primary care program where, again, most patients did

not own a cellphone and had no ability to do any video visits. And we, like Dr. Murali mentioned, did everything by telephone those first couple of months.

In my Hospital at Home program, we actually provide every patient with a telehealth kit. And even here in New York City, one kit that is set up with Verizon does not always work when they switch to the AT&T one. You know, even here in New York City we have these issues.

So, to be able to provide care for patients in their homes, we need to think through these things and make sure we have all options available.

Senator MENENDEZ. Ms. Farb, data collection has been an ongoing issue throughout this pandemic. I sent letters to the administration, as well as the last one, about the need for better data collection during the pandemic.

I am disappointed that HHS has still not consolidated data collection into one site with standardized reporting requirements. What data is needed about the flexibilities extended during this public health emergency to show the committee the impact of these flexibilities? And what, if any, flexibilities should be made permanent?

Ms. FARB. We do not have any recommendations yet on any flexibilities that should be made permanent. One thing I did want to point out that might be worth considering as the committee undertakes some of this work is ensuring that some of the program requirements between both Medicare and Medicaid—you know, looking at how well they align and what are some of the differences. Because I think the providers on the panel probably agree that having two very different sets of rules around how telehealth works can make it difficult for them to operate in that environment where they are dealing with that.

As far as data collection goes, yes, we have made a number of recommendations during the pandemic around providing better data, as well as ensuring that the data are contained in a site that is publicly accessible on cases, hospitalizations, et cetera.

For flexibilities, I think what we do not have is some of the information we need about differences between different telehealth modalities and some of the patient information demographics that we need and the sites of care so that we can look at quality and other things that would be important to measure.

Senator MENENDEZ. Thank you.

Finally, Mr. Chairman, I know we are all committed to building back a stronger health system, ensuring our Nation is ready for the next pandemic, and dealing with the inequities in our system, but if we are going to do that, I think one of the most effective and informed ways that we can come together on a nonpartisan basis is to conduct a thorough examination of the United States' COVID–19 response. What went right? What went wrong? How can we do it better? That is why we have a bipartisan, bicameral National Coronavirus Commission Act that my friend and colleague, Susan Collins, has joined me on. I appreciate your support as well, Mr. Chairman, as well as Senator Brown and Senator Kaine. And the House has Representatives Malinowski and Diaz-Balart on a bipartisan basis leading an effort. And I hope we can get that, because

I think that would provide us an unvarnished and fair process of understanding what went right and what went wrong. Thank you.

The CHAIRMAN. We will be supporting you. Thank you.

Senator Cardin is next.

Senator CARDIN. Well, thank you, Mr. Chairman, and I want to thank all of our witnesses. And I want to just join the overwhelming number of our members on lessons learned from COVID–19 about telehealth. But I just really want to follow up with Senator Menendez.

It also shows the inequities in our health-care system. And those communities that do not have the same degree of infrastructure, health infrastructure, or access to infrastructure, health care, were the ones who suffered the most during COVID–19. There is no question about that.

So it means we have to strengthen that. So as we look at telehealth—which was critically important for mental health—I hope we go forward with permanent changes in our reimbursement structures and in the reciprocal regulatory issues among States so that we can expand telehealth, because I think it gives timely access to care for so many individuals.

I just really want to underscore the point that Senator Menendez made about not developing a two-tiered system. It is very clear to me that, as a practical matter, having audio-only is better than not having any care. But if we set up a structure that has a two-tier system, those who have access to high-speed Internet or have the ability to access providers that can provide a much more comprehensive telehealth service, and other communities that do not have that same degree given only audio, we run the risk of a two-tier system. And if the reimbursement structure incorporates that, it then becomes also a two-tier system.

So I guess my question to all of you is, as we look at the reciprocal regulations, as we look at the reimbursement structures, as we look at access to broadband, and not just access to high-speed but the capacity to be able as an individual person to properly access that—some of our elderly have difficulty with this—what steps should be our top priority to make sure that, as we expand telehealth, which we all agree needs to be done, we do it in a way that does not set up a two-tier system?

Dr. BERENSON. I would be glad to start with——

Senator CARDIN. Jessica Farb, do you want to start? Or whoever wants to start?

Ms. FARB. I think one option that has been suggested, although it does not sort of completely align with what the panel has been talking about, is to make sure to cover audio-only where there is a documented barrier to audio-visual visits, and look at that for a brief period of time so that data could be collected to study the quality of care and determine the comparability to in-person visits.

And as I said earlier, we have heard from providers—and we have already heard from this panel—that they have had to resort to audio-only when the patient did not have access. And as you pointed out, Senator Cardin, just having something is better than nothing.

So trying to do some kind of targeted study of differences would be one way to try to make sure that we are giving comparable care.

Senator CARDIN. Dr. Davis?

Dr. BERENSON. If I could go next?

Senator CARDIN. Sure.

Dr. BERENSON. I have not had a chance to say this yet, but I will take this opportunity. I actually got interested in how to pay for telehealth after our Professor Ed Wagner at the University of Washington—who I am sure the chairman and Senator Cantwell know—proposed his chronic care model. And the chronic care model included—this was in 2003—it called for robust use of telephones, before we had video. I see video as being hyped a little too much here.

In many situations such as chronic care management, you only need a few minutes with a patient. You have already seen them, either in person or through a video conference, and you want to be checking on how they are doing. We have created in Medicare a chronic care management code, but that is for very sick people who need really intensive care management.

Most patients with hypertension or diabetes or congestive heart failure will benefit from a follow-up phone call. And so my view is that the phone calls are the encounters that take place for minutes. The video visit is for something longer, like an annual visit, or for something that really requires 20 or 25 minutes, and where visual contact is necessary.

And that would, I think, help a lot on the equity issue. I think that phones, audio-only as it is being called, should be equal. And that was one of my points, that the coding is sort of arbitrary. So I will pose the question, is the Zoom call with the video off, is that an audio-only? Or is that a defective video call?

Senator CARDIN. I think I will just underscore Ms. Farb's point. It would be good to have a study as to how audio works. Obviously follow-up conversations with health-care providers are one thing. But to do a diagnostic-type of interview is a lot of times easier and more effective with video.

Anyway, I look forward to that study, and thank you, Mr. Chairman; an excellent hearing.

The CHAIRMAN. Thank you, Senator Cardin. And I will tell you, Dr. Berenson, you are spot-on with respect to the history on chronic care. Senator Hatch and I always conceded that there would be a significant audio/phone component of it, and that is what we really envisioned in the first part of the bill.

Okay. Senator Portman, I believe, is next, if he is there.

[Pause.]

The CHAIRMAN. Senator Portman, are you out in cyberspace somewhere?

[No response.]

The CHAIRMAN. Senator Brown?

[No response.]

The CHAIRMAN. Senator Cassidy, a physician?

[No response.]

The CHAIRMAN. Senator Bennet?

[No response.]

The CHAIRMAN. Senator Lankford?

[No response.]

The CHAIRMAN. I do see Senator Whitehouse on the screen, and he is not even on our list, but we have no other Senators, so let's have Senator Whitehouse, who is a very knowledgeable person on health care.

Senator Whitehouse?

Senator WHITEHOUSE. Thank you, Mr. Chairman. Every once in a while, you get lucky and can jump the queue. I just wanted to pass along to the panelists the success that Rhode Island has had with these waivers during the COVID pandemic.

We have made very good use of the Hospitals Without Walls program, and I would love to see that continued. We kind of broke the back of opposition to telehealth generally, and I do not think there is really any going back on that. It has been particularly welcome in the behavioral health, mental health, addiction area, where practitioners report to me not only better compliance with showing up and participating, but also better substantive content.

It is hard for them to quantify that, but it is a repeated theme that there is something about being able to talk from your own home, from a comfortable place, rather than having to drive across town and fill out the clipboard and sit in somebody else's office. It just seems better.

And the medication-assisted treatment element, and allowing access to buprenorphine, for instance, with telehealth, has been a godsend for that population.

And the last thing I will mention is that I have been working for a long time to try to get CMMI to sign off on a bunch of waivers to deal with people who are nearing the end of life, for whom a lot of waivers make a lot of sense. It does not make any sense to fuss too much on how home-bound somebody is at that stage of their life. Home health services, waivers that we have seen through COVID, are very helpful.

Respite care is not "respite" if you have to stuff granny in the hospital and not get help to come to her in the house. And the whole 3-day/2-night rule is ridiculous for those patients. And those waivers, I hope we can extend.

I would ask Director Farb, with respect to the homebound and home health service and 3-day/2-night waivers, has GAO seen any evidence of heightened utilization as a result, heightened cost?

Ms. FARB. Senator Whitehouse, no, we have not examined that directly. We also tried to look to see what CMS has been reporting, and so far they have created an accomplishment report sort of describing effects of many of the waivers.

They have not included anything thus far in their reporting, but it is something that we are going to be tracking going forward, as we start to work on the additional waiver study that we are planning to do.

Senator WHITEHOUSE. Good. It is particularly important to me for people nearing the end of their lives, because it just does not make any sense. It is kind of cruel to the family to deny them those supports because of some funding requirement that is not even designed for that population but has terrible effects on families and their access to care.

Dr. DeCherrie, are you familiar with the Hospitals Without Walls program? And would you like to comment on the wisdom of extending that?

Dr. DECHERRIE. Yes, and it is specifically the Hospital at Home portion of that that we made use of during this pandemic. I want to also go back to one thing that you mentioned earlier about the comfort of someone in their home. You mentioned it in the context of behavioral health, but I would broaden that.

When we are in the home—and that could be either in person for the Hospital at Home, the nurses in person in the home, or through the video when a provider might be doing a video visit—seeing someone in their own context, to see what they are actually eating, might actually have long-term real impacts in their lives. And so these little snippets of getting into someone's home have really improved health for people long-term.

So I just wanted to make sure that that was understood.

Senator WHITEHOUSE. Let me close out with a little brag on Rhode Island ACOs. We have two—Rhode Island Primary Care Physicians, which operates an Integra ACO, and Coastal Medical in Rhode Island—and both of them are absolutely top-performing ACOs nationally. I mean they are right up in the upper corner of savings, and quality of outcome, and patient satisfaction.

And part of what they have done is to engage with patients in their home in order to get better information, and that is part of what has made it work so well. I will go as far as you want to go, Dr. DeCherrie, on this. My problem is, I have been jammed up in CMMI for 10 years trying to get it just for those patients. So that is our beachhead. But I do think a lot more can be done, and the ACOs have shown a lot of good results on that.

So I will yield back, because I think I am probably out of time, but I really appreciate this conversation. There is a lot to be done, and if people at CMMI are listening, I think we gave them these powers for a reason. Let's use them.

The CHAIRMAN. Well said.

Senator Brown?

Senator BROWN. Thank you, Mr. Chairman. I appreciated the comments of my friend from Rhode Island, and I know that Senators Cornyn and Menendez asked about audio health, audio-only telehealth. So I would like to follow up with a couple of questions, particularly about folks who live in more urban and suburban settings who may not have access to video conferencing or Internet capabilities to access video telehealth.

So my question is starting with Dr. Murali. Speak briefly, if you would, about the increased reimbursement for audio-only telemedicine, how it helped you stay connected with hard-to-reach populations throughout the pandemic, both in underserved urban areas and underserved rural areas, if you would, Dr. Murali.

Dr. MURALI. Thank you, Senator Brown. So as I said previously, out of the quarter-million visits that we did at the Marshfield Clinic Health System, greater than 50 percent of those visits were done by audio visits. So what it allowed us to do is manage patients with heart failure. In fact, we had studies that demonstrated that we were able to save close to $2.7 million while managing 600 pa-

tients. Just imagine the power of that if you were to take that across the entire country.

From the standpoint of behavioral health, I have already made my point about audio, because it gives you pretty much all of what you need to know from the standpoint of that care. So there are several benefits, but that is just a snippet of what audio can do.

Senator BROWN. Thank you, Dr. Murali——

Dr. MURALI. The other piece is——

Senator BROWN. Sorry.

Dr. MURALI. The other piece is that it is extremely difficult to get broadband access in rural Wisconsin. And so, if you do not provide that support on the audio side, you are geographically isolating these patients from seeking the care that they need, and therefore you are not being proactive. And that will increase your emergency care visits, as well as your urgent care visits, and overall costs from the standpoint of care.

Senator BROWN. Thank you.

Dr. DeCherrie, I appreciated your comments about nutrition and what the window into the home can provide.

Dr. Davis, my questions, my next couple of questions are for you. You recommend Congress act to require Medicare to cover audio-only evaluation and management services beyond the public health emergency to ensure equitable access to care. Talk, if you would, about two questions: how audio-only telemedicine services could help reduce disparities in access to care, and how should CMS monitor the impact of telehealth, including audio-only telehealth, in access inequity?

Dr. DAVIS. Sure. Thanks, Senator Brown. You know, as a primary care provider and also working in an Accountable Care Organization, we have lots of experience with this. And audio-only care, when used appropriately, is high-quality care. And so I want to make sure that we note that distinction, that studies comparing telephone-only visits to telehealth visits conducted prior to the pandemic found no significant difference in health outcomes or patients' reported satisfaction.

And so it certainly is an additional tool in the toolbox in order to be able to provide equitable care for patients, regardless of whether patients are rural or suburban. I have provided care for those patients; the docs I work with have provided care for those patients; and across the board, we have had challenges when they are restricted to only video services.

And so being able to interact with our elderly patients who may have trouble connecting and not have a family member close by who can help, or our non-English speakers who may have trouble connecting and using translation services, and for those who do not have access to broadband in a robust way, audio-only is essential for providing good care for them.

Senator BROWN. And CMS can monitor the impact of that?

Dr. DAVIS. Yes. I mean, I think we have coding and an ability to do that, paired with patient satisfaction, paired with care outcomes, the ability to collect data. Now I feel like, as a physician, my quality is monitored in many different ways and getting back to health outcomes. And I think it is important to distinguish that telehealth audio-only and with video should be differentiated be-

tween what happens in the primary care patient-centered medical home, versus a vendor that is providing just that service.

And so audio telehealth is provided best when it is part of the care continuum that a primary care provider is providing. You have the background and the history on the patient, the access to their chart, and that long-term trusting relationship.

Senator BROWN. Thank you, Dr. Davis.

I am on my last 30 seconds, Mr. Chairman, and thank you for your indulgence. I wanted to bring up another issue—no question, just an issue. Senator Capito and I have proposed, related to Medicare's hospice respite benefit, the COVID–19 Hospice Respite Care Relief Act of 2020, giving the Secretary of HHS the authority to allow hospice patients to receive respite care at home, and for longer periods of time during any public health emergency, including obviously the one we are in. It was not able to make a difference for family caregivers over the past year. So I hope the committee, Mr. Chairman, can consider ways to strengthen the hospice respite benefit moving forward.

So thank you, and thanks to the witnesses today for their insight.

The CHAIRMAN. We will follow up with you, Senator Brown, and Senator Capito. Very important.

Senator Lankford is next.

Senator LANKFORD. Mr. Chairman, thank you, and thanks to all of our witnesses and the insight that you are bringing, and for all your work during the pandemic. There is a great deal of work that was done and a lot of innovation that happened at your places to be able to actually take care of people. So thanks for that level of engagement that you have as we work our way through this.

There were over 200 flexibilities that were given by CMS during this time period. Congress is obviously very engaged. My office was engaged, as well as all the other offices here in this hearing today, trying to be able to go back and forth on it. We have talked a lot about telehealth, and I want to mention some of those things in a moment.

But, Dr. Berenson, I do want to be able to bring up an issue about the 3-day rule for skilled nursing facilities. When I called back to touch base with a lot of our hospitals and facilities and such and ask, of all the flexibilities that are there, which one really stands out as one that needs to last, everyone brought up telehealth, but then this 3-day rule for the skilled nursing facilities came up.

Can you talk about that a little bit?

[Pause.]

Senator LANKFORD. You are on mute, still.

Dr. BERENSON. I apologize for forgetting that I am on mute. It has been around since the beginning of the program, basically, because of the concern that Medicare would be turned into a long-term care program if you did not have a requirement that skilled nursing was associated with an inpatient hospitalization.

It is clear that an MA functions very well without the 3-day rule. There are exceptions for ACOs, and there is sort of general agreement that it has a perverse incentive, and it involves a lot of gam-

ing, in fact. I have been involved with a family member who was kept an extra day just to qualify for the 3-day rule.

So for me, if we can figure out a way to sort of eliminate it without running into the concern that we have created a long-term care benefit, I think we should do so. And the more we sort of move towards risk-taking and capitated type of arrangements where the organization itself has an incentive not to abuse the hospitalization, I think we can make good progress.

But I agree with you completely that it is very frustrating. It even affects the observation stay rule in Medicare where beneficiaries do not qualify because they actually were not on an inpatient stay, they were just in an observation stay, and therefore they do not get the same access to skilled nursing. It really is a problem that deserves real attention.

Senator LANKFORD. It is a serious issue. I would be interested in any other practitioners who have had observations on this 3-day rule.

Dr. DAVIS. Sure. This is Dr. Davis with AAFP. I would like to second that AAFP would be in favor of reducing that. And just to share an example from a patient that I had, a patient that I was actually doing home visits on, which is rare, but we still do home visits. And we could see in his home that he needed a higher level of care. He did not need to go to the emergency room or hospital. He just needed to be at a skilled nursing facility to receive some rehab. But in order to get him there, he had to go to the hospital.

He developed an infection in the hospital, which lengthened his length of stay and raised his Medicare costs. He eventually did end up in the nursing home, but the relationship that I had with that patient—I knew his history. I knew what the appropriate next level of care was, and it just created barriers and increased costs that were unnecessary.

Dr. MURALI. Senator Lankford, at Marshfield in 2014 we started our process for creating comfort and recovery suites, got skilled nursing facility bed licenses, and did all of our orthopedic surgery, our gall bladder surgery, our gynecological surgery, thyroid surgeries, and kept them in the SNF a little longer than 24 hours, and then we could send them home. Phenomenal cost savings that can be achieved on the commercial side as well as in Medicare Advantage, which we have shown in our data. And so I think it is an archaic rule that needs to be looked at, because its costs are wastefully spent.

The other piece is in the Hospital at Home. When somebody comes into the ER, you wind up putting them in an observation bed from the standpoint of 24 hours or whatever duration of time. If you have the skilled nursing facility option available, if somebody comes in the middle of the night and cannot go back home, you prop them up in the skilled nursing facility bed for 12 hours and then make arrangements for Hospital at Home care at home.

So that is what we do in the rural environment. Because, when you have the little old lady who is 84 years old come into the ER at midnight, you cannot possibly arrange for oxygen. It is easier to deliver pizza in Manhattan at midnight than it is to get oxygen delivered to a home at midnight.

So I think for all of those reasons, thinking about skilled nursing facilities differently and creatively is important on a risk basis model. So I will rest there.

Senator LANKFORD. All right; thank you.

Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you very much.

And, Doctor, you really highlighted the importance of care over some other things people are thinking about sometimes.

Senator Casey?

Senator CASEY. Mr. Chairman, thanks very much for having this hearing. It is critically important, the number of issues that we are learning so much about in the last more than a year now.

I will have a question for Dr. DeCherrie and Dr. Davis. The question for Dr. Davis will be about mental health for children and teens. But I wanted to ask you, Dr. DeCherrie, about the PACE program and the expansion of it.

We are learning so much and exploring today innovative models of care. I think if there is one thing we have learned over the course of the pandemic, it is the importance of services that allow seniors and people with disabilities to remain in their homes, in their communities, as we have heard over and over again today.

And that is of course the setting that they would prefer. They prefer to get care in the home, or in the community. And like the Hospital at Home model, which provides hospital-level care for people with acute illnesses, the PACE program, or the so-called Program of All-Inclusive Care for the Elderly—we refer to it in Pennsylvania by a different acronym, the LIFE program—is similarly a way that seniors and people with disabilities can receive wraparound care while remaining at home.

So I think we have to take the lessons we learned in the last year to improve and expand upon services like PACE to ensure that seniors and people with disabilities have access to the supports that they require.

I have introduced the PACE Plus Act just last month. This would provide funding for existing PACE programs to service more people. And it would allow these specialized programs to expand into areas that do not currently offer PACE as a long-term care option.

So, Doctor, I would ask for your perspective on what is the value of expanding programs like PACE that provide these wraparound services for seniors and people with disabilities?

Dr. DECHERRIE. Thank you for that excellent question. I have not worked at a PACE program since my residency. I was fortunate enough to get that opportunity to work at a PACE program for an entire year during my residency, and so I have familiarity with the model. But it is very much like home-based primary care, which I do every day. And so I do believe that expanding access for home-based programs, Hospital at Home, Home Based Primary Care, and PACE, is very important.

We have seen here in the pandemic that patients absolutely want that type of care, and we should act to expand it.

Senator CASEY. Doctor, I appreciate that.

I want to ask a question for Dr. Davis, as I mentioned earlier, about children. We know that if there was one problem that was

terribly, terribly exacerbated by the pandemic, it was the crisis in mental health, especially for children and teens.

Some of the most horrific stories and some of the numbers that are so horrific, I think will stay with us a long time. We are told, for example, of a 24-percent increase in emergency room visits for mental health crises among children ages 5 to 11, increased wait times to access inpatient mental health treatment, and so much else. And as we recover from the pandemic and the restrictions are lifted, children with mental and behavioral health needs, of course, are not going to be going away.

We have to make sure that we have programs in place and strategies to make sure we have the appropriate care for them. We need to make sure that they have the appropriate treatment in the appropriate setting at the appropriate time.

So, Dr. Davis, are there ways and existing tools or options in both Medicaid and CHIP that can be used to address mental and behavioral health needs of children and teens?

Dr. DAVIS. Thank you, Senator Casey. You know, as a mom of three school-aged sons, this is acutely aware to me, in the challenges that they have had in virtual schooling and not being able to connect with their friends. And I see it in my patients as well.

So, one, the expansion of telehealth for mental health is crucial for children. One of the biggest barriers as a primary care physician is just being able to find a therapist, or a psychologist, or psychiatrist in the area to be able to treat children. And so being able to expand that treatment network is really huge.

I think the second is creating parity in payment with Medicaid, continuing that. And we especially see low reimbursement for mental health providers who are offering Medicaid services. And so, if we really are trying to address that divide, we need to make sure that Medicaid is having reimbursement for mental health services, especially for children.

Senator CASEY. Doctor, thank you.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Casey.

Next is Senator Thune.

Senator THUNE. Thank you, Mr. Chairman and Ranking Member Crapo. I think if we can find a bright spot from this pandemic, the embrace of telehealth across the Nation is certainly one. For four Congresses, the Senate Telehealth Working Group has advocated for increased access to telehealth, and working with this committee, many provisions from past versions of our group's CONNECT for Health Act have become law. In fact, CONNECT informed a lot of our discussions on the CARES Act, which Senator Stabenow already mentioned.

So that bring us to where we are today. And I think the question is, what have we learned?

Dr. Murali, you represent a health system that utilized telehealth long before the pandemic, like many of the systems in South Dakota have. Do you support the CONNECT Act? And which provisions, in your view, are most important to improve access for rural and urban patients?

Dr. MURALI. First, I thank you for cosponsoring the CONNECT Act. It is one of the most important acts, especially in the space of

rural health care, particularly the provision to waive the requirements of geographic restrictions to allow FQHCs and RHCs to do the work that they need to do. It is one of the craziest rules.

For instance, you have a physician who can see say 20 patients a day. They are in a rural center as part of an FQHC or RHC, and they only have four patients to see that day. If they need to provide that service in some of the remote areas, they could not do it if not for the Act. So that is a wonderful piece of what that act has achieved, at least in remote and rural parts of Wisconsin.

So I hope I have answered your question as to the value of the CONNECT Act. And I think Sanford, which is in your State, has some of the same issues, and they are part of the Clinic Club, and we spent a lot of time trying to see how we can provide service.

So that is my response.

Senator THUNE. In your testimony, you discussed what could be the, quote, "new norm" with telehealth and phone. You predict that 15 or 16 percent of all appointments per month may be handled this way moving forward. Could you talk to us a little bit more about how you came to that conclusion, and if your data includes both Medicare and commercially insured patients?

Dr. MURALI. As to the last question, our answer is "yes," for both commercial as well as Medicare patients at this point in time for that calculation.

So let me just make a quick illustration. My wife is a pediatric neurologist. She is one of three pediatric neurologists in the 45,000 square miles where we provide care. If a mother has to bring her child for general epilepsy care, which is a 30-minute visit, she needs to bundle those kids in winter gear, in the peak of winter, and travel 2 hours, and then back 2 hours, for a 30-minute visit. This can be done through telehealth.

Like that, there are lots of established visits that can be done through telehealth, once you have had the first physical visit, and can be done efficiently. Think about the impact of that to the employer; think of the impact to the mother; the cost of driving these kids, paying for their lunches, paying for the gas, and losing 1 day's work. That is happening all across rural America. So that is the number one point.

You can extend that to E&M visits for dermatology. You can do that for pretty much all specialties in terms of how you can manage that care. And that number is about 15 to 16 percent in our present numbers, and could go up to 20 percent if we are actually allowed to adopt these services in a creative manner. And that is confirmed by my colleagues in APG who also do some of that same work, and further confirmed—when the pandemic happened, when we shut down all services, 22 percent of all care, even by physicians who were unwilling to do telephone or telehealth visits, was the number that we had in our institution.

So it is a phenomenal step if we can go down that direction.

Senator THUNE. So as Congress continues to discuss which of these pandemic flexibilities should be made permanent, there have been discussions about whether increased program integrity measures are needed. And some have suggested a requirement for a face-to-face encounter.

Concerning this from a health disparity standpoint, I think we have to be careful about a one-size-fits-all approach that could prevent rural patients in particular from taking the first step to seek care.

So as things stand today, is there any reason that a clinician could not tell their patient that an in-person visit is needed, without having a mandate to do that?

Dr. MURALI. Yes; so all clinicians will do the right thing for their patients. If we believe a physical visit is required, we will do it, because we have signed the Hippocratic Oath and we want to provide the best care for our patients. And we carry the burden of their sickness or outcomes.

So I do not think that that is a concern at all. Like I said in my testimony, I manage a 67-year-old lady for complex heart failure at a distance of 200 miles, and she came to visit me once a year for 4 years, and she is well even now 13 years after the episode. She still sends me a Christmas card. A lot can be done from the standpoint of how care is provided.

Senator THUNE. Good. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Carper? Senator Carper, I think you are out there somewhere?

[No response.]

The CHAIRMAN. Okay, we are missing Senator Carper. Let's see; yes, Senator Daines would be next, and then Senator Warner and Senator Hassan.

Senator Daines?

Senator DAINES. Yes.

The CHAIRMAN. All right.

Senator DAINES. Thank you, Mr. Chairman. I appreciate it.

Well, I appreciate this hearing today. We are a rural State in Montana, and we have faced the access challenge to health care before the pandemic. And so when folks were told to stay home to prevent the spread of COVID and avoid exposure to the virus, virtual care became even more important. It was a lifeline in many cases for Montana patients.

Montanans now are telling me that that test drive of COVID health-care flexibilities was a success, especially when it comes to expanded access to telehealth. I believe we need to do what we can to make expanded access to telehealth permanent for Montanans and all Americans, especially in rural areas, and not cut access back once we are in the post-pandemic period.

Back in March of last year, I introduced the Telehealth Expansion Act to allow American workers and families to access virtual care without the burden of first meeting their deductible. My bill was signed into law as part of the CARES Act, allowing these high-deductible health plans with Health Savings Accounts to offer cost-free telehealth services. This ensures patient access to critical care during the pandemic.

Today I am teaming up with my colleague Senator Cortez Masto, and we are introducing legislation to make this policy permanent. One of the lessons certainly we learned from the pandemic is the value of leveraging telehealth to meet rising demand for health-care services.

Access to virtual care should not solely be considered a COVID–19 policy. Our legislation, entitled The Telehealth Expansion Act of 2021, will meaningfully expand access to care by permanently allowing first-dollar coverage of virtual care under high-deductible health plans.

My question for Dr. Murali is, practicing in Wisconsin, you are all too familiar with rural health-care challenges. Could you speak to the value of reducing barriers to telemedicine, and specifically the advantage of making this particular policy permanent?

Dr. MURALI. We actually strongly support that policy. I think you are talking about your first-dollar policy with respect to high-deductible health plans, and we believe that that brings immense value to our communities. And if that is expanded to behavioral health and other pieces, I think it is a wonderful thing.

I have discussed this with our health plan CEO, as well as our folks who are on the ground, and the information I received from them is, it will be extremely well received from the standpoint of care, and for providing access to care, which is critical in rural Wisconsin.

Senator DAINES. Thank you, Doctor.

When it comes to accessing telehealth in Montana, our people in rural communities who lack sufficient broadband Internet connectivity do not have the option of that face-to-face virtual care. In some cases, audio telehealth using a phone is the only option.

In fact, I just met with some of my primary care docs from Montana this morning. They talked about being forced to audio telehealth when we sometimes do not have the visual option. And that is why I worked with my colleagues last year to ensure payment parity for audio-only telehealth, ensuring that rural Montanans can access telehealth no matter where they live, and no matter what access they might have.

Dr. Murali, how important is payment parity when it comes to ensuring that folks in rural communities can access care?

Dr. MURALI. I think, as I have said before, there is a lot of investment that goes into infrastructure to maintain that ability to provide telehealth and actually lower the cost of care. So payment parity is absolutely important from that standpoint.

Senator DAINES. So expanded access to telehealth services, including physical therapy, has helped our seniors in Montana and around our country who have been the most vulnerable to the virus. It also helped demonstrate that therapy needs to be, and can be met with the use of technology, and that patients can have improved access in rural areas particularly.

Ms. Farb, what has GAO found when it comes to the value of expanded telehealth, including physical therapy, during this pandemic? And is there evidence that using telehealth has helped remove delays, or perhaps barriers to people accessing preventive services that have helped to prevent the deterioration of a patient's condition?

Ms. FARB. So, Senator Daines, we are still working on our study looking at the effects of telehealth on the beneficiaries who have received it. I can say from some of the interviews we conducted with beneficiary advocacy organizations that much of what you just said in terms of serving as a lifeline, and serving as a way for bene-

ficiaries to access services that they otherwise would not have been able to do—we definitely have heard that.

We will be breaking out some of the utilization both pre-pandemic and during the pandemic in terms of looking at some of the data by various demographic characteristics, including urban areas, as well as particular services, as you mentioned, such as physical therapy and other services that were available.

So I do not have any preliminary data yet to share on that, but that is what we are currently working on in our study that we are doing right now.

Senator DAINES. Thank you, Ms. Farb.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Daines.

Senator Crapo is going to help us keep this going. So I believe our next three will be Senator Carper, Senator Warner, and Senator Hassan. We can get all three in before the vote.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman. I was out during our last recess, Mr. Chairman and colleagues, I was out in the Bay Area and visited a number of technology companies. Some of them were startups, some have been around for a while. One of the companies I visited—I think her name was, I want to say Ginger—and they are involved in behavioral science. And they work with helping people who have behavioral science challenges in their lives, mental health and so forth, and it is a company that uses telemedicine to try to bring some help to more people early on in their illnesses.

So for me it is something in real life, and I saw it for myself, and it is, I think, another way to get results, and hopefully better results, for less money in helping people who are dealing with those kinds of challenges in their lives.

But I very much welcome this hearing today. During the pandemic, telehealth has been an essential, and is becoming a more essential, tool in our toolbox to try to make sure that not just adults, but children receive the care that they need, while minimizing risk.

And although telehealth in Medicare has been a focus, close to 40 million children, I am told, are enrolled in Medicaid or the Children's Health Insurance Program—close to 40 million. And across our Nation, families experience barriers that prevent them from accessing routine health services, like a limited availability of providers, or long lead times for an appointment.

And for many in Medicaid and the Children's Health Insurance Program, increased access to telehealth services can mitigate those barriers to improve the timeliness and convenience of care delivery, while also improving health-care outcomes, and do so at reduced cost.

I have a question for Dr. Berenson, if I could. What are the main policy changes, Dr. Berenson, that we need to ensure the broader use of telehealth can be continued for children beyond the pandemic? Dr. Berenson?

Dr. BERENSON. Well, I—there is an echo—it tends to be a Medicare effort, and I am not a CHIP expert, but I think basically States need to have generous telehealth policies. But I am not the

person who really can tell you precisely what we should do for children in this area.

Senator CARPER. Okay; thank you. Anybody else among the panelists who would like to take a shot at that, please?

Dr. DAVIS. This is Dr. Davis. Again, Medicaid payments for children are really important [much echoing] to ensure they have access.

Senator CARPER. All right; thank you. Anyone else, please?

[No response.]

Senator CARPER. All right; let me move to the next question. This is my follow-up question that deals with guidance for State Medicaid and CHIP programs. And during the COVID–19 public health emergency—which we are still struggling to get out of, but making progress—a wide variety of policy waivers have been put in place across our country to expand access to telehealth services, unleashing the power and potential of telehealth to safely and effectively provide care to children and to their families.

However, there is a wide variation in telehealth policies among State Medicaid programs. And as States consider how to expand coverage of telehealth services, there is limited guidance or information to aid in their planning.

Moreover, there are limited comprehensive studies specifically looking at the impact of telehealth on the Medicaid population, including during national public health problems.

And if I could, Dr. Davis and Ms. Farb, according to MACPAC's March 2018 report on telehealth in Medicaid, States looking to expand telehealth in their Medicaid and CHIP programs would benefit from additional research and a more robust understanding of the impact of telehealth.

My question of Dr. Davis and Ms. Farb: do you believe that further study in this space is still needed? And do you think the real-world evidence gathered during the pandemic could provide further insights that support the expansion of telehealth for our children? Dr. Davis, Ms. Farb, please.

Dr. DAVIS. Thank you, Senator Carper. There has been a lot of study already, and I think from MACPAC's work and work that we have seen, we can start to move forward and recognize the importance of Medicaid, especially for the benefit of our children who are participating in the CHIP program and in the Medicaid program.

Ms. FARB. And I will just add, we are actually studying telehealth and the Medicaid program as we speak, as well. My statement today has been based on the ongoing work that we are doing both in Medicare and Medicaid. So we are looking at the effects of the use of telehealth during the pandemic and trying to garner some lessons learned.

As far as guidance from CMS, we understand that they are planning to issue some additional guidance to States, but some of that guidance is still in review within the agency. So, in our ongoing work, we have talked to CMS about what plans they have to provide that guidance, especially in looking at sort of program integrity types of things that they need to be aware of.

But we are doing work. So it is hard for me to say we should not study it more, I think, given where I sit at GAO, but I defi-

nitely think there is a lot of evidence out there, as Dr. Davis pointed out.

The CHAIRMAN. There is an important vote, and let us get Senator Warner and Senator Hassan in before we have to run. And we are going to keep this going.

Senator Warner?

Senator WARNER. Thank you, Mr. Chairman. I will try to make sure I address the quick timelines.

First, I think we all know that obviously COVID exposed some of the racial disparities we see in health-care coverage. I think this committee and others have tried to do a better job of making sure we get good data on some of those racial disparities.

One of the things that I have worked with the chairman and others on is making sure that we encourage States to go ahead and expand Medicaid, and that we increase our premium payments. I actually hope on the ACA, I hope we can make some of those things permanent.

But, Dr. Berenson, do you want to weigh in on this issue of whether the expansion of Medicaid in States that were not covered, whether the ACA additional premium payments support that we put in place in some of the legislation recently will actually start to help diminish some of the racial disparities that were exposed by COVID–19?

[Pause.]

Senator WARNER. I think you are on mute, Dr. Berenson.

Dr. BERENSON. Sorry about that. Again, I am not a Medicaid expert, but my understanding of the results from Oregon, which had that study where they sort of randomly selected people into Medicaid, demonstrated better access when people did get Medicaid. And I think that the outcomes were a little mixed, but the study was not conducted long enough to be able to demonstrate those.

So I basically agree with the premise of your question there. There need to be incentives for all States without Medicaid as an expansion.

Senator WARNER. Well, thank you. I think I am going to, obviously, continue working with the chairman and others on this.

Let me move to a slightly more probing question for Dr. Davis and Ms. Farb. You know—and let me preface this question with, obviously we all realize the opioid abuse and substance abuse issues are a huge challenge, and this committee again, with folks like my friend Senator Portman, has been grappling with that for some time.

On the other hand, I have been trying to get the DEA, literally for close to 10 years, to allow for physicians to—and frankly, for the DEA to promulgate rulemakings, which they were supposed to have done by law, to allow certain physicians to prescribe certain controlled substances via telehealth. We have made sure to make this happen in legislation called The SUPPORT Act last Congress. But the DEA continues to refuse to take up this rulemaking.

I have reached out to them multiple times on this. I do believe that the Biden administration is trying to work in good faith, but with the importance of telehealth being accentuated by COVID, by this panel, Dr. Davis, I would like to hear from you, given your ex-

perience with patient care, and, Ms. Farb, maybe GAO may have taken a look this issue as well.

I know we want to make sure there is not abuse, particularly when it comes to controlled substances, but I do think we have been waiting 10 years. It is in the law. And while we need to put appropriate protections in place, we need to let physicians have these tools.

So, Dr. Davis and Ms. Farb, will you comment on that subject?

Dr. DAVIS. Sure. Thank you, Senator Warner.

I do also want to go back to your previous question. As Vice Chair of MACPAC, I do want to echo that we have already started to see a reduction in health disparities in those States that have expanded Medicaid. And we need to continue to study that and look and see those drivers.

In terms of substance abuse treatment, as a buprenorphine provider myself, I have seen the benefit, especially throughout COVID–19, of being able to conduct those services by telehealth. Being able to prescribe remotely and electronically, being able to keep patients from relapsing, has been essential, especially with all of the stresses that have happened over the last year.

And so I encourage continuation of, as well as passing new legislation getting us further along to be able to conduct that service electronically, both in terms of prescription and in terms of the visit by telehealth or audio.

Senator WARNER. Thank you, Doctor. I agree with you. And again, DEA, on some of this rulemaking, has just been dragging its feet.

Ms. Farb, do you want to make a comment?

Ms. FARB. Sure. So GAO does have prior work kind of looking at some of the barriers to medication-assisted treatment for opioid use disorder. And we have noted that some of what you are discussing did occur, in terms of prior authorization requirements, and restrictions on distribution, and just the Federal waiver that providers need to prescribe or administer some of the prescriptions that are needed.

So we did not make any recommendations out of that study, but we definitely did enumerate all the barriers that are being faced by providers and various health-care programs.

Senator WARNER. Well, I hope we can keep working on this. I think I will turn it back now to, I guess, Senator Crapo, you are filling in. Thank you.

The CHAIRMAN. Thank you, Senator Warner. This is great.

We are—let's see. It is Senator Hassan there, and Senator Crapo is back, and I will run and vote and come right back. But Senator Hassan is up now, Senator Crapo.

Senator HASSAN. Well, thank you so much, Chairman Wyden and Ranking Member Crapo, for this hearing. I want to echo what Senator Warner was just talking about when it comes to facilitating medication-assisted treatment, and I look forward to working with colleagues on both sides of the aisle on that.

And before I get to my questions, I also want to reinforce my colleagues' calls to continue to expand telehealth access, including in rural communities. The dramatic expansion in telehealth services

during the pandemic has benefited a large number of patients, including in my home State of New Hampshire.

I want to turn now to Dr. Davis. The news that there could be an authorized COVID–19 vaccine for all children by the end of this year is truly an exciting development for many families. However, I am very concerned that over the past year routine child wellness visits and pediatric vaccinations have declined significantly, particularly for children enrolled in Medicaid and the Children's Health Insurance Program.

Telehealth expansions have improved access to many routine primary care services, but unfortunately you cannot get a vaccination over Zoom.

So, Dr. Davis, as telehealth becomes more integrated into primary care services, how can we ensure that children will continue to attend routine, in-person wellness visits that help ensure that children are receiving lifesaving vaccinations, as well as critical developmental and physical screenings? And how do we get children who missed their routine vaccinations over the past year back on track?

Dr. DAVIS. Thank you, Senator Hassan. The answer is, you know it is very important, and I do worry about the kids who are delayed in their vaccines because of hesitancy in going into care. But I have seen the resilience of our family physicians and pediatricians, especially at our community health centers, in getting creative and innovative and making sure that kids are getting their vaccines in terms of drive-up clinics, parking lot operations, and being able to make sure that they are getting them.

I am not worried that telehealth is going to replace what we do as physicians. And in combination with the primary care relationship, doctors are going to make sure that their kids are coming in for their vaccines, and I have really seen them being stalwarts and champions in continuing that.

I think that there are other things that we can do to encourage vaccines, requirements that happen at schools, you know, to make sure that kids are getting the vaccines. But I am not worried that—there is a lot of catch-up to do, but I think that we can get there.

Senator HASSAN. Thank you so much for that.

To Dr. DeCherrie, I want to talk with you a little bit about home and community-based services. The American Rescue Plan increases Federal funding for home and community-based Medicaid services. However, while this initial investment is an important step, we need to do more to ensure that older adults and individuals with disabilities have access to this care.

Many of us on the committee are continuing to work towards some long-term solutions here, but what changes do you believe are needed to expand the home health workforce and improve the quality and accessibility of home and community-based services?

Dr. DECHERRIE. Thank you so much for this question. We cannot—you know, in geriatrics we cannot do what we do without the family support, without the aides who are there to care for our patients. Our work is like one-tenth of the daily work that these people do to help support our patients. And it is so important that we are able to support the caregivers.

So I agree with you that we need to think about how to expand that workforce, how to make sure that patients are able to get quality care through that workforce. And it could be through family caregivers or paid caregivers.

Senator HASSAN. Thank you. Is it fair to say that families who can get some support and relief from home care health aides, for instance, often are able to support their loved ones better at home than when they try to do it all by themselves?

Dr. DECHERRIE. Yes. Definitely.

Senator HASSAN. Thank you.

Dr. Davis, one more question. The COVID–19 pandemic has demonstrated the value of providing critical vaccines to vulnerable populations at no cost. Women covered through Medicaid are less likely to receive the tetanus and influenza vaccines during pregnancy than those who have commercial insurance.

Earlier this year, Senator Cassidy and I reintroduced the Maternal Immunization Coverage Act to help address this disparity. This is a bipartisan bill that would ensure that State Medicaid programs cover ACIP-recommended vaccines for pregnant beneficiaries at no cost.

Dr. Davis, how should we parlay the lessons that we have learned from this public health emergency about the benefits of providing vaccines to vulnerable populations at no cost in order to ensure that all Americans have access to life-saving vaccinations?

Dr. DAVIS. You know, we have really learned from the COVID–19 vaccination that when you are able to offer it without cost, that removes a significant barrier. And the AAFP agrees that we should expand access to all ACIP-recommended vaccines at no cost through Medicare and Medicaid, CHIP, and all other commercial insurers.

Senator HASSAN. Thank you very much.

And thank you, Senator Crapo.

Senator CRAPO [presiding]. Thank you.

And Senator Young is next on the list, but I do not see him on the screen. Is Senator Young with us?

[No response.]

Senator CRAPO. All right, Senator Warren, I see you. Go ahead, please.

Senator WARREN. Thank you, Mr. Chairman.

So when coronavirus hit, patients still needed access to basic health services like primary care and mental health visits, but COVID made it harder for patients to get the care that they needed. On top of the usual struggles like taking off time from work, people now had to keep themselves safe from infection. Services that were already difficult to manage even in the best of times became much harder to get.

Take hearing loss, which affects 48 million Americans. On average, it takes 7 years for patients to seek treatment for hearing issues, even when we are not in a global pandemic. And COVID–19 only added additional burdens.

So that is a key reason why the Centers for Medicare and Medicaid Services made it easier for providers like audiologists to offer hearing services remotely during the pandemic.

Ms. Farb, what steps has CMS taken to make it easier for patients to access care from audiologists through telehealth during this pandemic?

Ms. FARB. Well, Senator, as you pointed out, CMS initially expanded the types of providers that could furnish telehealth services to include all those eligible to bill, which included physical therapists and speech language pathologists, as well as audiologists.

At the beginning, they were able to bill for certain codes starting in March of 2020, and some of those codes are not typically the codes that are billed by audiologists, but CMS added additional codes to the list at the end of March of 2021. And that coverage is effective retroactively back to January of 2021. The list included services such as tone decay tests and assessments of tinnitis. And so that expanded sort of the ability for audiologists to provide those services.

We spoke with ASHA, the association that covers speech language pathologists as well as audiologists, and they were very supportive of those changes.

Senator WARREN. So, Ms. Farb, if I can just summarize, CMS considered all the audiologists to be important enough to include in the response to the pandemic, but audiologists usually are not treated equally in the Medicare program. Despite their years of schooling and training, audiologists are considered, quote, "suppliers" not, quote, "practitioners" in the program. And outdated Medicare rules require patients to get their doctor's permission to see an audiologist rather than letting patients make the decisions they need to improve their hearing.

So let me ask, Dr. DeCherrie, why is it so important that seniors with hearing loss can access the providers they need, including audiologists, without bureaucratic limitations that make it harder for them to get care?

Dr. DECHERRIE. Thank you for that question. Yes, I mean being able to hear is so important, especially for our elderly patients. I mean, there have been numerous studies that have shown reduced risk of falls, improved mood, improved memory, all by being able to hear better. I mean, we see this every day on home visits now when we are trying to do something by video. If they cannot hear, just turning up the volume does not work.

So these patients really do need their hearing assessed, and then potentially a hearing aid or whatever is needed.

Senator WARREN. In other words, audiologists provide critical services to people with hearing loss. That is why I am joining Senator Paul and Senator Grassley in reintroducing the Medicare Audiologist Access and Services Act. This is a bill that would expand seniors' access to hearing services by reclassifying audiologists as practitioners in the Medicare program. And that will allow them to bill for services without a physician referral, and to provide patients with both the diagnostic and treatment services that are within an audiologist's scope of practice.

It seems to me that the COVID–19 pandemic has forced us all to reconsider bureaucratic limitations to health care, including hearing care. So I believe that the Senate should prioritize the passage of our bill to help seniors get the care that they need.

Thank you, Mr. Chairman.

Senator CRAPO. Thank you, Senator Warren.

And I see Senator Cortez Masto, so, Senator, you may proceed.

Senator CORTEZ MASTO. Senator Crapo, thank you. And thank you to the panelists. This has been a very, very informative conversation. And let me echo and agree with my colleagues. I think making telehealth permanent is so important for the reasons that we are discussing today. But I also recognize and really appreciate the challenges that we still need to understand, the data. We need to capture the accurate data, the diversity in the data. We need to make sure we put up guard rails but still to study it. But for the many reasons we have talked about, I think it is so important.

I have seen the benefits in Nevada alone, but here is one thing—and we have talked about this already this morning—which is audio-only diagnostic information. I absolutely have concerns that we are not allowing the diagnostic information for audio-only to occur. This is information that I have been talking to CMS about.

And so, because I think it is so important that we address this—and clearly my colleagues feel the same way after listening to the conversation this morning—Senator Tim Scott and I introduced a bill, the Ensuring Parity in Medicare Advantage for Audio-Only Telehealth Act.

It would really require CMS to include diagnosis obtained via an audio-only telehealth visit in a Medicare Advantage risk adjustment program. And it is so important for the very reasons that you talked about.

So I want to get that out there. But let me also—Dr. Davis, let me ask you this. In your experience, are patients with high-deductible health plans more or less likely to seek regular treatment?

Dr. DAVIS. Pre-public health emergency, I certainly saw patients who were hesitant to come in because of the high-deductible health plans, and just not being able to afford it.

The AAFP supported temporarily waiving the deductible for telehealth visits, because the investment was necessary for providers to really be able to make that investment in telehealth. We are concerned, though, with the permanent waiver of that and the possibility of creating a two-tiered system where low-income enrollees are only able to afford virtual care.

And so we recommend that the committee pass legislation to allow high-deductible health-care plans to waive the deductible for primary care and mental health services, both in person and telehealth, to promote timely access to high-value care and preserve patients' freedom to choose the most appropriate modality of care.

Senator CORTEZ MASTO. Yes, I could not agree more. And I thank you for that.

And so let me jump to Ms. Farb. There was conversation about identifying the quality of telehealth health services. And I know you were asked what were the metrics that GAO was looking at. And you said that GAO had not defined yet the metrics for identifying the quality of telehealth services.

Can you give me a timeline? Is this something that is a priority now for GAO? And is this something you will be further looking into, or GAO will, in identifying those metrics?

Ms. FARB. Yes, Senator. So, as far as identifying and creating the metrics, that is a role that GAO does not play. We rely on the institutions that are sort of responsible and contracted with HHS, such as the National Quality Forum, to develop consensus-based quality metrics.

And as I mentioned earlier, both the NCQA, another quality organization, and NQF have been working this past year to sort of adapt some of the metrics and frameworks that they use to incorporate telehealth, the concept of telehealth, and focusing it on things that are clinically meaningful for patients and providers to measure quality.

So that is sort of what we are waiting on: to see what these other institutions are going to do in terms of how they are going to define quality. There are ways to compare particular end points and outcomes where you could compare telehealth to in-person care. But that is still a ways away for us in terms of our work that we are doing right now.

Senator CORTEZ MASTO. Well, thank you. And so then, let me jump to Dr. DeCherrie, because I think it is important. In your testimony you really talked about the acute Hospital at Home waivers, and particularly the front-end costs of getting things started, whether it is telehealth, acute Hospital at Home waivers, whatever is needed—that the hospitals were not making some of these investments long-term because they were not sure if the waivers would become permanent.

And I guess my question to you is, what is it that you need from us on a Federal level, or you would think that the hospitals need, to really be thinking long-term that we want to move in this direction, short of passing legislation?

Dr. DECHERRIE. Yes, well, the Hospital at Home waiver came about last November. Obviously we do not know exactly when the public health emergency is going to end, but it is tied to the public health emergency. Right now, that date is July. And so, making an investment now for a program that might end in July, that is a big decision for a hospital.

So making the waiver permanent for another year, or another 2 years, or extending the waiver while things are being analyzed, I think that that would be one way that would entice the hospitals to apply for it.

Senator CORTEZ MASTO. Thank you. Thank you again.

Thank you to the panel members.

The CHAIRMAN. Thank you, Senator Crapo, for filling in. It has gotten to be a tradition. We juggle all of this.

Senator Young, I believe, is next. We are moving into the home stretch, colleagues, if members have not gotten a chance to ask questions. We are putting out the word that we are almost done.

Senator Young?

Senator YOUNG. Thank you, Mr. Chairman.

Well, I welcome our panelists, and I will begin with the topic of telehealth. Even prior to the pandemic, I heard from my constituents in Indiana, particularly those in rural areas, about the ways in which telehealth can both increase access to underserved Americans and reduce health-care costs.

Since the start of the public health emergency, the telehealth flexibilities provided by Congress and the Department of Health and Human Services have been a lifeline for vulnerable seniors. I have seen it up close and personal. It is amazing how we have been able to leverage telehealth to provide vital services, to our seniors in particular.

But others have taken advantage of this as well to access all manner of care from the safety of their own homes. Currently, authorizations are included in the CARES Act to create additional flexibility for patients and providers using telehealth that only extend through the pandemic.

So I will ask some questions of Dr. Murali. The Federal Government has relaxed, waived, or changed many regulations to extend access to telehealth during COVID–19. What regulatory flexibilities are key to providing telehealth today and should be made permanent after COVID–19?

Dr. MURALI. So I personally think that all the telehealth waivers that came in during the pandemic need to be extended. The particular focus on behavioral health is something that you have been a strong proponent of, and looking at what is happening in the rural geography. And I heard a story of a 63-year-old farmer who had to sell all his cows and would not come in to our institution for psychiatric care if telehealth was not available. So it is fundamentally important to extend that.

In terms of the acute care without walls, that is something that we are all invested in, and we know it works very well. The outcomes from the standpoint of fall prevention, the outcomes from the standpoint of reducing infections, length of stay, cost of care, safety, patient satisfaction, patient acceptance rates, are all phenomenal and off the charts. And that is something that should be extended beyond the pandemic. So those are two things.

And then in terms of the geographic site requirements, I think that that also has to be remote because the geographic site requirements restrict care. So it does not make sense that a Medicare Advantage patient can go to an MSA and seek care, when the Medicare fee-for-service patient cannot go to the same location and seek care. So it works for one, but it does not work for the other.

So there are several of these waiver programs that just need to be disposed and done with. And if there are prospective payment mechanisms for groups that are taking risk or capitation, they will figure a way of how to manage the cost of health care within the budget that they are allocated. But actually making sure that outcomes and quality are tied to the provider who is providing care is important. So you want to take the middle man out of the equation and say, physician groups, care delivery groups, you are responsible for delivering on this, and this is the expectation, and they will telework. Because if you have front-end money to invest on that, we can provide care creatively, just as we did during the pandemic.

And so those are things we would support.

Senator YOUNG. So you just provided a very concise and compelling tutorial on the extension, I think, of these waivers. I appreciate that.

Just from personal experience—I visited mental health providers, and they have indicated to me that not only have they seen an increase in the rate of maintaining appointments, which increases their efficiencies, but there are certain individuals, for private reasons, who would prefer to have their initial consultation, or in some instances all their consultations, through telehealth, irrespective of the public health condition at a particular period of time.

The providers are generally very happy with the ability to provide telehealth. It took a period of time for many of them to become used to it, but one could envision hybrid services, here again even for those who have access to or are able to physically go into the office. But there are just so many efficiencies, conveniences to the consumer as well as to the provider, that can be realized here.

And as we talk about bending the cost curve down—actually we stopped talking about that, because we have utterly failed, for a number of reasons. Number one, I do not think we have invested enough in prevention across a number of different areas. But this is another area where I see just sort of a fertile opportunity to reduce the actual cost of care, and therefore reduce the cost of insurance for my constituents and others.

So it is very important. Thank you for your quick summary.

How much time do I have left, Mr. Chairman? It looks like 30 seconds. And so, for that reason, I will yield back the balance of my time.

The CHAIRMAN. All right. If my colleague, because he is the last one, has a last question, I do not want to see him stifled.

Senator YOUNG. I have a vote to cast, but thank you for your time, Mr. Chairman.

The CHAIRMAN. Great. Thank you.

All right, I believe we have heard from all of our members. I have a brief closing statement, and I always like Senator Crapo to have a chance to do one as well.

Senator Crapo, would you like to go now?

Senator CRAPO. Well, certainly. I will be very brief, Mr. Chairman. I again thank you for holding this hearing, and I thank our witnesses. I think we have had a very strong support for a number of the provisions that you and I, Mr. Chairman, think we need to address on a permanent basis, particularly telehealth. I appreciate your helping us confirm what the issues are, and what the benefits are of making that loop.

And, Mr. Chairman, I turn it back to you.

The CHAIRMAN. Okay. Let me say "thank you" to all our witnesses.

Back in the days when I was director of the Gray Panthers, we dreamed of being able to tap the technology treasure trove that exists today. It is extraordinary what can be accomplished. And you all made so many important points. Certainly this question of equity is fundamental.

I would probably say telemedicine during the pandemic was a godsend for people who could get access to it. And you all have made a compelling case that a number of people could not. We started, I guess, 3 hours ago.

Dr. Davis, you and I were talking about the importance of making sure that audio-only telehealth is expanded. I also share your

view about the fact that it ought to be accessible in other languages as well. And you could hear the strong sentiment from my colleagues of both political parties on that. Because you know, audio-only can be a lifeline in rural communities and communities of color where access to telehealth is limited at best.

We also got a lot of good recommendations. Dr. DeCherrie made the recommendation to allow permanent waivers for Hospital at Home. It strikes me as a very good suggestion.

I think several of you made the point that it was time for Congress to remove geographic site restrictions on telehealth. I think you, Dr. Davis, and maybe the good souls at GAO recommended that, but several of you said that there really was not a substantive case for doing that.

And Dr. Murali, off on the corner of my screen, really brought it home when he said there is no place like home for American health care, and probably if Americans could have heard the news you were giving, you would have gotten a digital standing ovation for that one.

Now in terms of the challenges, I was really struck when Dr. Berenson described, several hours ago, the process of billing and approval bouncing from office to office to office, leaving both patients and providers in something resembling a bureaucratic Never-Never Land.

And, Dr. Berenson, you and I have known each other for a lot of years. We have appreciated your good work. But we would like to conscript all of you good people into this question of sorting out the bureaucracy. And Senator Crapo and I have made this kind of a special priority, because if we are really going to get it right and squeeze out every bit of value for both patients and providers, as well as taxpayers, we have to sort this out. And I will tell you, Dr. Berenson, you brought it home, because I have been hearing that at home too about billing and approval and the like. Because this was something that was put together so quickly—and that is another story, because then-Chairman Hatch and I thought it would have been done well before the pandemic, because the CHRONIC Care Act was passed in 2017. It was stood up very quickly. And when you painted that picture of billings and approvals, it was almost like the days when I ran the legal aid office for the elderly and we just bounced bill after bill after bill, and program after program from office to office, and eventually they said, "Well, Ron is going to run it down."

Well now, Senator Crapo and I are going to do this together. We are going to sort this bureaucracy challenge out, and we are going to conscript all of you. But it has been a terrific panel. In my time in public service, we have had a chance to talk to a lot of thoughtful people, and we managed to get everybody together who was thoughtful this morning. So a big thanks, and with that the Senate Finance Committee is adjourned—excuse me. One bit of business. For members, all questions in writing for our guests are due a week from today.

And with that, the Finance Committee is adjourned, and we thank you all.

[Whereupon, at 12:45 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT A. BERENSON, M.D.,*
INSTITUTE FELLOW, URBAN INSTITUTE

Chairman Wyden, Ranking Member Crapo, and members of the committee, telehealth offers the promise of an important disruptive innovation in health-care delivery. With broad adoption, the approach could simultaneously (1) increase access to care for the American public, (2) raise the quality of that care, and (3) substantially reduce spending growth. However, decisions on how to pay for expanded use of telehealth—decisions that need to be made in the near future—will determine whether that promise is achieved or, alternatively, whether telehealth adoption will raise spending substantially without corresponding benefits to patients or society.

I have spent a good part of my professional career, first as a practicing, general internist in a Washington, DC, group practice; then as a government official in charge of Medicare payment policy at the Centers for Medicare and Medicaid Services (CMS) in the Clinton administration; and for nearly 20 years as a policy researcher at the Urban Institute, exploring better ways of compensating physicians and other health professionals. (The views expressed here are my own and should not be attributed to the Urban Institute, its trustees, or its funders.) I have focused both on making improvements to the predominant fee schedule method of paying practitioners and on seeking workable payment alternatives to fee-for-service. I have also worked on these payment method issues as vice chair of the Medicare Payment Advisory Commission, better known as MedPAC, and more recently as an initial member of the Physician-Focused Payment Model Technical Advisory Committee, or PTAC, which was established under the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA.

Payment reform has not been easy or particularly successful. Over the past 40 years, "alternative payment models" (APMs) have come and gone as clinicians and hospital providers have continued to battle more for their share of the fee-for-service pie rather than embrace alternatives that in the long run would enhance their own practice environment and sense of professionalism, provide economic stability to practices, and better serve their patients.

Although I am sure that with so many other issues to address following the COVID–19 pandemic, there is temptation to simply ratify as permanent what were intended to be temporary policies during this public health emergency. But Congress needs to recognize that it has a unique (though maybe short-lived) opportunity to act decisively to move away from nearly complete dependence on the Medicare Physician Fee Schedule (MPFS) to more successful, alternative payment approaches that will open the door to further APM development and adoption. In my view, making permanent the temporary public health emergency work-arounds could be a years-long setback to the compelling need for fundamental provider payment reform for Medicare and, because Medicare typically establishes the model for other payers, the entire health-care system.

The committee should understand that over the past decade as public policy has encouraged the development of so-called "value-based payment," I have been something of a contrarian, pointing out that all payment methods have strengths and weaknesses, including fee-for-service. Accordingly, I argue that the legacy payment

---

*The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

models (for physicians, the MPFS) need attention to improve value and to better complement proposed APMs. I have also argued that many proposed APMs, although conceptually compelling, are operationally challenged if not impossible, yet they consume a lot of what economists call "opportunity costs." The result is that I sometimes defend the MPFS and point to recent improvements that have clearly added to the value produced by the MPFS (i.e., that improve access and quality at an acceptable cost). But as I will try to make clear in this testimony, fee-for-service is a particularly inappropriate payment method for most telehealth services.

My interest in finding a payment method appropriate for what we are calling virtual care (*i.e.,* not in person, using a growing range of communication technologies) is not new. I co-authored a paper in 2003 commenting on the Chronic Care Model, which had been recently developed by Edward Wagner and colleagues at the University of Washington.[1] Besides advocating for other innovative approaches to caring for the increasing number of individuals living with one or more chronic condition, the Wagner Model called for robust communications with patients outside of the occasional in-office visit (largely by telephone at the time). In the paper, I explained why payment for what should be high-frequency communications should not be through fee schedules; instead I called for telehealth payment primarily through per person per month (PPPM) payments. In essence, these would be telehealth accounts that would provide practices a lump sum that patients spend down to support virtual care. It is fair to say that that paper was thoroughly ignored. However, the urgency and interest in finding an alternative to fee schedule payments for telehealth has now increased substantially. In this testimony I will expand on that perspective, laying out the main barriers to fee schedule payment for telehealth services and suggesting alternatives.

Last year, CMS acted with decisive speed to provide a safety net for practices and ongoing access for patients during the public health emergency. CMS (1) introduced flexibility in the requirements for a qualifying telehealth video visit by permitting the patient's home (rather than only a medical facility) to be an accepted telehealth originating site; (2) reversed a long-standing policy, now designating phone calls as short as 5 minutes as a reimbursable service; (3) softened security and privacy requirements to permit usage of a broad range of communication devices and methods; and as I will discuss in more detail below, (4) raised fees substantially, in the process ignoring the resource-based relative value scale approach that the organization has followed since 1992, however imperfectly. The public health emergency modifications also expanded the range of clinicians, such as physical therapists, eligible to bill telehealth services.

I will identify three major reasons why maintaining most of these rule flexibilities and increased payments should not be maintained over the long term. Adele Shartzer (an Urban Institute colleague) and I outlined these concerns in a recent paper in *JAMA Forum.*[2]

1. ADMINISTRATIVE COMPLEXITY

Fee schedules can function reasonably well when code descriptions are concise and specific, thereby producing reliable and accurate coding. For example, there are about 20 different payment codes for colonoscopies, with each one detailing whether there was a polyp removed, a biopsy taken, or some other distinctive feature of the procedure. Colonoscopies represent a clearly defined procedure. Operationally, it is easy to bill for and receive fee schedule payment for a colonoscopy. Most procedures, tests, and imagings lend themselves operationally to payment by fee schedule. But codes for telehealth services are not concise; indeed, CMS telehealth codes attempt to delineate the specific communication technology employed, the patient's location during the communication, which party initiated the service, the duration of the virtual encounter, the time interval from prior and subsequent office visits, the frequency of allowed billing for the service, and other characteristics specific to the particular telehealth services. Importantly, these coding parameters were established for payment purposes alone: they do not provide useful clinical distinctions. Given rapidly evolving technological capabilities, telehealth codes will quickly become outdated. The tangle of telehealth codes (now numbering about 250 and counting in the MPFS), combined with lots of code requirements, will lead to fraud in some cases, but also more commonly to "gaming behavior" by provider practices. For

[1] Berenson, RA and Horvath J. "Confronting the Barriers to Chronic Care Management in Medicare," *Health Affairs,* 22, Suppl 1 (2003): W3–1—W3–14.

[2] Robert Berenson and Adele Shartzer, "The Mismatch of Telehealth and Fee-for-Service Payment," *JAMA Health Forum* 1, no. 10 (2020): e201183.

example, if a phone call needs to last at least 5 minutes to qualify for payment, how will Medicare ferret out 4-minute calls that were billed (many of which will be as clinically important as calls lasting a minute longer). Will the agency require use of timing devices on phones?

Especially if overly generous payments are made through pay parity for telehealth visits and phone calls, CMS will feel compelled to impose additional burdensome (and ultimately ineffective) documentation requirements as these telehealth services proliferate. In short, following the COVID–19 pandemic, using the standard MPFS to pay for telehealth services would likely produce a quagmire of confusion, inadvertent or intentional miscoding, and lots of clinician and patient complaints about burden and counterproductive rules.

2. BILLING COSTS IN RELATION TO PAYMENT LEVELS

For reasons that practices and hospitals know well but policymakers rarely acknowledge, fee-for-service payments can generate high billing costs relative to the payment sought and received. The result is that it is imprudent to pay for high-frequency, low-payment services by fee schedule, at least when the low-priced service is the only service billed rather than one line on a larger claim. A recent study from an academic health center found that the cost for billing and related documentation activities for an office visit was $20.49, including 13 minutes of work for various individuals, including clinicians.[3] There is no obvious reason why billing and documentation costs for submitting telehealth services would be much less than that. Indeed, studies have documented that the costs of billing and related functions make up 10 to 15 percent of operating revenue for practices.[4] In short, because a major portion of billing costs are fixed and apply to any service regardless of the payment level, practices would bear transaction costs approaching or exceeding the payment they would receive.

And that is just the billing cost for the first submitted claim from the practice. A typical claim for a MPFS service is generated by the practice and sent to a Medicare administrative contractor, which adjudicates the claim and makes a payment to the practice for Medicare's portion. The contractor passes the claim to a supplemental insurer, such as a Medigap carrier, which determines its portion and informs the practice what it can bill the patient for applicable beneficiary cost-sharing, at which point the practice generates another bill for the patient. Even with electronic transfer, this cycle of claiming and paying requires many manual steps, and the cumulative costs clearly exceed the $20 for the initial claim.

Practices understand this billing reality. CMS adopted a "virtual check-in" code in the 2019 MPFS for short (5- to 10-minute) phone calls with patients to sort out whether patients needed to come in for an office visit. The "correct" national fee according to usual relative cost determination was about $15. Although the check-in call may make good clinical sense in some situations, it failed from a financial point of view. Not surprisingly, practices rarely billed for the service, suggesting that practices considered the relatively meager payment too little to justify the even higher billing costs. The result was that Medicare allowed less than $200,000 for this code in 2019 (compared with total spending under the MPFS of more than $90 billion.)

Perhaps CMS learned the lesson of payment levels below billing costs. Within a few weeks of adopting payment for phone calls during the public health emergency, CMS raised the payment for a 5- to 10-minute phone call from $15 to a more acceptable $46—the rate for a level 2 office visit. It made perfect policy sense during the public health emergency to get money out to financially strapped practices while also facilitating needed access for beneficiaries to their practitioners. However, retaining this three-fold increase in the proper fee (indeed, adopting complete pay parity) presents an unresolvable dilemma for policymakers. Using standard, relative

[3] Phillip Tseng, Robert S. Kaplan, Barak D. Richman, Mahek A. Shah, and Kevin A. Schulman, "Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System," *JAMA* 319, no. 7 (2018): 691–97.

[4] Bonnie B. Blanchfield, James L. Heffernan, Bradford Osgood, Rosemary R. Sheehan, and Gregg S. Meyer, "Saving Billions of Dollars—and Physicians' Time—by Streamlining Billing Practices," *Health Affairs* 29, no. 6 (2010): 1248–54; James G. Kahn, Richard Kronick, Mary Kreger, and David N. Gans, "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals," *Health Affairs* 24, no. 6 (2005): 1629–39; Julie Ann Sakowski, James G. Kahn, Richard G. Kronick, Jeffrey M. Newman, and Harold S. Luft, "Peering into the Black Box: Billing and Insurance Activities in a Medical Group," *Health Affairs* 28, no. 4 (2009): w544–54.

cost calculations, the fees for many desirable "small-ticket" items would be too low to justify practices performing them and/or billing for them. Yet raising the fees to make it financially worthwhile for the practices would create a major precedent for ignoring relative values based on relative resources, thereby opening up the fee schedule to special pleadings from many stakeholders.

Paul Ginsburg (the Vice Chair of MedPAC) and I wrote a paper in 2019 arguing that it is time for the MPFS to move off of strict adherence to relative costs to determine fees (Berenson and Ginsburg 2019).[5] This could be accomplished by both (1) altering fee levels for likely overpriced services by examining service volume changes that occur in response to initial fee changes, usually fee reductions, and (2) seeking to accomplish specific policy objectives that could be supported by fee changes, usually providing increases in underpriced services, such as to increase the attractiveness and supply of primary care health professionals. Pay parity for telehealth services in the face of research that shows substantially lower production costs[6] should not be adopted as a policy "one-off" under the current pressure to generously expand telehealth. Rather, such parity should be considered only as part of a more comprehensive approach to modifying how MPFS fees are determined. Doing otherwise could lead to a policy free-for-all in which plausible (but self-interested) pleadings are advanced outside of a disciplined process for weighing the merits of fee changes. Dr. Ginsburg and I argued that CMS, under the guidance of a formal Federal Advisory Committee Act—compliant committee, should have the authority to change fees considering factors other than relative costs.

3. INCREASED VOLUME AND SPENDING

I anticipate that patients and their families will love the alternative of video-based telehealth and much greater use of phone communications with their practitioners and primary care team members. Patients face substantial time costs and inconvenience in traditional travel, waiting rooms, and actual time with the practitioner. I recently waited 20 minutes *after* my visit just to check out. The routine annual wellness visit took about three hours altogether (admittedly with some delays created by COVID–19 concerns).

I would reiterate that telehealth should be advanced substantially as a potential game-changer in how care is delivered. My objection lies in using fee schedule payments as the way to compensate the practices when alternatives exist that can be adopted and adapted over time. Without the constraints of consumer time and inconvenience, the potential for a spending explosion is real, especially if policymakers resolve the pricing dilemma posed above by paying far above production costs, as pay parity would do. Furthermore, important work by researchers at RAND (performed before the COVID–19 pandemic) found that 90 percent of telehealth services were additional services rather than substitutes for in-person services.[7]

Clearly, that has not been the case during the public health emergency, during which virtual visits became the only way for patients to receive timely care for a period of time. Nevertheless, used properly, telehealth very often *should* be an add-on to often insufficient in-person care, especially for chronic care management but also, for example, to clarify whether a tentative diagnosis was correct, to monitor the effect of adding a medication or changing a dosage, or for myriad other potential clinical reasons. But those add-on, virtual services need to be managed by the practice within a spending constraint to help assure that virtual visits are used appropriately.

4. ALTERNATIVE PAYMENT METHODS FOR TELEHEALTH

Fee schedule payments should be limited to virtual visits equivalent to high-level office visits and paid somewhat less than office visits, in line with relative cost calculations as usual. There may be compelling reasons to pay fee-for-service for unique provider types. A challenging issue is whether Medicare should routinely pay for telehealth vendors that do not have established relationships with beneficiaries as do many private insurers (but not Medicare). Younger patients often do not have established relationships such that an occasional telehealth vendor encounter can

---

[5] Robert A. Berenson and Paul B. Ginsburg, "Improving the Medicare Physician Fee Schedule: Make It Part of Value-Based Payment," *Health Affairs* 38, no. 2 (2019): 246–252.

[6] J. Scott Ashwood, Ateev Mehrotra, David Cowling, and Lori Uscher-Pines, "Direct-to-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending," *Health Affairs* 36, no. 3 (2017): 485–491.

[7] Ashwood et al., "Direct-to-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending."

make good clinical sense as a reasonable convenience for patients. But for Medicare beneficiaries, policy in general should encourage continuous, established relationships, not occasional telehealth vendor visits supported through fee-for-service.

Assuming established relationships between clinicians and patients, telehealth is best paid through PPPM payments to cover the costs of robust telehealth. Currently, CMS is working to test various forms of hybrid payment models that would pay partly by fee schedule and partly by a monthly PPPM, called capitation. The latter approach pays the practice for patients who are expected to seek care initially from their chosen or assigned practice (but remain free to seek care elsewhere). The payment is adjusted for the person's underlying health risks and represents an average amount for the population of beneficiaries with similar health risks.

Capitation incentives are fundamentally different from fee-for-service: the practice receives the funds regardless of how many services they provide an individual for whom payment is received. The incentives are reversed—the practice is rewarded for keeping patients healthy and not in need of health services.And the approach should reward broad use of telehealth when a virtual visit or phone call suffices without need for an in-office visit. There would be no billing costs associated with the telehealth provision, and, indeed, beneficiary cost-sharing for the capitation portion of the hybrid payment could be waived altogether under a well-functioning hybrid model. Initially, maintaining fee schedule payments for some services (including in-office visits) would help mitigate the expressed concern about stinting on care (*i.e.,* accepting the PPPM payments but stinting on actually providing care).

In my view, the compelling need to find an alternative to fee schedule payments for telehealth calls for expediting the design and testing of the Center for Medicare and Medicaid Innovation's (CMMI) model called Primary Care First on a regional and mandatory basis. It has the potential to be the alternative permanent payment model for primary care practices while also addressing payment for telehealth services.

Paying for telehealth for specialists presents a different challenge, because many specialists do not and should not have continuous, established relationships. Based on analyzing the use of telehealth by specialty during the public health emergency, specialty practices that provide a large amount of telehealth services could receive lump sum, monthly payments that they control and use for appropriate application of virtual care. The practices would allocate the funds for telehealth services as they deem appropriate and not have to submit claims for each instance. Some accounting would be necessary to ensure that the telehealth services were actually provided.

5. CONCLUSION

Congress and CMS face an urgent need to adequately fund telehealth services as an essential component of 21st-century health-care delivery. However, payment should not simply continue public health emergency-based flexibilities and generous payments that are important to allow during the COVID–19 pandemic. It would be a policy mistake not to use this unique opportunity not only to provide a better payment method to support virtual health care and other evaluation and management services, including in-office services, but also to reform how Medicare Physician Fee Schedule fees are determined in the first place.

Telehealth should not be supported primarily through fee-for-service, but rather through hybrid payment methods that should include capitation for primary care practices and periodic lump sum payments for specialists. The latter approach has not been tested and will need immediate development and pilot testing. Continued fee schedule payments for telehealth should be limited to lengthy, virtual care encounters and for particular clinicians and other providers that do not have continuous, established relationships with patients. Policy should encourage development of established relationships, especially for the Medicare population, who often have multiple, interacting chronic conditions.

Admittedly, pursuing these recommendations would be challenging; it would be easier politically and operationally to simply ratify the PHE changes going forward, as many stakeholders advocate. That would be a mistake both because it could produce sustained increases in Medicare spending for years to come and because of the missed opportunity presented by telehealth to adopt alternative payment models that would produce greater value than even improved fee-for-service is able to produce. True value-based payment, although aspirationally worthy, has been difficult to accomplish. Telehealth provides a ready opportunity to make a virtue of necessity. Congress should not allow the opportunity to pass by.

QUESTIONS SUBMITTED FOR THE RECORD TO ROBERT A. BERENSON, M.D.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. More than a quarter of Medicare beneficiaries lacked digital access at home in 2018, a figure that is higher among those with low socioeconomic status, those 85 years or older, and in communities of color. States have just received unprecedented funding from the American Rescue Plan to support COVID–19 response and recovery efforts, including expanding digital infrastructure that communities need to get up and running again.

What could be done at the State level to leverage the funding provided in the American Rescue Plan to close the gap in access to telehealth services?

What more could be done at the Federal level to support communities?

Answer. The prospects for passage of the American Rescue Plan are uncertain at this time. I suggest that a large portion of unspent funds from the Provider Relief Fund of the CARES Act be reprogrammed for the purpose of building comprehensive, national digital infrastructure. On June 21, 2021, *The Washington Post* again documented that many large non-profit health systems actually improved their financial margins in 2020. In addition, research work that I have helped lead and is now in the process of journal peer review, when published, will demonstrate that many health systems have many billions of dollars readily available as cash and marketable securities and have no need for additional CARES Act bailout. They have substantial surpluses as days cash on hand to meet their expenses, even if they had no new revenues at all, in some cases exceeding 365 days. Building up digital infrastructure to support telehealth and for a range of other purposes should take priority over further funding of already flush health systems.

In the longer term, Federal and State action to increase antitrust scrutiny of mergers and acquisitions and of anticompetitive behavior from extant health system oligopolies would reduce health-care spending increases, again freeing up funds to support access to basic health-care services in all communities.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. During the pandemic, telehealth has been an essential tool to get children the care that they need while minimizing risk. Although telehealth under Medicare has been a focus, close to 40 million children are enrolled in Medicaid.

What are the main policy changes we need to ensure this broader use of telehealth can continue beyond the pandemic for children?

Answer. I have limited expertise on Medicaid and CHIP issues and, so, will not respond.

Question. During COVID–19, many States adopted temporary changes to their telehealth policies, such as expanding the scope of services and providers able to furnish telehealth, relaxing of licensure requirements and modifying reimbursement policies. Many States legislatures have also begun the work to adopt more permanent telehealth policy changes.

How can the Federal Government best support State Medicaid programs in their efforts to expand telehealth?

Are there Medicaid supports, incentives, and learnings that Federal policymakers could provide?

Answer. I have limited expertise on Medicaid and CHIP issues and, so, will not respond.

Question. COVID–19 has introduced additional stress and trauma for children and families. Telehealth, and particularly audio-only telehealth has been a crucial tool to connect children and adolescents to needed mental health-care services.

How can telehealth be best utilized to meet kids' mental health-care needs, and can you speak to the use of audio-only telehealth specifically?

Answer. I will repeat two points I emphasized in my testimony and in response to questions raised by Senators at the hearing. One, fee-for-service is a particularly poor payment method for telehealth. Public and private payers need to promptly move away from total dependence on fee schedule payments to health professionals in include a substantial amount of lump sum payments that allow clinicians to de-

ploy telehealth appropriately, rather than be dependent on incomplete and changing code-level descriptions of fee schedule services. Two, audio-only services (which used to be called phone calls) should be considered an essential, "must include," component of telehealth services. When patients are well known to their clinicians, video-based calls in health-care delivery often is needed only for group conversations or for visual display of clinically-relevant physical appearance and data transfer. In many situations, the phone can be as effective and certainly more efficient than a video visit, assuming appropriate attention to security and confidentiality. At the same time, fee-for-service payment for audio-only services would be particularly challenging in the long term and would likely generate intrusive and ultimately counterproductive compliance requirements. The solution, again, is moving telehealth payment to lump sum payments, such as primary care capitation (per person month payments for patients empaneled with a primary care practice).

Question. As State Medicaid programs look at expanding their use of telehealth, it is particularly important that vulnerable populations like children are not negatively impacted. Policies must be looked at through a health equity lens, considering access to reliable and affordable broadband services, access to devices that support HIPAA-compliant telehealth platforms and coverage policies.

How can Medicaid programs work to ensure telehealth policies are equitable for children and mitigate potential inequities that may arise?

Answer. Again, given my lack of expertise on Medicaid, I will not respond to this question.

QUESTION SUBMITTED BY HON. PATRICK J. TOOMEY

Question. In your testimony, you cited pre-pandemic research undertaken by RAND that found 90 percent of telehealth services were additional services rather than substitutes for other in-person services and consultations. Moreover, other witnesses' testimony clearly demonstrates that telehealth utilization in Medicare and Medicaid has increased over the past year in light of the COVID–19 pandemic.

Given the unsustainable fiscal trajectory of the Medicare program and the need for payment reforms, what types of tools exist or may be needed in the Medicare fee-for-service program or Medicare Advantage program that will ensure appropriate utilization management of telehealth services?

Answer. In my writing and speaking on Medicare, I do not refer to the "Medicare fee-for-service program," for the simple reasons that most of the payment methods in this program are no longer fee-for-service and calling it fee-for-service supports an inaccurate, negative caricature of the program. For example, the inpatient prospective payment system in 1984 abandoned fee-for-service by adopting case rate payment, known as diagnosis-related groups (DRGs). Nearly two dozen other countries have now adopted various versions of DRGs, precisely because this payment method is not fee-for-service. The Medicare Physician Fee Schedule stands out as true fee-for-service and in need of reform.

It is true, however, that most Medicare payment methods, remain volume-based, if not fee-for- service. That is total payment depend on the number of payment units generated and billed for, whether at the individual service level or whether bundled into larger payment units. Many payment policy experts are currently recommending that the traditional Medicare program adopt a hybrid payment model for primary care practices, consisting of a hybrid of equal parts fee schedule and capitation relying on patient empanelment with their preferred primary care practice. Such a payment system would substantially restrain the potential explosion of telehealth services; telehealth services would be covered under the capitation portion of the hybrid paymemt. Limited exceptions to permit fee schedule payments for telehealth should be considered, *e.g.,* for other categories of health professionals, such as physical therapists, or for especially long and unusual telehealth visits. Nevertheless, I strongly recommend that Medicare generally should not pay mainstream physician practices for telehealth through the fee schedule payments.

Medicare Advantage plans are in a position to pioneer the use of innovative payment methods. They need not—and sometimes do not—adopt traditional Medicare's payment methods for various reasons. Unfortunately, MA plans have tended to be followers rather than innovators, perhaps because of their limited market shares compared to traditional Medicare's. Ideally, payment reform would occur as a collaboration between traditional Medicare, Medicaid agencies and MCOs, and both

MA plans and commercial insurers. That kind of collaboration has not been very successful over the past decade, but needs to be reinvigorated, with CMS taking the lead.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Throughout the public health emergency, the Centers for Medicare and Medicaid Services (CMS) issued over 200 waivers under Medicare and approved more than 600 waivers and other flexibilities under Medicaid. While some of the regulations waived are specifically for responding to a pandemic, ensuring patient safety, controlling costs, and maintaining program integrity its clear innovation and common sense ideas in our health-care system have been stifled too often by Federal regulations. For example, CMS permanently added certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic. Some regulations play an important role in protecting safety and maintaining program integrity but others may stifle good ideas.

Is health care too regulated that it's stifling good ideas?

Should executive agencies sunset regulations in the future to enable more innovation in health care?

Answer. Unfortunately, a primary reason for relative lack of innovation in health-care results from fee-for-service and other volume-based payment incentives. Providers with well-established, profitable revenue streams typically are not eager to consider disruptive innovation that might undermine these streams. Both horizontal and vertical integration based around hospitals has resulted to a significant extent in non-responsive, health systems that dominate health delivery to the detriment of independent practitioners and patients. The Nation has needed more and more creative antitrust enforcement. Although some deride assertive antitrust enforcement as "over-regulation," antitrust serves to preserve competition and choice, which is where innovation takes place.

Currently, in the face of increasingly non-competitive health provider markets, policy is needed to actively regulate the "monopoly prices" that health systems demand of commercial insurers. Indeed, regulated, rather than market- determined, prices have allowed Medicare Advantage plans to thrive as a choice that 40 percent of Medicare beneficiaries have exercised. In short, regulating prices now would allow markets to work better to reward innovation rather than preserve what economists call "monopoly rents." Regulations can have negative effects on innovation, but in my opinion are not a major source of the current high spending, poor quality health system the U.S., regrettably now exhibits. And, as I emphasized in my testimony and in other responses here, paying telehealth through fee-for-service would undoubtedly produce substantially increased, intrusive and counterproductive regulation to try to protect against the inevitable fraud and abuse that telehealth would spawn if paid for that way.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. Before coming to the Senate, I had the privilege of practicing medicine in Wyoming. Rural health care faced challenges prior to the pandemic. In particular, we know since 2010 more than 135 rural hospitals have closed.

In the Senate, I am proud to help lead the bipartisan Rural Health Caucus. This group is committed to ensuring patients in rural America can get access to the care they need.

Can you specifically discuss the changes in Federal health-care policy that you believe have helped rural providers the most during this pandemic?

Can you please discuss any specific changes that Congress should consider to better support rural health-care providers?

Answer. The Affordable Care Act authorized creation of a Workforce Commission, which was constituted with appointments of commissioners but never met because of the absence of the requisite appropriation. Workforce policy is desperately needed to address access to basic health services for rural populations, which now face a drastic shortage of health professionals. Medicare Graduate Medical Education policy needs overhaul to redistribute funds to primary and preventive care education and to require academic health centers to better educate and provide ongoing edu-

cational support to rural practitioners. The workforce issues have mostly been ignored over the past decade, partly because the Workforce Commission has not been able to carry out its legislated mission.

Telehealth provides a new opportunity to reconfigure workforce needs for rural communities, once the requisite electronic infrastructure is deployed, Again, there is need for a dedicated commission to present a set of comprehensive recommendations for congressional consideration.

Question. Prior to the pandemic, I introduced bipartisan legislation with Senator Tina Smith, which among other things, would allow Rural Health Clinics (RHCs) to provide more telehealth services.

I was pleased that Congress through the CARES Act authorized both Rural Health Clinics and Federally Qualified Health Centers to furnish telehealth services to Medicare beneficiaries during the public health emergency.

Can you discuss the importance of Rural Health Clinics and Federally Qualified Health Centers continuing to provide telehealth services after the public health emergency has ended?

Answer. RHCs and FQHCs are crucial for access to basic health services in rural areas and underserved urban areas. As I emphasized in my testimony, fee-for-service is a poor way to compensate for telehealth services, even if based on costs, as in these two programs. Both RHCs and FQHCs receive cost-based per visit payments subject to limits relying on rates from 2000 trended forward 20 years. That method will not work to encourage telehealth services. There has been interest in moving payment for RHCs and FQHCs away from per visit rates. Telehealth can be a catalyst for moving to a population-based payment method for these important centers.

Question. My wife Bobbi and I are passionate about improving access to mental health services. This pandemic has clearly impacted the mental, as well as the physical health of our Nation.

For people living in rural America, getting help from a mental health provider was challenging before the pandemic. This is why Senator Stabenow and I have long supported professional counselors and marriage and family therapists participating in Medicare. We believe that increasing the number of mental health providers able to care for our Nation's seniors is an important priority.

Please discuss how telehealth has impacted the ability of patients to receive mental health services during the pandemic.

Can you please identify ways Congress can improve access to mental health services, including expanding the number of providers that can participate in Medicare?

Answer. I have no expertise in provision of mental health and other behavioral health services. However, in interviews with primary care physicians and other discussions I have participated in, I have heard a consensus viewpoint expressed that mental health services are particularly amenable to telehealth interactions with health professionals, who do not have to reside in the community. An operational issue that needs ongoing attention is the need to assure confidentiality and security of the telehealth services. But that is a soluble problem.

Question. I agree telehealth is transforming the way we are providing care. However, in Wyoming, most of our providers are part of smaller hospitals and practices. We need to make sure government regulation is not making it more difficult for these providers to serve their patients.

Can you discuss specific ways Congress can reduce the administrative burden in providing care through telehealth?

Answer. One of the responses to the telehealth imperative for adoption use during the public health emergency was the relief expressed by clinicians to the lessened administrative burden that disappeared because of the regulatory waivers. That said, maintaining the flexibility waivers and continuing to pay fee-for-service is a dangerous mix and likely to encourage even more fraud and abuse. To avoid that outcome I called for prompt adoption of new payment methods—capitation for primary care physicians, and telehealth-based, lump sum payments for specialists—as substitutes for fee schedule payments for telehealth services. Doing so should substantially reduce administrative burden for providing care through telehealth while also reducing the likelihood of fraud and abuse. There surely will need to be accountability for the telehealth services provided when using these alternative pay-

ment methods, but such accountability would likely require much less burden for practices than what would be required under standard fee schedule payments.

Question. Wyoming has many passionate advocates supporting both hospice and palliative care. These folks are committed to ensuring patients have the highest quality of life and are able stay out of the hospital and with their families. This is why I help lead the bipartisan Comprehensive Care Caucus. Our mission is to improve both palliative and hospice care for patients.

Can you please discuss how telehealth flexibilities have impacted access to palliative care and how we can continue making progress in this area?

Answer. I have no knowledge about impact of telehealth flexibilities on the provision of palliative care.

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

Thank you, Mr. Chairman, for holding this important hearing.

Congress and the administration provided certain health-care flexibilities during the pandemic so that patients could continue to receive high-quality care. Making permanent changes based on lessons learned is a top priority.

I have shared my interest with President Biden's nominees for the key health-care positions who have come before this committee, and I appreciate their commitment to work with me and this committee. Republicans and Democrats often disagree on the best way to achieve shared health-care goals. This hearing, however, highlights an area of common ground.

In fact, Senator Wyden and I asked the majority and minority staff to jointly plan this hearing, demonstrating strong bipartisanship. Acting on legislative changes and using administrative authority, the Centers for Medicare and Medicaid Services waived over 200 payment rules during the pandemic in Medicare alone.

Needless to say, there is a lot we can learn.

Today's witnesses will provide insight to guide our efforts in evaluating these flexibilities. Hearing firsthand about the patient experience during the pandemic from providers who overcame challenges to provide care will be invaluable. Understanding how the flexibilities are used in fee-for-service, Medicare Advantage, and in alternative payment models will be insightful.

Much of the hearing will focus on care provided during the pandemic through telehealth. Telehealth has been a lifeline for patients and providers, especially in the early months of the pandemic. The reliance on telehealth increased in rural and urban areas alike, allowing patients to receive remote care from the safety of their home. Telehealth services have been especially useful for Idahoans.

According to the Idaho Department of Insurance, telemedicine visits went from an average of about 200 appointments per month to 28,000 telehealth visits in April 2020 alone. To ensure financial stability, providers have been paid at the same rate as if the service was furnished in-person. This has facilitated care that otherwise would be risky or unavailable, and patients have appreciated the convenience. It has reduced the frequency of missed appointments, and assisted provider investment in the infrastructure needed for remote care.

This long period of expanded telehealth will help us understand the impact on quality of care and program costs. It serves as a robust test project on a scale few could have imagined. The promise of telehealth is clear, but it is important that we gather evidence on its impact on access, quality, and cost.

There are approaches to providing care in the most efficient setting that go beyond telehealth. Some hospitals are using a waiver that provides flexibility to triage patients who present to the hospital to see if they can be best cared for in their home.

Whether through telehealth, Hospital at Home, or other innovative care arrangements, it is important to find ways to get patients care that best meets their needs, and at the lowest cost possible. Congress has taken permanent steps to do just that in recent years.

Nephrologists can conduct remote evaluations of patients receiving home dialysis. Providers can administer certain drugs to vulnerable patients in their own homes.

Hearing from our provider witnesses helps us to continue down this path. The Government Accountability Office will supplement what we hear from our provider experts, offering a perspective on how to track and evaluate flexibilities in Medicare and Medicaid as we chart the right course forward. I fully expect we will take what we learn from this hearing to continue our bipartisan efforts to help providers give patients the best care possible.

Permanent changes based on lessons learned from the pandemic to modernize Medicare payment systems lend to the pressing need to address Medicare's financial struggles. Identifying smart reforms that make Medicare more efficient will be better for patients and better for taxpayers. Such changes alone will not put Medicare on a sustainable path, but they should be part of that broader conversation.

Addressing Medicare solvency should also be a bipartisan issue, with time best spent determining how to shore up the current system instead of expanding it to a broader population. Finding the right path on these priority issues is important to patients and the health programs in the committee's jurisdiction.

This hearing will help us to capitalize on the bipartisan opportunity.

Thank you, Mr. Chairman. I yield back.

PREPARED STATEMENT OF KISHA DAVIS, M.D., MPH, FAAFP, MEMBER, COMMISSION ON FEDERAL AND STATE POLICY, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Chairman Wyden, Ranking Member Crapo, and members of the committee, I am Dr. Kisha Davis, a member of the American Academy of Family Physicians (AAFP) Commission on Federal and State Policy, and I am honored to be here today representing the 133,500 physician and student members of the AAFP.

I am a practicing family physician and the vice president of health equity at Aledade. In addition to seeing patients in Baltimore, MD, through my role at Aledade, I support physicians in private practices and community health centers across the country. I have experienced the impact of the COVID–19 pandemic and resulting Federal policy changes firsthand as a front-line physician, and I have had the opportunity to observe them on a broader scale.

Many of the emergency flexibilities that the Centers for Medicare and Medicaid Services (CMS) made available during the COVID–19 pandemic have improved patients' access to primary and preventive care, bolstered the physician workforce in rural and underserved communities, and alleviated administrative burdens on clinicians, enabling us to focus on patient care. As Congress considers whether to extend these flexibilities beyond the public health emergency and how to build upon recent advances, **it is vital that Medicare and Medicaid policy changes are designed to advance health equity, protect patient safety, and enable clinicians to provide the right care at the right time.**

The AAFP offers the following recommendations.

- Adopt telehealth policies that enhance the physician-patient relationship rather than disrupt it, and incentivize coordinated, continuous care provided by the medical home.
- Adopt payment models that support patients' and clinicians' ability to choose the most appropriate modality of care and ensure appropriate payment for care provided.
- Permanently remove geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth care at home.
- Require Medicare to cover audio-only evaluation and management services beyond the public health emergency to ensure equitable access to care.
- Permanently cover telehealth services provided by Federally Qualified Health Centers (FQHCs) and rural health clinics and ensure adequate payment.
- Monitor the impact of telehealth on access and equity by ensuring that data collection and evaluation include race, ethnicity, gender, language, and other key factors.
- Invest in infrastructure to promote digital health equity.

- Mandate Medicaid coverage of all Advisory Committee for Immunization Practices (ACIP)—recommended vaccines for all adults.
- Permanently allow physicians to provide direct supervision and teaching services via telehealth to expand access to primary care services and increase training opportunities.
- Reduce the volume of prior authorization requirements to decrease unnecessary administrative burden on physicians.
- Grant HHS the authority to waive reporting and other administrative requirements for the Quality Payment and Medicare Shared Savings programs in future public health emergencies without rulemaking to enable physicians to focus on patient care during emergencies.
- Restore Medicare and Medicaid physician supervision requirements to safeguard patient safety and maintain access to appropriate, high-quality care.

Over the last year, family physicians rapidly changed the way they practice to meet the needs of their patients amid a global pandemic. Arguably, the most dramatic shift was the unprecedented uptake and increase of telehealth services. Last spring, out of necessity, physicians quickly pivoted from providing a majority of care in-person to caring for their patients virtually to promote social distancing and infection control. This would not have been possible without the swift legislative and regulatory action that expanded coverage, increased payment, and added flexibility for telehealth services.

Prior to COVID–19—due in large part to Medicare restrictions and inadequate reimbursement—fewer than 15 percent of family physicians were providing virtual visits to their patients, and during the public health emergency that number surged to more than 90 percent. Despite technical challenges on the part of patients and physicians, both quickly came to realize the value of virtual care. According to a recent survey of AAFP members, seven in ten family physicians want to continue offering more virtual visits in the future.

Telehealth benefit expansions must increase access to care and promote high-quality, comprehensive, continuous care. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care and expand access to care for under-resourced communities and vulnerable populations. As outlined in our Joint Principles for Telehealth Policy,[1] in partnership with the American Academy of Pediatrics and the American College of Physicians, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. Expanding telehealth services in isolation, without regard for previous physician-patient relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care. In fact, a recent nationwide survey found that most patients prefer to see their usual physician through a telehealth visit, feel it is important to have an established relationship with the clinician providing telehealth services, and believe it is important for the clinician to have access to their full medical record.

Telehealth can enable timely, first-contact access to care and supports physicians in maintaining long-term, trusting relationships with their patients, both of which are central to continuity of care. Allowing physicians to provide telehealth services from their home enables them to extend their availability beyond traditional office hours for patients who, due to work or childcare constraints, are unable to take time off work for an appointment. This not only advances equitable access to care but also can prevent unnecessary trips to urgent care or the emergency room. Telehealth can also be a tool to help alleviate physician burnout by facilitating better work-life balance. One example: Some employers allow physicians to be on "telehealth duty" in the period leading up to and following their maternity leave.

Given these benefits, patients and physicians agree that some current telehealth flexibilities should continue beyond the public health emergency.

Congress should permanently remove the section 1834(m) geographic originating site restrictions to ensure that all Medicare beneficiaries can access care at home. The COVID–19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients'

[1] *https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-Congress-TelehealthHELP-070120.pdf.*

and clinicians' risk of exposure and infection but also increase accessibility for patients who may be homebound or lack transportation. It can also offer opportunities to engage distant family members and caregivers. Telehealth visits allow physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit. This helps us to identify environmental factors that may be affecting their health, and to develop more personalized treatment plans.

Transitional care management (TCM) services are another example of how permanently eliminating geographic and originating site requirements could improve utilization of high-value care and ultimately improve care coordination and patient outcomes. TCM services are provided after a patient is discharged from a hospital stay, with the goal of ensuring care continuity once they return home. Prior to the public health emergency, patients were hesitant to come into the office after just being discharged from the hospital. Once TCM services were available to all Medicare patients via telehealth, many more received TCM services, allowing me as their primary care physician to check on them, update their medications, schedule follow-up visits with specialists, and prevent hospital readmissions.

There are many more examples of how telehealth visits can be used to promote prevention through conducting Medicare Annual Wellness visits as well as for monitoring and treatment of chronic diseases such as diabetes and hypertension for patients in their home thereby increasing accessibility for patients who may be homebound or lack transportation and create opportunities to engage distant family and caregivers.

Require Medicare to cover audio-only Evaluation and Management (E/M) services beyond the public health emergency. Coverage of audio-only E/M services is vital for ensuring equitable access to telehealth services for patients who may lack broadband access or be uncomfortable with video visits. In September, after using telehealth for several months due to the pandemic, more than 80 percent of family physicians responded to an AAFP survey indicating they were using phone calls to provide telehealth services. Together with ongoing reports from physicians that phone calls are vital to ensuring access for many patients, this survey data indicate that phone calls are more accessible for many patients than video visits. This may be particularly true for Medicare beneficiaries. According to the Pew Research Center, only about 53 percent of patients over the age of 65 own smartphones, while 91 percent own any type of cell phone. Recent studies of telehealth utilization by patients with limited English proficiency show that non-English speakers have used telehealth far less than English-speakers. Many physicians routinely use telephone translation services to provide linguistically appropriate care, and these services can be more seamlessly integrated into telephone visits, whereas integrating translation services into audio-video platforms can be costly and complex. Outside of the PHE, Medicare allowed physicians to bill for brief phone calls as "virtual check-ins." During the PHE we conducted telephone visits, realizing that we would not get reimbursed appropriately, but did so because it was the right thing for our patients. Unfortunately the payment rate for those services does not adequately reflect the level of time and effort required, and often the cost to bill the services exceeds that amount.

Payment should support patients' and clinicians' ability to choose the most appropriate modality of care (*i.e.,* audio-video, audio-only or in-person) and ensure appropriate payment for care provided. Some patients and some cases are better suited to virtual care, and others require in-person care; some issues can be effectively treated through a phone call, whereas others require a visual examination. As a physician, I want telehealth to be a tool in my toolbox, and I want to choose when and how to deploy it based on my clinical judgment, not based on whether I will get paid.

Permanently ensure that beneficiaries can access telehealth services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). FQHCs and RHCs serve as the primary source of care for millions of low-income and underserved patients across the country. In order to promote care continuity and ensure that beneficiaries have access to affordable, comprehensive care, Medicare should permanently cover telehealth services provided by these health centers. Medicare and Medicaid payment methodologies should also be modified to provide appropriate and timely payment to community health centers for telehealth services.

In order to make long-term investments in telehealth platforms and workflow modifications, physician practices need advanced notice of changing Medicare and Medicaid telehealth policies. While more data will be needed to make determina-

tions on whether to permanently continue certain telehealth services, temporary policies should be avoided for well-established, high-value telehealth services such as E/M office visits and mental health services.

The AAFP is supportive of broadly expanding access to telehealth services. However, we recognize that Congress and CMS are concerned about preventing waste, fraud, and abuse and considering policy options to reduce those risks. In addition to promoting the use of telehealth within the medical home, we also recommend relying on existing Medicare policies to minimize confusion and administrative burden imposed on physician practices. For example, Medicare defines an established patient as one that has received professional services from a clinician in the same practice and of the same medical specialty within the last 3 years. This definition should be repurposed in any new telehealth policies, instead of creating a new definition for an established patient that could conflict with current coding guidelines.

While the rapid expansion of telehealth has yielded many benefits for patients and clinicians, not everyone has benefited equally. Without sufficient investment and thoughtful policies, telehealth could actually worsen health disparities. Prior to the COVID–19 pandemic, evidence suggests that telehealth uptake was higher among patients with higher levels of education and those with access to employer-sponsored insurance. Another study found that patients with limited English proficiency utilized telehealth at one-third the rate of proficient English speakers. Anecdotes from family physicians suggest that the same trend may hold true for the past year—that those benefitting most from telehealth are those who already had better access to care. **As the committee seeks additional studies to inform the direction of permanent telehealth policies, you should ensure the collection and reporting of data stratified by race, ethnicity, gender, language, and other key factors.**

One in three households headed by someone over the age of 65 do not have a computer, and more than half of people over age 65 do not have a smartphone. Children in low-income households are less likely to have access to a computer, and 30 percent of black or Hispanic children do not have a computer, compared to 14 percent of whites. Digital literacy also varies with age, income, and ethnicity. **In order to achieve the full promise of telehealth, Congress must act to address these structural barriers to virtual care.** The AAFP supports the creation of a pilot program to fund digital health navigators; development of digital health literacy programs; and deployment of digital health tools that provide interpretive services at the point of care, are available in non-English languages, easily and securely integrate with third-party applications and include assistive technology. Such a pilot should include a robust evaluation to demonstrate how the interventions addressed gaps in care or increased access for underserved populations.

Beyond telehealth, CMS implemented several other flexibilities to facilitate access to care and prevent the spread of COVID–19. We recommend making several of these flexibilities permanent, while others should remain in place only during this and future public health emergencies.

Congress took several actions to secure access to the COVID–19 vaccine for free for most Medicare, Medicaid, and CHIP beneficiaries. We recommend that Congress explore further actions to facilitate affordable, equitable coverage of routine adult immunizations. Currently, only 43 percent of State Medicaid agencies cover all recommended adult vaccines, and overall adult utilization remains low. **The AAFP believes**[2] **that all public and private insurers should include as a covered benefit immunizations recommended by the ACIP without co-payments or deductibles.**

CMS should allow physicians to provide direct supervision and teaching services via synchronous audio/video communication nationwide. During the public health emergency, CMS allowed this to improve access to care in areas with physician shortages and prevent the transmission of COVID–19. The flexibility to provide these services virtually had clear benefits, as evidenced by CMS's recent decision to permanently allow virtual teaching and supervision in rural areas. If made permanent nationwide, it would increase training opportunities in rural and other underserved communities and improve patients' access to comprehensive, continuous care.

A similar permanent policy was finalized for all levels of E/M office visits provided at a primary care center during the PHE: Teaching physicians can permanently use

[2] *https://www.aafp.org/about/policies/all/immunizations.html.*

video conferencing to supervise residents providing primary care in rural areas. The AAFP is supportive of this policy being made permanent, and we believe that, applied nationwide, it would bolster primary care training opportunities and improve access to primary care in other underserved areas. The rural designation may not capture many areas of the country that are experiencing primary care shortages.

Medicare and Medicaid both waived prior authorization requirements for durable medical equipment (DME) and other services early on during the public health emergency. While these requirements have since been reinstated, **Congress should permanently reduce the volume of prior authorization requirements across Medicare and Medicaid payers.** Prior authorization requirements delay care for patients and contribute to alarming rates of physician burnout. Commonsense solutions are needed to preserve and strengthen our physician workforce. For example, prior authorization should not be required for most DME ordered by a primary care physician for an established patient, regardless of whether it is ordered during a telehealth or in-person visit.

Family physicians were relieved when CMS took swift action to delay and/or waive reporting requirements for the Quality Payment Program, Medicare Shared Savings Program, and other programs. However, many practices were frustrated that CMS delayed the implementation of the extreme and uncontrollable circumstances policy for the 2020 performance year. **This policy, along with other waivers, should be quickly applied in future PHEs so physicians can focus on providing patient care with minimized administrative tasks without fearing negative financial repercussions.** The AAFP also has urged CMS to update measure benchmarks used across various programs to account for changes in utilization of health-care services during the pandemic.

CMS waived requirements for physician supervision, including requiring certain services to be ordered by a physician, in Medicare, Medicaid, and the VA system. To safeguard patient safety and maintain access to appropriate, high-quality care, these waivers and flexibilities should not be made permanent, because patients are best served by a physician-led care team. Family physicians are particularly qualified to lead the health-care team because they possess distinctive skills, training, expertise and knowledge that allow them to provide medical care, health maintenance and preventive services for a range of medical and behavioral health issues. While certain flexibilities during the PHE addressed the historic nature of the pandemic, **flexibilities to loosen supervision requirements should be restricted by Congress to ensure continuity of care and high-quality, accessible health care for all patients.**

Thank you for the opportunity to discuss with this committee the impact of health care regulatory flexibilities made available during the current public health emergency on family physicians and the AAFP's recommendations for permanent policy to advance accessible, equitable, high-quality health care beyond the pandemic.

QUESTIONS SUBMITTED FOR THE RECORD TO KISHA DAVIS, M.D., MPH, FAAFP

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. During the pandemic, telehealth has been an essential tool to get children the care that they need while minimizing risk. Although telehealth under Medicare has been a focus, close to 40 million children are enrolled in Medicaid.

What are the main policy changes we need to ensure this broader use of telehealth can be continued beyond the pandemic for children?

Answer. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care and expand access to care for vulnerable populations, including children enrolled in Medicaid. Children have unique medical needs and the appropriateness of virtual care can differ between children and adults and based on the amount of information that the treating clinician has about the patient. Family physicians and pediatricians form long-term, trusting relationships with their patients and parents, which not only enables them to provide personalized care but also to assess and recommend the optimal mode of care. Some care such as treatment for mild illness, follow-up care and behavioral health services may be well-suited for telehealth; whereas other health needs require hands-on examination or treatment, and essential preventative services such as immunizations and health screenings must be done in-person. In most instances children can benefit from a hybrid of in-person and virtual care, which is optimized when all care

is coordinated through the patient's medical home. The AAFP joined with the American Academy of Pediatrics to develop these joint principles [1] for permanent telehealth policy that support the medical home. Congress should support coverage and payment models that enable primary care clinicians to provide virtual care to their patients and discourage the proliferation of direct-to-consumer, virtual-only telehealth vendors as a substitute for primary care.

The AAFP also encourages Congress to invest in initiatives to bridge the digital divide including expanding broadband coverage and subsidizing access, providing lower-income individuals with end devices (*i.e.,* tablets, laptops, remote monitoring tools) and/or access points and ensuring that digital health platforms and tools are culturally and linguistically appropriate and accessible for vision and hearing impaired.

Question. During COVID–19, many States adopted temporary changes to their telehealth policies, such as expanding the scope of services and providers able to furnish telehealth, relaxing of licensure requirements and modifying reimbursement policies. Many States legislatures have also begun the work to adopt more permanent telehealth policy changes.

How can the Federal Government best support State Medicaid programs in their efforts to expand telehealth?

Are there Medicaid supports, incentives, and learnings that Federal policymakers could provide?

Answer. States have adopted a broad range of telehealth flexibilities during the pandemic, including waiving restrictions on distant and originating sites, adjusting provider reimbursement rates, and issuing guidance on the use of telehealth in particular areas (behavioral health, reproductive health, physical therapy). Most flexibilities expire with the end of the public health emergency and coverage of particular services provided via telehealth is inconsistent across the States. With information and data on the most effective and beneficial State policies during the pandemic, incentives and guidance on best policies would be helpful to facilitate information sharing among States who wish to make changes permanent.

Federal financial support to States is critical in increasing both provider and patient access to telehealth technologies, starting with the need for investment in broadband Internet for rural areas across the country and additional funding for telehealth technologies for underserved areas and populations. There is a significant digital divide that is even more visible in the context of telehealth. Adults in rural areas lack access to broadband Internet and are more likely to be covered by Medicaid than those in other areas. Expanded broadband can lead to increased access to telehealth, giving adults in rural areas the access to care they need, especially those living in health professional shortage areas.

The AAFP encourages Federal policymakers to provide clear guidance to States on ways to adopt alternative payment models that provide sustainable funding for clinicians to incorporate telehealth into the medical home. The AAFP also encourages CMS and States to provide guidance and oversight to Medicaid managed care plans to ensure coverage and payment policies are not inappropriately steering patients toward one modality of care or limiting their choice of provider.

Question. COVID–19 has introduced additional stress and trauma for children and families. Telehealth, and particularly audio-only telehealth has been a crucial tool to connect children and adolescents to needed mental health-care services.

How can telehealth be best utilized to meet kids' mental health-care needs, and can you speak to the use of audio-only telehealth specifically?

Answer. Telehealth has been shown as highly effective mode of delivering mental health care and can reduce access barriers and stigma. One model for expanding access to mental health services that the AAFP supports is the Collaborative Care Model (CCoM) for integrating behavioral health into primary care, and services provided virtually could extend the benefits of CCoM.

The AAFP strongly supports extending coverage of audio-only telehealth services beyond the PHE to ensure that patients in rural areas and who lack access to broadband or technology devices can access services.

---

[1] *https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-Congress-TelehealthHELP-070120.pdf.*

Question. As State Medicaid programs look at expanding their use of telehealth, it is particularly important that vulnerable populations like children are not negatively impacted. Policies must be looked at through a health equity lens, considering access to reliable and affordable broadband services, access to devices that support HIPAA-compliant telehealth platforms and coverage policies.

How can Medicaid programs work to ensure telehealth policies are equitable for children and mitigate potential inequities that may arise?

Answer. Prior to the COVID–19 pandemic, evidence suggests that telehealth uptake was higher among patients with higher levels of education and those with access to employer-sponsored insurance. Another study found that patients with limited English proficiency utilized telehealth at one-third the rate of proficient English speakers. Anecdotes from family physicians suggest that the same trend may hold true for the past year—that those benefitting most from telehealth are those who already had better access to virtual care. At a minimum, Congress, CMS, and State Medicaid programs should ensure the collection and reporting of data on telehealth utilization by Medicaid beneficiaries is stratified by race, ethnicity, gender, language, and other key factors. Such data will be critical for identifying access disparities and informing equitable policy decisions.

The AAFP also encourages Congress to invest in initiatives to bridge the digital divide including expanding broadband coverage and subsidizing access, providing lower-income individuals with end devices (*i.e.*, tablets, laptops, remote monitoring tools) and/or access points and ensuring that digital health platforms and tools are culturally and linguistically appropriate and accessible for vision and hearing impaired. In the interim, the AAFP also supports Medicaid coverage for audio-only services to ensure all patients can access virtual care.

Medicaid coverage and payment for telehealth should promote virtual care that is connected to patients' medical home and should support physicians and patients' freedom to choose the most appropriate modality of care—video, telephone, asynchronous, in-person, etc.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. We have seen licensure limits substantially restrict access to cross-State medical care during this unprecedented COVID–19 emergency period. To maximize the utility of telehealth options and ensure provider accountability, some experts have suggested that States should do more to ensure mutual licensing reciprocity in the post-pandemic environment.

I am a cosponsor of Senator Murphy's Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168/H.R. 708)—a narrowly tailored bill to enable providers licensed in good standing in one State to treat patients in any State for the duration of the COVID–19 Public Health Emergency.

In 2018, Congress allowed clinicians working within the U.S. Veterans Affairs health system to practice both in-person and telehealth across State lines, as long as they were licensed in good standing in their home States. Congress did the same thing for Homeland Security providers in the CARES Act last year.

Would the American Academy of Family Physicians support a temporary, time-limited reciprocity proposal like that in the TREAT Act given the extraordinary public health crisis?

How should Congress help remove licensure barriers caused by the current patchwork of State laws in the post-pandemic environment?

Answer. State-based licensure is part of the larger State-based infrastructure to ensure patient safety. Monitoring medical practice and performing disciplinary actions is performed by State medical boards. Removing State licensure would bypass that consumer protection performed by State medical boards. As well, the standard of care and the practice of medicine does vary across States to support the varied needs of individuals in the different States. We recommend that Congress should look at options that strengthen and ease participation in the Interstate Medical Licensure Compact[2] by both physicians and States.

---

[2] *https://www.imlcc.org/*.

To prepare for the next public health crisis, Congress should look to support research of the varied approaches that were performed by States during the COVID–19 public health emergency with the goal of providing States with analysis of potential best practices. This would inform State Governers and Legislators on how best to prepare their State for the next public health emergency. Such research could also inform the Federal Government on best practices for their action in the next public health emergency.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Throughout the public health emergency, the Centers for Medicare and Medicaid Services (CMS) issued over 200 waivers under Medicare and approved more than 600 waivers and other flexibilities under Medicaid. While some of the regulations waived are specifically for responding to a pandemic, ensuring patient safety, controlling costs, and maintaining program integrity its clear innovation and common-sense ideas in our health-care system have been stifled too often by Federal regulations. For example, CMS permanently added certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic. Some regulations play an important role in protecting safety and maintaining program integrity but others may stifle good ideas.

Is health care too regulated that it's stifling good ideas?

Answer. Family physician practices continue to be deeply overburdened by administrative functions at the point of care and after patient care hours, which hinders their ability to provide high-quality care and contributes to physician burnout. The AAFP and other frontline physician organizations developed joint principles[3] on reducing administrative burden in health care.

- The AAFP urges CMS to adopt our recommendations[4] on prior authorization (PA) and step therapy to promote efficiency, reduce administrative complexity and improve patient access to treatment including exempting physicians participating in financial risk-sharing agreements from PA, exempting generic medications from PA, and not requiring step therapy for patients already on a course of treatment.
- The AAFP has called on CMS to simplify Medicare rules surrounding prescription of diabetic supplies and other DME ordered by a primary care physician for an established patient for the treatment of ongoing health conditions.
- The AAFP remains concerned that Medicare Incentive Payment System (MIPS) reporting requirements necessitate expanded human and technological infrastructure that many smaller physician practices cannot afford. To reduce reporting burden for all MIPS clinicians, CMS should provide scoring flexibility through multi-category credit. There should be a single set of performance measures across all payers that are universal, meet the highest standards of validity, reliability, feasibility, importance, and risk-adjustment. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs.
- The AAFP calls on Congress and CMS to work together to repeal Meaningful Use requirements for physicians' utilization of health IT and reform the MIPS promoting interoperability measure category. Health IT vendors should be held accountable for interoperability before physicians are measured on EHR use. Health IT should be a means to achieving desirable outcomes such as improved quality of care and reduction of health disparities. Health IT utilization is not an end goal in and of itself.
- The AAFP urges[5] Congress to delay implementation of the Medicare Appropriate Use Criteria (AUC) program. Physicians led the way in development of AUC for diagnostic imaging and use it, but the AUC program as authored by Congress is outdated and, if implemented, would add regulatory and financial burden to practices.

---

[3] *https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/ST-Group6-AdministrativeBurden-061118.pdf.*

[4] *https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/BKG-PriorAuthorization.pdf.*

[5] *https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/medicare/LT-Congress-AUCProgram-110720.pdf.*

The AAFP calls on Federal agencies to provide financial, time and quality-of-care impact statements for new regulations and administrative tasks and to revise regulations or administrative tasks that negatively affect the ability to provide timely, appropriate, high-value patient care.

Question. Should executive agencies sunset regulations in the future to enable more innovation in health care?

Answer. While the AAFP supports efforts to reduce the regulatory burdens on physicians, we believe that automatically sunsetting regulations would increase regulatory complexity and lead to disruptions for a myriad of health-care stakeholders. States, insurance issuers, physicians, and other health-care professionals all rely on existing regulations and the regulatory process in order to serve patients. Patients themselves also rely on clear regulatory guidance on the safety of food and medications, as well as health care coverage programs. Sunsetting these regulations would undermine safety standards and could result in barriers to accessing essential health services. Further, we are concerned that sunsetting regulations would interfere with agencies' ability to perform their essential functions and promulgate important new regulations to implement legislation passed by Congress. To ensure agencies can focus on administering vital health care and public health programs that advance the health of our Nation, we recommend against sunsetting regulations. However, we look forward to working with Congress to find other legislative solutions for reducing physicians' administrative burdens.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. Before coming to the Senate, I had the privilege of practicing medicine in Wyoming. Rural health care faced challenges prior to the pandemic. In particular, we know since 2010 more than 135 rural hospitals have closed.

In the Senate, I am proud to help lead the bipartisan Rural Health Caucus. This group is committed to ensuring patients in rural America can get access to the care they need.

Can you specifically discuss the changes in Federal health-care policy that you believe have helped rural providers the most during this pandemic?

Can you please discuss any specific changes that Congress should consider to better support rural health-care providers?

Answer. Rural physicians have benefited from nearly all telehealth changes during the pandemic including removal of geographic and originating site restrictions and coverage of audio-only E/M services. The AAFP has advocated for CMS to permanently cover audio-only E/M services to ensure access to virtual care for patients in rural areas who lack access to reliable broadband.

The Teaching Health Center Graduate Medical Education (THCGME) is one of the most successful, efficiently run programs in the country. Since its inception, this program has trained 1,148 primary care physicians and dentists, and evidence suggests that physicians who train in community-based underserved settings are more likely to practice in those settings. Data from the American Medical Association Physician Masterfile show that the majority of family medicine residents will stay within 100 miles of where they train, which often includes rural areas. **Congress reauthorized the THCGME program in 2020 for 3 years and should permanently reauthorize and expand the program by passing the Doctors of Community (DOC) Act (S. 1958).**

In the FY 2022 Inpatient Prospective Payment System (IPPS) proposed rule, CMS laid out a proposed methodology for distributing one thousand new Medicare GME residency positions that were enacted by Congress in December. This is the first increase to the number of available positions under the Medicare GME program in nearly 25 years. The same legislation also allowed for the creation of new rural training track sites. While the AAFP was largely supportive of CMS's proposals to allow for the creation of new rural training track sites, we strongly recommend that CMS allow existing rural track sites to increase the number of physicians they are able to train. These existing sites are successfully training rural physicians and addressing physician maldistribution and CMS should invest in their expansion.

Specifically for rural areas, Congress should consider the impact of low patient volumes on physician payment. As payment transitions from volume to value, physicians are being increasingly held accountable for quality and utilization perform-

ance. A physician's performance is more easily skewed by outliers when they have a lower patient volume. **Congress should ensure value-based payment models make appropriate adjustments on quality and utilization assessment for rural practices.** Practices should not be assessed on measures unless the measure is both valid and reliable for low patient volumes, and payers should consider the high resource burden associated with quality reporting.

Increased funding for the National Health Service Corps (NHSC) primary care physicians would allow more rural Health Professions Shortage Areas (HPSAs) to qualify for family physician placements. Primary Care HPSA scoring prioritizes population-to-provider ratio over travel time to the nearest source of care. This leaves rural communities at a disadvantage when there is not adequate funding of the National Health Service Corps (NHSC) to provide a family physician for areas with lower HPSA scores. Those areas need physicians, but the funding does not extend far enough to provide a NHSC clinician.

The rising cost of liability insurance premiums contributes to the growing loss of obstetrical services in rural communities. Higher premiums threaten the viability of some rural hospitals and make it difficult for rural areas to recruit or retain an adequate number and mix of physicians. Through the Federal Tort Claims Act (FTCA), the Federal Government offers a way for certain rural health centers to lower their malpractice insurance costs. **FTCA expansion could help rural communities struggling to provide high-risk services due to the increasing cost of private medical malpractice insurance.**

Physicians utilizing J–1 visa waivers play an important role in addressing the current physician shortage in rural areas. Conrad 30 has been a highly successful program, enabling underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. **The AAFP recommends streamlining the green card program for the J–1 visa program.**

Question. Prior to the pandemic, I introduced bipartisan legislation with Senator Tina Smith, which among other things, would allow Rural Health Clinics (RHCs) to provide more telehealth services.

I was pleased that Congress through the CARES Act authorized both Rural Health Clinics and Federally Qualified Health Centers to furnish telehealth services to Medicare beneficiaries during the public health emergency.

Can you discuss the importance of Rural Health Clinics and Federally Qualified Health Centers continuing to provide telehealth services after the public health emergency has ended?

Answer. FQHCs and RHCs must continue to be allowed to be the distant site in telehealth encounters beyond the PHE. This has improved health-care access for historically marginalized populations and will be beneficial as we continue to strive for health equity.

Question. My wife Bobbi and I are passionate about improving access to mental health services. This pandemic has clearly impacted the mental, as well as the physical health of our Nation.

For people living in rural America, getting help from a mental health provider was challenging before the pandemic. This is why Senator Stabenow and I have long supported professional counselors and marriage and family therapists participating in Medicare. We believe that increasing the number of mental health providers able to care for our Nation's seniors is an important priority.

Please discuss how telehealth has impacted the ability of patients to receive mental health services during the pandemic.

Answer. Often, the only access rural patients have to mental health providers is through telehealth. It is not unusual for a family physician to be the only healthcare provider in the county or in several counties driving distance. The pandemic has opened access to mental health providers that were previously not accessible due to Medicare's arbitrary geographic and originating site restrictions, which previously only exempted certain substance use disorder treatment.

Question. Can you please identify ways Congress can improve access to mental health services, including expanding the number of providers that can participate in Medicare?

I agree telehealth is transforming the way we are providing care. However, in Wyoming, most of our providers are part of smaller hospitals and practices. We need to make sure government regulation is not making it more difficult for these providers to serve their patients.

Can you discuss specific ways Congress can reduce the administrative burden in providing care through telehealth?

Answer. We encourage Congress to adopt and support policies that streamline coverage and payment for telehealth services across public and private payers. Variations in coverage and coding requirements add undue complexity that is especially burdensome for small and solo physician practices. Telehealth services provided by a primary care physician to an established patient should not be subject to different oversight than comparable in-person services.

PREPARED STATEMENT OF LINDA V. DECHERRIE, M.D., CLINICAL DIRECTOR, MOUNT SINAI AT HOME; AND PROFESSOR OF GERIATRICS AND PALLIATIVE MEDICINE, ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, MOUNT SINAI HEALTH SYSTEM

Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, it is my distinct pleasure on behalf of the Icahn School of Medicine at Mount Sinai and Hospital at Home Users Group to submit this testimony in support of Hospital at Home, specifically extending the current Hospital Without Walls and Acute Hospital Care at Home flexibilities currently being offered under the public health emergency (PHE).

The Mount Sinai Health System is New York City's largest academic medical system, encompassing eight hospitals, a leading medical school, and a vast network of ambulatory practices throughout the greater New York region. Mount Sinai is a national and international source of unrivaled education, translational research and discovery, and collaborative clinical leadership ensuring that we deliver the highest quality care—from prevention to treatment of the most serious and complex human diseases. The Health System includes more than 7,200 physicians and features a robust and continually expanding network of multispecialty services, including more than 400 ambulatory practice locations throughout the five boroughs of New York City, Westchester, and Long Island. The Mount Sinai Hospital is ranked No. 14 on *U.S. News and World Report*'s "Honor Roll" of the Top 20 Best Hospitals in the country and the Icahn School of Medicine as one of the Top 20 Best Medical Schools in the country. Mount Sinai Health System hospitals are consistently ranked regionally by specialty and our physicians in the top 1 percent of all physicians nationally by *U.S. News and World Report*.

The Hospital at Home Users Group is a dynamic collaborative of Hospital at Home programs around the United States and Canada. We are sharing resources and best practices, working together to expand the reach of our programs, and developing the program and policy standards to inform regulatory and reimbursement policies necessary to spread this hopeful model broadly throughout North America.

Hospital at Home (HaH) is a patient-centric model of care which provides hospital-level care at home for patients with select acute illnesses and acuity level who would otherwise be hospitalized. The traditional hospital can be dangerous for older adults with resultant functional decline, iatrogenic illnesses, and other adverse events. Multiple HaH studies have demonstrated improved patient safety, reduced mortality, enhanced quality, and reduced cost. This was a model that many Medicare Advantage, commercial, and Medicaid managed care plans already covered before the pandemic. Adding the rest of Medicare beneficiaries allows equitable care and has been extremely helpful since November 2020, when the Acute Hospital Care at Home waiver was approved. I believe the coverage of Hospital at Home or Acute Hospital Care at Home should be covered beyond the pandemic as a 30-day bundle of care.

Typically, HaH starts in the emergency departments where a patient is evaluated by the emergency physicians and staff and if they are determined to need inpatient care they are screened for HaH. This screening first starts with a clinical screen to see if the conditions and treatment plan can be effectively delivered in the home, then the patients home environment is screened through a bedside survey. Common diagnoses are Pneumonia, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Cellulitis. The patient then is offered the opportunity to participate in the program and consents. Other physicians see the patient and write admission orders. Patients go home with an IV in place, in an ambulance,

with a telehealth kit and potentially with oxygen. The ambulance staff sets them up in the home and within a couple of hours, a nurse arrives at the home and further assesses the home for safety and starts the treatment plan. Multiple deliveries typically occur such as IV and oral medications, equipment, and supplies. In the subsequent days, nurses come twice a day (some programs use mobile integrated health paramedics), and a physician or nurse practitioner sees the patient daily (in person or via video visit). They have access to other services such as physical therapy, occupational therapy, speech therapy, social work, and nutrition—all as needed based on the patient's individualized care plan. Patients usually require frequent blood draws, IV fluids, antibiotics, x-rays, or oxygen, all of which can be done in the home. Teams will round a couple times a day to review the care plan. There is 24/7 immediate availability of the team, including in person within 30 minutes if needed. This care is inclusive, patient centric, and equitable, as 41 percent of our patients have some form of Medicaid. Once a clinician is in the home many additional barriers to improved health care, including health literacy, food insecurity, nutritional misinformation, and medical equipment needs are all readily identifiable, allowing our social worker to get involved, and referrals to be made to help improve the patient's health longer-term.

There are other pathways into Hospital at Home, such as from a patient's outpatient doctors' offices, urgent care, or from the inpatient floors as long as the patient requires inpatient level care and would otherwise have been admitted to the hospital.

The model of Hospital at Home has existed for several decades internationally with Australia, France, Spain, and Israel being some of the early adopters. In the mid-1990s the first trials of Hospital at Home were performed in the U.S. at Johns Hopkins. It was shown to be safe, efficacious and the patients desired this type of care. Never the less, no payment was available and existing payment structures did not adequately cover the costs of the program. Between the mid-1990s and 2014, a number of veterans' hospitals developed similar programs as they had payment flexibilities. One integrated health system in New Mexico with their own Medicare Advantage plan has offered a HaH program since 2008. In 2014, we at Icahn School of Medicine at Mount Sinai in New York City applied and received a Center for Medicare and Medicaid Innovation (CMMI) award to develop and test Hospital at Home for a fee-for-service Medicare population. We did one thing differently than previous iterations of Hospital at Home, we cared for the patients for 30 days. It was split into two phases—the acute phase where the patient would have been in the hospital and a transitional phase for monitoring and ensuring the patient was stable and back under the care of their primary care provider and outpatient specialists.

From our CMMI period, we examined more than 500 fee-for-service Medicare beneficiaries who received HaH care. We received additional funding from The John A. Hartford Foundation, and were able to compare care to a group of patients who received traditional inpatient care. For both groups of patients, the full 30 days of care were examined, and more than 65 Diagnosis-Related Groups (DRGs) were included in this analysis. Length of stay was reduced from 5.5 days to 3.2 days, 30-day readmissions were reduced from 15.6 percent to 8.6 percent, and Skilled Nursing Facility transfers on discharge were reduced from 10.4 percent to 1.7 percent with a resultant higher use of Certified Home Health for this HaH cohort. With regards to patient satisfaction, 45.3 percent of traditionally hospitalized patients were highly satisfied with care, while with HaH it increased to 68.8 percent.

While some programs may start with a limited number of DRGs for which they can provide HaH care, we currently believe there are more than 150 DRGs that HaH can serve, and believe this is probably a conservative estimate. As many programs expand into oncology and surgical cases, the number will increase.

From this work, we submitted a proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)—"HaH Plus" (Hospital at Home Plus)—Provider-Focused Payment Model. Moreover, after evaluation, PTAC recommended two separate HaH proposals in 2018: (1) our proposal, the Hospital at Home Plus Model (HaH-Plus); and (2) the Home Hospitalization: An Alternative Payment Model for Delivering Care in the Home (HH–APM), to the Secretary of the Department of Health and Human Services for implementation. The Secretary expressed interest in testing home-based, hospital-level of care models and agreed with the PTAC that these models hold promise for testing. The agency has the authority to further refine the recommended PTAC models; however, to-date, they have not utilized this authority. While we recognize the broader need for a refined

HaH model, and we look forward to working with the agency to advance such a model to ensure greater availability of hospital care in the home to all patients, we believe congressional action to extend the current waivers and flexibilities is necessary and particularly valuable for patient care in the immediate and near term.

We believe these regulatory flexibilities should be made permanent beyond the PHE and will be an effective foundation for establishing Medicare reimbursement that is specific to Hospital at Home services. We applaud The United States Department of Health and Human Services (HHS) for providing these flexibilities to ensure hospital services in the home during the PHE, and we encourage Congress and HHS to consider extending these flexibilities as a new model of care that prioritizes the patient's safety and care needs.

In 2017 when the CMMI award was finished, our Hospital at Home program no longer provided care for fee-for-service patients as there was no fee-for-service reimbursement and the program shifted to focus on Medicare Advantage, commercial, and Medicaid managed care plans. We created a joint venture with Contessa Health and together have negotiated contracts with most of the major insurance providers in our area.

During the initial surge of COVID–19 in March 2020 we were an important part of helping the Mount Sinai Health system admit both COVID negative and positive patients to open up more capacity for patients needing higher levels of care like ICUs, but were still unable to admit a fee-for-service Medicare patient from the emergency room. The PHE has demonstrated the need to have Hospital at Home accessible to fee-for-service Medicare patients.

We were very excited to be part of the original group of hospitals approved for the Acute Hospital Care at Home waiver in November 2020. Despite having operated since 2014, we still needed some time to set up and meet the new requirements. We are appreciative that CMS made this available to fee-for-service Medicare patients. My colleagues and I have been happy to engage with CMS as stakeholders in this process. In addition, we formed the Hospital at Home Users group with funding from The John A. Hartford Foundation, which provides technical assistance, office hours and a member community which has engaged in multiple work groups. To date, there have been 129 hospitals approved for the Acute Hospital Care at Home waiver, with 56 health systems in 30 States since November. This shows that there is great interest. It does take significant start up resources and time and many are not planning to launch until this summer. I believe even more hospitals would apply if they knew this program would be made permanent. This waiver allowed many hospitals to jump start a program in the pandemic, which has been helpful in many communities for the provision of high quality and safe patient hospital inpatient care.

Having a payment model for Hospital at Home/Acute Hospital Care at Home is needed to serve Medicare beneficiaries beyond the pandemic and especially if an emergency of this type ever happens again. These programs are complex to start, and many places could not start instantaneously; therefore, if the flexibilities continue beyond the PHE, I believe many additional hospitals will join. There is a strong interest in the community of Hospital at Home programs to continue this.

Due to the regulatory barriers outlined above, hospitals have been wary about and disincentivized from implementing the innovations of providing acute level care in the home. Therefore, we request Congress and HHS to consider a permanent extension of the Hospital Without Walls and Acute Hospital Care at Home waivers beyond the PHE to mitigate the residual impacts of COVID–19 on public health and encourage broader adoption of providing patient centered health-care services in the home. Thank you for the opportunity to provide this testimony to the committee. My colleagues and I look forward to continuing to work with Congress and HHS on this important issue.

QUESTIONS SUBMITTED FOR THE RECORD TO LINDA V. DECHERRIE, M.D.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. Mount Sinai health system was one of the first group of hospitals that CMS approved for the Acute Hospital Care at Home waiver last year. Medicare pays hospitals participating in the program at the same reimbursement rate that the facility otherwise would have received if the beneficiary had been admitted to the hospital. In your testimony, as well as during interviews with my staff, you indicated

that the Mount Sinai Hospital at Home program has demonstrated improved patient outcomes, increased quality of care, enhanced patient safety, reduced mortality, and lowered costs. This committee wants to identify smart Medicare payment reforms that show the greatest potential to ensure beneficiaries get the right care, in the right setting, at the right time, and in a cost-efficient manner. Not only do Medicare beneficiaries deserve high-quality care, but any innovative payment arrangements that we consider implementing beyond the PHE, must also help put Medicare on a more sustainable fiscal path.

If it was less expensive for Medicare to furnish certain acute inpatient services in the home during the pandemic, and beneficiaries saw better health outcomes, then how do you think these efficiencies should be factored into the Medicare hospital inpatient payment rates?

Answer. In my opinion, the services provided by Hospital at Home (HaH) programs should be billed as a DRG based 30-day bundled value-based payment to better manage the care of HaH patients, which was studied through our CMMI Innovation Grant from 2014–2017. It is our belief that this is the most cost effective and appropriate manner to bill these services going forward. While this value-based payment model is built, the current Acute Hospital Care at Home waiver should extend to enable programs, like Mount Sinai, to continue providing and being paid for hospital inpatient care in the home. I do not believe the two offerings and approaches to hospital care in the home are mutually exclusive, and do believe they collectively benefit patients, providers, and the Medicare program.

Question. Should CMS calculate separate Medicare claims codes in order to reimburse for these specific services?

Answer. No, it is not necessary to create separate Medicare claims codes to reimburse for Hospital at Home specific services. The services provided through HaH are indeed the same level of services provided in an acute care setting for patients. Creation of a new set of Medicare claims code would add unnecessary burden to providers needing to learn a new set of codes for the same set of services. Importantly, the patients seen under HaH receive higher quality, lower cost care, and have a higher patient satisfaction scores than patients receiving the same level of care in an acute care setting.

Question. The Congressional Budget Office (CBO) would analyze and provide a cost-estimate for any legislative proposal seeking to make the Acute Hospital Care at Home program permanent once the PHE expires. CBO has previously indicated that Medicare fee-for-service programs are generally subject to unnecessary utilization as well as potential fraud, waste, and abuse.

What specific policies do you recommend in order to minimize these risks?

Answer. HaH allows for treatment of patients that meet Milliman Care Guidelines or other equivalent guidelines for medical necessity for hospital admission by a qualified team of care providers. In order to qualify for HaH, we advise that patients and their homes meet a strict set of screening criteria, as per our study at Mount Sinai, before being deemed eligible for HaH. Additionally, we believe based on our experience with the HaH plus model that home-based acute care services resulted in less waste than traditional hospital inpatient care. Further studies could be conducted to confirm these findings and expand upon the work previously done.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. During the pandemic, telehealth has been an essential tool to get children the care that they need while minimizing risk. Although telehealth under Medicare has been a focus, close to 40 million children are enrolled in Medicaid.

What are the main policy changes we need to ensure this broader use of telehealth can be continued beyond the pandemic for children?

Answer. Telehealth and audio-only telehealth need to continue to be reimbursed as they were during the Public Health Emergency. Allowing the continuation of these services for Medicaid beneficiaries is an important step to improving access to care and health equity for children. During the PHE, Mount Sinai used grant funding from the Federal Communications Commission (FCC) to provide 700 devices to children and their families requiring telehealth monitoring and care, on a rotating basis, in addition to another 150 tablets for homebound adults in the Mount Sinai Visiting Doctors Program. Through innovative partnerships, telehealth was

provided to thousands of patients by removing obstacles to receiving health-care services. This model could be expanded upon to the larger population in order to provide convenient, cost-efficient, high-quality home-based health-care services to children and adults.

Question. During COVID–19, many States adopted temporary changes to their telehealth policies, such as expanding the scope of services and providers able to furnish telehealth, relaxing of licensure requirements and modifying reimbursement policies. Many States legislatures have also begun the work to adopt more permanent telehealth policy changes.

How can the Federal Government best support State Medicaid programs in their efforts to expand telehealth?

Answer. The Federal Government can help support State Medicaid programs by ensuring telehealth and audio only telehealth continue to be reimbursed for the care provided to beneficiaries. In addition, the Federal Government can help support State Medicaid to cover Hospital at Home (Acute Hospital Care at Home) services. HaH can provides acute levels of care to all adults, and during the pandemic that has included patients within the Medicare and Medicaid population, who often struggle with access to convenient health-care services. Additionally, the lifting of geographic restrictions for providers of health-care services is another important step that will allow telehealth to be provided across State lines and fill gaps of care where access is limited. Lastly, enhancing the rollout of broadband Internet to rural communities will ensure everyone has access to telehealth services.

Question. Are there Medicaid supports, incentives, and learnings that Federal policymakers could provide?

Answer. Federal policymakers could help State Medicaid programs by continuing to rollout access to broadband Internet services across the country and subsidizing affordable technology provided to Medicaid patients to allow telehealth and audio-only telehealth visits. Extending the Acute Hospital Care at Home waiver beyond the PHE is an additional step that should be taken to support the Medicaid population. These supports and incentives would greatly improve access to care and allow for continued innovation in how cost-efficient care is delivered to Medicaid (and all) patients.

Question. COVID–19 has introduced additional stress and trauma for children and families. Telehealth, and particularly audio-only telehealth has been a crucial tool to connect children and adolescents to needed mental health-care services.

How can telehealth be best utilized to meet kids' mental health-care needs, and can you speak to the use of audio-only telehealth specifically?

Answer. Telehealth effectively increases access to mental health services for kids. It is a cost-efficient, barrier removing (*i.e.,* travel, parent/guardian time, access) solution to provide much needed mental health services to children in need. As we have seen during the public health emergency, mental health in our country is at an inflection point and desperately needs to be addressed. The CDC found that suicide rates among teenagers increased by more than 50 percent during the PHE, worsening mental health issues long ignored. As such, audio only telehealth reimbursement needs to continue, as it provides additional coverage to children without the financial and technological capabilities to engage in video enabled telehealth visits and provides further options of convenient, cost-effective care.

Question. As State Medicaid programs look at expanding their use of telehealth, it is particularly important that vulnerable populations like children are not negatively impacted. Policies must be looked at through a health equity lens, considering access to reliable and affordable broadband services, access to devices that support HIPAA-compliant telehealth platforms and coverage policies.

How can Medicaid programs work to ensure telehealth policies are equitable for children and mitigate potential inequities that may arise?

Answer. Subsidizing access to affordable technological resources to engage in video enabled telehealth, like the grant funding Mount Sinai received from FCC to provide children and their families devices, will help to improve equity of telehealth policies. Reimbursement should also be allowed to continue for audio-only telehealth services and HaH post-PHE. Additionally, Medicaid programs should enable providers to treat patients across State lines in order to improve access to care for States that do not have enough health services providers. Lastly, it is crucial to fill

the gap in rural broadband service to ensure rural populations have the same access to telehealth services as other populations.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. We have seen licensure limits substantially restrict access to cross-State medical care during this unprecedented COVID–19 emergency period. To maximize the utility of telehealth options and ensure provider accountability, some experts have suggested that States should do more to ensure mutual licensing reciprocity in the post-pandemic environment.

I am a cosponsor of Senator Murphy's Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168/H.R. 708)—a narrowly tailored bill to enable providers licensed in good standing in one State to treat patients in any State for the duration of the COVID–19 Public Health Emergency.

How have health systems and patients benefited from State licensing reciprocity during the COVID19 public health emergency?

Answer. This allows providers to treat their patients regardless of what State they are currently in. Patients have benefited from being able to access the providers of their choice. If a patient is traveling and needs their care managed by their PCP who is in another State, they should be able to receive that care telephonically and by video and be managed by the physician that knows them and their specific health status best.

Question. I recently reintroduced the Home Health Emergency Access to Telehealth Act (HEAT) Act with Senators Collins and Shaheen. This bill would allow Medicare home health providers to be reimbursed for the telehealth services during a public health emergency. I also have heard from other home-based care providers, like hospice and palliative care as well as home-based primary care about the importance of telehealth during the emergency and into the future as services in the home and community continue to grow.

Could you talk about your experiences using telehealth to supplement care for the populations you take care of?

Answer. We have learned to be creative in this pandemic. In March 2020 a small portion of our home-based primary care patients were able to access telehealth, mostly those who lived with their adult children. However, with a grant from the FCC where we provided tablets to some patients and working with other patients who had consistent home health aides who had smart phones we were able to expand those we could use video visit. However, it still did not reach all patients, and regular telephone was utilized instead.

When a patient is able to use video technology it is tremendously helpful to us, when the call with an urgent complaint such as leg swelling, a new rash or ulcer, our nurses can immediately get a visual on the issue and provide that to the provider who can decide how urgently and in what way a patient needs to be seen. In the past we would do that telephonically only and then next day send a provider out to the home.

In our Hospital at Home program (Acute Hospital Care at Home) we also heavily utilize video technology, which allows the provider and care coordinator to participate in all visits to the home.

Question. What lessons from the pandemic would you like to see brought forward into the future of care for home health, hospice, palliative, and other home-based care providers?

Answer. The need for patient-centered, acute level care that can be furnished in a patient's home is the biggest lesson from the PHE that needs to be brought forward into the future of care. We learned that a decades old model of care, Hospital at Home, which provided value pre-pandemic despite lack of a Medicare payment structure could bring value during the PHE by providing payment for and access to hospital inpatient services. Moreover, this model can and should carry beyond the PHE. While we recognize the broader need for a refined HaH model as part of the shift to a value-based payment system, we believe congressional action to extend the current Acute Hospital Care at Home waiver and associated telehealth flexibilities is necessary and particularly valuable for patient care in the immediate and near term. We believe these regulatory flexibilities should be made permanent beyond the PHE and will be an effective foundation for establishing Medicare reimbursement that is specific to HaH services. We look forward to working with Congress

and the agency to advance such a model to ensure greater availability of hospital care in the home to all patients.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Throughout the public health emergency, the Centers for Medicare and Medicaid Services (CMS) issued over 200 waivers under Medicare and approved more than 600 waivers and other flexibilities under Medicaid. While some of the regulations waived are specifically for responding to a pandemic, ensuring patient safety, controlling costs, and maintaining program integrity its clear innovation and common-sense ideas in our health-care system have been stifled too often by Federal regulations. For example, CMS permanently added certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic. Some regulations play an important role in protecting safety and maintaining program integrity but others may stifle good ideas.

Is health care too regulated that it's stifling good ideas?

Answer. In the case of the Hospital Without Walls and Acute Hospital Care at Home waivers, policymakers have lifted critical regulatory barriers that have prevented or at minimum dissuaded hospitals and health systems from investing in Hospital at Home. Specifically, these waivers have allowed the home to be a permissible site for acute level care and allowed section 482.23 of the Medicare Conditions of Participation for 24-hour nursing services to be fulfilled virtually. These waivers have allowed for necessary innovations to maintain patient safety, and we need to continue to foster this innovation after the end of the PHE. This should be extended as a distinct hospital program of hospital inpatient care as an integrated model of hospital services, separate and distinct from home care services.

Due to the pre-pandemic aforementioned regulatory barriers, hospitals and health systems have been unable to receive Medicare fee-for-service reimbursement. Hospitals and health systems need time, funding, and predictability beyond 90-day intervals to build the necessary infrastructure to administer Hospital at Home. Without the continuation of these waivers, these regulatory barriers will resume and innovations like the Hospital at Home program (Acute Hospital Care at Home) will not be adopted across health systems and hospitals.

Question. Should executive agencies sunset regulations in the future to enable more innovation in health care?

Answer. Prior to the public health emergency, Hospital at Home was only reimbursed in certain circumstances under commercial arrangements. With traditional Medicare covering 15 percent of the population, it is vital that executive agencies consider a formal payment model for fee-for-service patients. Having a payment model for Hospital at Home is needed to serve Medicare beneficiaries beyond the pandemic and especially in the event of a future public health emergency.

Moreover, executive agencies should allow a reinterpretation of section 482.23 of the Medicare Conditions of Participation to allow nursing services to be fulfilled virtually for Hospital at Home programs. Agencies should also sunset regulations that limit the home as an originating site for acute level services and telehealth.

Question. In March 2020, CMS announced an effort known as Hospitals Without Walls designed to rapidly increase hospital capacity at the start of the pandemic. In November 2020, CMS established the Acute Hospital Care at Home demonstration model. This model allows approved hospitals to deliver home-based care and meet patients' needs with quality, convenience, and comfort. The model has proven to be effective in better quality outcomes, shorter lengths of stay, and higher patient satisfaction all while lowering overall cost of care. The UnityPoint at Home, an Iowa health-care provider, was one of the first providers to be approved by CMS and the first in the Nation in February 2021 to admit and bill for patients. Hospitals under Medicare FFS were not previously allowed to offer this type of care that is more intensive than home health. This model was already utilized by Medicare Advantage, commercial, and Medicaid managed care plans. I have supported similar innovations for hospitals in rural areas. Last Congress, we passed the Rural Emergency Hospital Designation (REH) that will let rural hospitals right-size their infrastructure while maintaining essential medical services in their communities like 24/7 emergency care and outpatient care.

Should CMMI extend the current waiver for the Medicare FFS program to exist into the future?

Answer. Yes, the coverage of Hospitals Without Walls and Acute Hospital Care at Home should be covered permanently beyond the PHE. Multiple studies on the Hospital at Home program have demonstrated improved patient safety, reduced mortality, enhanced quality, and reduced cost. We applaud the Department of Health and Human Services for providing these flexibilities to ensure hospital services in the home during the PHE, and we encourage Congress and HHS to also consider a CMMI model that allows a reimbursement pathway for a new Hospital at Home 30-day bundle value-based model of care that reduces costs of care and prioritizes the patient's safety and care needs.

Question. What efforts can be made to improve the model?

Answer. The shift of care in the community will require further training of providers, alignment with community partners, and shifting the current framework that usually results in hospitalization. Successful treatment in the home of individuals with acute illness requires a skill set that includes hospital care, home-based care, and a strong focus on coordination of care and transitions. Hospital at Home programs require home inspections and patient safety protocols that can respond to abrupt changes in clinical status and needs when certain clinical resources are not readily available. Leveraging the experience of a home-based primary or palliative care program can help create that infrastructure. While we recognize the broader need for a refined Hospital at Home value-based model of care, and we look forward to working with the agency to advance such a model to ensure greater availability of hospital care in the home to all patients, we believe congressional action to extend the current waivers and flexibilities is necessary and particularly valuable for patient care in the immediate and near term.

Question. What similar cost-effective innovations are being stifled by Federal law and regulations?

Answer. Value-based arrangements have historically been stifled by regulatory barriers. Cost-saving innovations such as care coordination services have been difficult to implement with Federal laws restricting information sharing and access to data between providers. Recently, CMS published the Modernizing and Clarifying the Physician Self-Referral Final Rule, which mitigated some of these barriers by giving greater flexibility to providers to participate in value-based care delivery models and provide coordinated care or patients. While this rule offers exciting new opportunities for providers, payers, and others to innovate, there are still limitations. The safe harbors and exceptions in the Final Rule are highly prescriptive so existing value-based arrangements will likely not satisfy all AKS or Stark Law value-based requirements without review and amendment.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. Before coming to the Senate, I had the privilege of practicing medicine in Wyoming. Rural health care faced challenges prior to the pandemic. In particular, we know since 2010 more than 135 rural hospitals have closed.

In the Senate, I am proud to help lead the bipartisan Rural Health Caucus. This group is committed to ensuring patients in rural America can get access to the care they need.

Can you specifically discuss the changes in Federal health-care policy that you believe have helped rural providers the most during this pandemic?

Answer. During COVID–19, CMS allowed many evaluation and management codes to be furnished via telehealth. Telehealth has become an essential service for patients and primary care providers have led the charge in its use. Telehealth has allowed providers to maintain, and in certain cases expand, the reach of their medical services to populations in need. Many provider practices and the patients they serve will remain reliant on telehealth services as a care tool for the immediate future, if not longer.

Waiving originating and distant site requirements, allowing Medicare reimbursement for audio-only, and increased funding for broadband infrastructure have all helped rural health-care providers and contributed to increased access for patients.

Question. Can you please discuss any specific changes that Congress should consider to better support rural health-care providers?

Answer. There are a few avenues Congress can consider to better support rural health-care providers:

- **Support extending the Acute Hospital Care at Home waiver:** There are already many rural hospitals participating, and this will allow rural providers options of site of care for their patients. Simultaneously or subsequently encourage and work with the Secretary to finalize a 30-day bundle value-based payment model for HaH as proposed to the PTAC in 2017.
- **Increase funding for telecommunications services and connected devices for provider practices and patients:** Small practices in rural areas often do not have the upgraded technological platforms needed to provide telehealth services for their patients. Additionally, funding opportunities for these services and devices have been limited for independent provider practices. Applications for additional funding should be streamlined as much as possible to preclude any unnecessary administrative burden for independent practices that may lack some of the support services and administrative staff that larger entities can take advantage of.
- **Increase support for broadband infrastructure:** The expanded use of telehealth, including video visits and remote patient monitoring, require the use of broadband which many patients in rural and underserved areas do not have. Congress should consider the needs of this population and commit to providing universal broadband to all who need it.
- **Permanent removal of originating and distant site requirements:** This ensures that providers can provide needed care for patients without regulatory barriers and patients themselves have continued access to telehealth services beyond the PHE when they need it.
- **Permanently implement a separate payment for telephone-only services:** Post COVID–19, many physician practices and the patients they serve will continue to rely on telehealth services for the foreseeable future. Not covering these codes post-PHE will disproportionally put patients without the means or access to technology and the Internet at risk of not having access to care.

Question. Prior to the pandemic, I introduced bipartisan legislation with Senator Tina Smith, which among other things, would allow rural health clinics (RHCs) to provide more telehealth services.

I was pleased that Congress through the CARES Act authorized both Rural Health Clinics and Federally Qualified Health Centers to furnish telehealth services to Medicare beneficiaries during the public health emergency.

Can you discuss the importance of Rural Health Clinics and Federally Qualified Health Centers continuing to provide telehealth services after the public health emergency has ended?

Answer. As you know, Rural Health Clinics and health centers are required to offer comprehensive services in areas of high need, and many are using telehealth to address geographic, economic, transportation, and linguistic barriers to healthcare access. During the PHE, Medicare and Medicaid adopted policies that have allowed health centers to provide primary and preventive care virtually. These policies allow health centers to ensure their patients continue to receive the care they rely on, often from the comfort and safety of their own homes. Disparities will not disappear after the PHE, rather they will be exacerbated as a result. It is vital now more than ever that Rural Health Clinics and FQHCs continue to provide telehealth services after the PHE has concluded.

Question. My wife Bobbi and I are passionate about improving access to mental health services. This pandemic has clearly impacted the mental, as well as the physical health of our Nation.

For people living in rural America, getting help from a mental health provider was challenging before the pandemic. This is why Senator Stabenow and I have long supported professional counselors and marriage and family therapists participating in Medicare. We believe that increasing the number of mental health providers able to care for our Nation's seniors is an important priority.

Please discuss how telehealth has impacted the ability of patients to receive mental health services during the pandemic.

Answer. Telehealth has greatly increased access to mental health services during the pandemic. COVID–19 has far reaching mental health implications for a large proportion of the US population. Prior to the pandemic, nearly one in five U.S.

adults reported living with a mental illness, but only half received treatment. Many obstacles remain in place for those living with a mental illness, including stigma and lack of mental health services in urban and rural areas. With digital tools and access to broadband Internet, patients can now consult with a mental health professional remotely using live video. Patients living in "mental health professional shortage" areas can use these tools to speak with a licensed professional without driving long distances. They can also receive care discretely if their loved ones or colleagues perpetuate stigmas about receiving care. A large body of evidence has demonstrated that telemental health programs help increase access to care in areas with limited mental health resources, provide effective treatment for mental health conditions, and improve medication adherence.

Question. Can you please identify ways Congress can improve access to mental health services, including expanding the number of providers that can participate in Medicare?

Answer. There are multiple ways in which Congress can improve access to mental health services, including:

- Implementing a Federal statute permanently requiring payers to reimburse telehealth encounters at the same rate as in-person or to generally cover telehealth as parity remains an issue for widespread implementation of telemental health.
- Revision to section 123 of the Consolidated Appropriations Act passed in December 2020, which expanded telehealth mental services but imposed a requirement that the patient must be seen in person within 6 months of the telehealth visit and periodically in person thereafter. This has imposed unnecessary obstacles to a service that is well suited for telehealth.
- Improving care reimbursement rates by enforcing parity laws and developing new payment models for services such as telehealth group therapy.
- Increasing funding to train and develop more behavioral health professionals.
- Removing regulatory impediments to care coordination and information sharing.
- Partnering with community organizations, patients, and caregivers to identify and expand programs that reduce stigma and combat barriers to care.
- Ensuring sufficient coverage for behavioral health services.
- Increasing funding to schools to ensure administrators and teachers have the tools and funding to help students deal with mental health issues and promote wellness.

Question. I agree telehealth is transforming the way we are providing care. However, in Wyoming, most of our providers are part of smaller hospitals and practices. We need to make sure government regulation is not making it more difficult for these providers to serve their patients.

Can you discuss specific ways Congress can reduce the administrative burden in providing care through telehealth?

Answer. It is critical that Congress remove originating and distant site requirements to increase access for patients and reduce administrative burden for providers. CMS added a few evaluation and management codes to Category 1 of the Medicare telehealth list for the CY 2021 Medicare Physician Fee Schedule and omitted many others. Category 1 codes are considered permanently payable under the Medicare Physician Fee Schedule. CMS notes that while the home is generally not a permissible telehealth originating site, certain services could be billed as telehealth only for treatment of a substance use disorder or co-occurring mental health disorder under the flexibility afforded by the SUPPORT for Patients and Communities Act. This rule is limiting as many other patients with serious conditions also highly benefit from telehealth visits. The home needs to be a permissible telehealth originating site to ensure that patients have continued access to telehealth services beyond the PHE.

Question. Wyoming has many passionate advocates supporting both hospice and palliative care. These folks are committed to ensuring patients have the highest quality of life and are able stay out of the hospital and with their families. This is why I help lead the bipartisan Comprehensive Care Caucus. Our mission is to improve both palliative and hospice care for patients.

I was particularly impressed with your background in palliative care.

Can you please discuss how telehealth flexibilities have impacted access to palliative care and how we can continue making progress in this area?

Answer. Telehealth flexibilities have created greater access to palliative care for many patients, particularly with the reimbursement of audio-only codes. In response to COVID–19, CMS permitted certain services to be furnished using audio only telehealth. In the CY 2021 Medicare Physician Fee Schedule Final Rule, CMS noted that audio-only evaluation and management codes will not be reimbursed after the end of the PHE and proposed an interim final rule on coding and payment for virtual check-in services to support reimbursement for lengthier audio-only services outside of the PHE. However, these audio-only services can only be used to determine whether the beneficiary requires an in-person services and are not services that can be provided in lieu of in-person services.

Many physician practices, and the patients they serve will continue to remain reliant on telehealth services for the foreseeable future. Discontinuing the use of these codes will disproportionally put patients without a means to technology or access to the Internet at risk of not having access to care. Many complex palliative care patients are without Wi-Fi, computers, or smart devices and may be cognitively or physically impaired in using video technology. Therefore, they require medical intervention and guidance via audio-only telephone calls when they are not receiving in-person care. Congress needs to permanently implement a separate payment for telephone-only services that specifies what is included in the visit.

In our Home-based Primary Care and our Home-based Palliative Care practices we utilized the telehealth flexibilities heavily during the pandemic. We were able to quickly take patients from the emergency room home under palliative care where we provided both video and audio only telehealth to work with patients and their families.

PREPARED STATEMENT OF JESSICA FARB, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

WHY GAO DID THIS STUDY

Medicare and Medicaid—two federally financed health insurance programs—spent over $1.5 trillion on health-care services provided to about 140 million beneficiaries in 2020. Recognizing the critical role of these programs in providing health-care services to millions of Americans, the Federal Government has provided for increased funding and program flexibilities, including waivers of certain Federal requirements, in response to the COVID–19 pandemic.

The CARES Act includes a provision for GAO to conduct monitoring and oversight of the Federal Government's response to the COVID–19 pandemic. In response, GAO has issued a series of government-wide reports from June 2020 through March 2021. GAO is continuing to monitor and report on these services.

This testimony summarizes GAO's findings from these reports related to Medicare and Medicaid flexibilities during the COVID–19 pandemic, as well as preliminary observations from ongoing work related to telehealth waivers in both programs. Specifically, the statement focuses on what is known about the effects of these waivers and flexibilities on Medicare and Medicaid, and considerations regarding their ongoing use.

To conduct this work, GAO reviewed Federal laws, CMS documents and guidance, and interviewed Federal and State officials. GAO also interviewed six provider and beneficiary groups, selected based on their experience with telehealth services.

GAO obtained technical comments from CMS and incorporated them as appropriate.

WHAT GAO FOUND

In response to the COVID–19 pandemic, the Centers for Medicare and Medicaid Services (CMS), the Federal agency responsible for overseeing Medicare and Medicaid, made widespread use of program waivers and other flexibilities to expand beneficiary access to care. Some preliminary information is available on the effects of these waivers. Specifically:

Medicare. CMS issued over 200 waivers and cited some of their benefits in a January 2021 report. For example, CMS reported that:

- **Expansion of hospital capacity.** More than 100 new facilities were added through the waivers that permitted hospitals to provide care in non-hospital settings, including beneficiaries' homes.

- **Workforce expansion.** Waivers and other flexibilities that relaxed certain provider enrollment requirements and allowed certain nonphysicians, such as nurse practitioners, to provide additional services expanded the provider workforce.
- **Telehealth waivers.** Utilization of telehealth services—certain services that are normally provided in-person but can also be provided using audio and audio-video technology—increased sharply. For example, utilization increased from a weekly average of about 325,000 services in mid-March to peak at about 1.9 million in mid-April 2020.

Medicaid. CMS approved more than 600 waivers or other flexibilities aimed at addressing obstacles to beneficiary care, provider availability, and program enrollment. GAO has reported certain flexibilities such as telehealth as critical in reducing obstacles to care. Examples of other flexibilities included:

- Forty-three States suspended fee-for-service prior authorizations, which help ensure compliance with coverage and payment rules before beneficiaries can obtain certain services.
- Fifty States and the District of Columbia waived certain provider screening and enrollment requirements, such as criminal background checks.

While likely benefiting beneficiaries and providers, these program flexibilities also increase certain risks to the Medicare and Medicaid programs and raise considerations for their continuation beyond the pandemic. For example:

- **Increased spending.** Telehealth waivers can increase spending in both programs, if telehealth services are furnished in addition to in-person services.
- **Program integrity.** The suspension of some program safeguards has increased the risks of fraud, waste, and abuse that GAO previously noted in its High-Risk report series.
- **Beneficiary health and safety.** Although telehealth has enabled the safe provision of services, the quality of telehealth services has not been fully analyzed.

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to discuss flexibilities related to Medicare and Medicaid that were made available during the current public health emergency. More than a year after the Secretary of the Department of Health and Human Services (HHS) first declared a public health emergency for the U.S. and the World Health Organization characterized the Coronavirus Disease 2019 (COVID–19) as a pandemic, COVID–19 continues to result in catastrophic loss of life and substantial damage to the global economy, stability, and security.[1]

In response to COVID–19, the Centers for Medicare and Medicaid Services (CMS), the Federal agency responsible for overseeing Medicare and Medicaid, provided increased Federal funding and made widespread use of program waivers and other flexibilities to expand the availability of services, maintain access for beneficiaries, and give providers more flexibility in treating beneficiaries. For example, CMS issued waivers to expand telehealth services in Medicare fee-for-service (FFS).[2] Many of these waivers and flexibilities CMS granted were to States, which administer their Medicaid programs within broad Federal rules and according to State plans that CMS approves.

The CARES Act includes a provision for us to conduct monitoring and oversight of the Federal Government's efforts to prepare for, respond to, and recover from the COVID–19 pandemic.[3] In response, we issued government-wide reports on the Fed-

---

[1] On January 31, 2020, the Secretary of HHS declared a public health emergency for the U.S., retroactive to January 27th. Subsequently, on March 13, 2020, the President declared COVID–19 a national emergency under the National Emergencies Act and a nationwide emergency under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). *See* 50 U.S.C. § 1601 et seq. and 42 U.S.C. § 5121 et seq. The President has also approved major disaster declarations under the Stafford Act for all 50 States, the District of Columbia, and five territories.

[2] Medicare FFS consists of two separate parts: Medicare Part A, which primarily covers hospital services, and Medicare Part B, which primarily covers outpatient services. Medicare FFS beneficiaries may also enroll in Medicare Part D, which offers prescription drug coverage. Telehealth services include certain clinical services that are typically furnished in person but are instead provided remotely via telecommunications technologies. By law, Medicare FFS generally only pays for these services under limited circumstances; such as when the patient is located in certain health-care settings and certain (mostly rural) geographic locations.

[3] Pub. L. No. 116–136, § 19010(b), 134 Stat. 281, 580 (2020).

eral efforts, have examined and reported on Medicare and Medicaid flexibilities during the pandemic, and we have ongoing work examining related topics such as Medicare and Medicaid telehealth waivers.[4]

My testimony today will summarize key findings from issued reports as well as preliminary observations from our ongoing work related to expanded telehealth services in the Medicare and Medicaid programs and flexibilities related to the provision of Medicaid home- and community-based services during the COVID–19 pandemic.[5] In particular, my statement will address: (1) what is known about the effects of Medicare waivers on the Medicare fee-for-service program; (2) what is known about the effects of Medicaid waivers and flexibilities on the Medicaid program; and (3) considerations for the ongoing use of these waivers and flexibilities for Medicare and Medicaid.

In developing this statement, we relied primarily on reports we issued from June 2020 to March 2021. For our previously issued reports on which my comments are based, we reviewed applicable Federal laws; CMS documents, including guidance on program waivers and guidance to States on resuming normal operations after the end of the public health emergency; CMS written responses to questions regarding Medicare waivers; and our prior work related to Medicare and Medicaid. We also interviewed Medicaid officials from selected States regarding flexibilities they requested during the COVID–19 pandemic.[6] More detailed information on the scope and methodology for our past work can be found in these published reports.

My comments also include preliminary observations from ongoing work, including interviews with CMS officials and representatives from six beneficiary advocacy and provider groups, selected based on their experience with telehealth services and Medicare telehealth waivers, as well as Medicaid waivers and flexibilities.[7] We reviewed CMS documents and other published research on the effects of Medicare telehealth waivers on these types of services during the pandemic. In particular, we reviewed a January 2021 report from CMS on the preliminary effects of some Medicare and Medicaid waivers on both programs—including the effect of telehealth waivers on Medicare utilization of services.[8] We also reviewed data from the Kaiser Family Foundation on Medicaid waivers and flexibilities.[9] We reviewed the utilization data and Medicaid waivers and flexibilities data for any obvious errors and determined these data were sufficiently reliable for the purpose of our objectives.

We shared our preliminary observations from this ongoing work with CMS officials to obtain their views. CMS officials provided us with technical comments, which we incorporated as appropriate.

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

---

[4] GAO, *COVID–19: Opportunities to Improve Federal Response and Recovery Efforts,* GAO–20–625 (Washington, DC: June 25, 2020); GAO, *COVID–19: Urgent Actions Needed to Better Ensure an Effective Federal Response,* GAO–21–191 (Washington, DC: November 30, 2020); GAO, *COVID–19: Sustained Federal Action Is Crucial as Pandemic Enters Its Second Year,* GAO–21–387 (Washington, DC: March 31, 2021).

[5] Medicaid home- and community-based services cover a wide range of services and supports to help individuals remain in their homes or live in a community setting, such as personal assistance with daily activities, assistive devices, and case management services to coordinate services and supports that may be provided from multiple sources.

[6] For more information about the scope and methods for our past work, please see our enclosures on Medicaid Enrollment, Spending, and Flexibilities; Medicaid Spending; Medicaid Financing, Waivers, and Flexibilities; Medicare Telehealth Waivers; and Medicare Waivers.

[7] The provider groups included umbrella organizations representing four broad specialty types—primary care, medical, surgical, and mental and behavioral health specialties. We also interviewed two beneficiary advocacy groups with knowledge of Medicare beneficiaries' experience with Medicare telehealth.

[8] *See* Centers for Medicare and Medicaid Services, *Putting Patients First: The Centers for Medicare and Medicaid Services' Record of Accomplishments from 2017–2020* (January 13, 2021). We refer to this report as the CMS "Accomplishment Report" throughout this report.

[9] *See* Kaiser Family Foundation, *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID–19,* accessed May 10, 2021, *https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/*.

BACKGROUND

Medicare Waivers and Flexibilities

In 2020, Medicare—the federally financed health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease—spent about $910 billion on health-care services provided to about 62.8 million Medicare beneficiaries.[10] Providers and suppliers furnishing services to beneficiaries must comply with Medicare requirements and conditions of participation that are set in statute and regulations. In response to COVID–19, CMS expanded the availability of Medicare services through widespread use of program waivers. Specifically, section 1135 of the Social Security Act authorizes the Secretary of HHS to temporarily waive or modify certain Federal health-care requirements, including in the Medicare program, to increase access to medical services when both a public health emergency and a disaster or emergency have been declared.[11] The Administrator of CMS typically implements section 1135 waivers for Medicare.

The president authorized HHS to issue waivers under section 1135 beginning March 1, 2020. This authority will end no later than the termination of one of the underlying emergencies or 60 days from the date the waiver is published, unless the Secretary extends it for additional periods of up to 60 days.

There are two types of Medicare 1135 waivers:

- **Blanket waivers** apply automatically to all applicable providers and suppliers in the emergency area, which encompasses the entire United States in the case of the COVID–19 pandemic. Providers and suppliers do not need to apply individually or notify CMS that they are acting upon the waiver. They are required to comply with normal rules and regulations as soon as it is feasible to do so.
- **Provider/supplier individual waivers** may be issued upon application for States, providers, or suppliers only if an existing blanket waiver is not sufficient.

Congress also enacted legislation to expand the Secretary's authority to temporarily waive or modify application of certain Medicare requirements, such as the geographic restrictions on where telehealth services can be provided. The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, amends section 1135 of the Social Security Act to allow the Secretary to waive certain Medicare telehealth payment requirements during the emergency period.[12] The CARES Act further expands the Secretary's authority to waive telehealth requirements during the emergency period.[13]

Medicaid Waivers and Flexibilities

Medicaid is one of the Nation's largest sources of funding for health-care services for low-income and medically needy individuals, covering an estimated 77 million people and spending an estimated $673 billion (total Federal and State) in fiscal year 2020. Medicaid allows significant flexibility for States to design and implement their programs. For example, States can request waivers of certain Federal requirements to target certain populations or to test new or innovative approaches for managing the health-care needs of beneficiaries. In addition to its normal authority to approve these State waiver applications, CMS has additional authorities to waive Medicaid requirements to help ensure the availability of care in certain emergency circumstances.

Since the beginning of the COVID–19 pandemic, CMS has issued guidance to States on implementing various flexibilities and on resuming normal activities once the public health emergency has ended. (See fig. 1.)

---

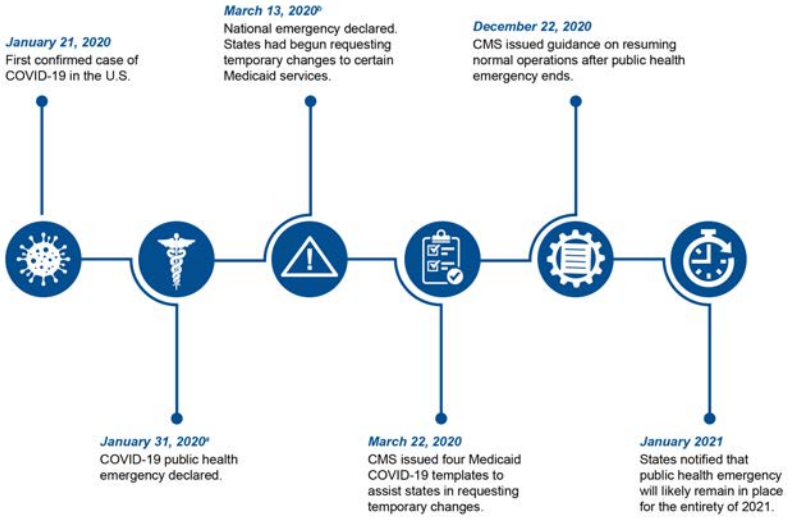
[10] Total Medicare spending is for fiscal year 2020 and from the Centers for Medicare and Medicaid Services' Office of Financial Management. Count of Medicare beneficiaries is for calendar year 2020 and from the Centers for Medicare and Medicaid Services' Medicare Enrollment Dashboard. *See https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard;* accessed May 12, 2021.

[11] *See* 42 U.S.C. § 1320b–5 (authority to waive requirements during national emergencies).

[12] Pub. L. No. 116–123, Div. B, § 102, 134 Stat. 146, 155–157 (adding 42 U.S.C. § 1320b–5(b)(8)).

[13] Pub. L. No. 116–136, § 3703, 134 Stat. 281, 416 (2020) (amending 42 U.S.C. § 1320b–5(b)(8)).

Figure 1: Selected CMS Medicaid Guidance to States during the COVID-19 Pandemic, January 2020 to January 2021



Legend: CMS=Centers for Medicare & Medicaid Services.

Source: GAO analysis of Department of Health and Human Services and CMS guidance. | GAO-21-575T

Note: Beyond the selected guidance noted in the figure, CMS officials have noted other steps related to states' implementation of various flexibilities. For example, CMS shared the Medicaid Disaster Relief Toolkit with states in March, 2020. According to CMS officials, the toolkit—first made available in August 2018—was designed for states and served as a foundation for available state flexibilities. CMS also held numerous all-state calls, as well as individual calls with each state and territory in early- to mid-March, 2020.

[a]The declaration of the public health emergency was retroactive to January 27, 2020.

[b]The declaration of the national emergency was retroactive to March 1, 2020.

For example, CMS created and released four templates to help States receive Federal waivers and assist them in identifying other authorities to implement program flexibilities more efficiently. Specifically, CMS issued templates for four authorities for the following purposes:

- **Medicaid disaster State plan amendments:** To revise or implement new policies in Medicaid State plans related to eligibility, enrollment, benefits, premiums and cost sharing, or payments in response to a public health emergency or disaster.
- **Section 1115(a) demonstrations:** To furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID–19.[14]
- **Section 1135 waivers:** To temporarily waive or modify certain Medicaid requirements to ensure that sufficient health-care items and services are available to meet the needs of individuals enrolled in the respective programs and that health-care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID–19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.
- **Section 1915(c), Appendix K waivers:** To request amendment to an approved section 1915(c) home and community-based waiver authority to re-

[14] Under section 1115 of the Social Security Act, the Secretary of HHS may waive certain Federal Medicaid requirements and approve expenditures that would not otherwise be eligible for Federal Medicaid funds for certain experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives.

spond to an emergency, for example, expanding the pool of providers authorized to provide waiver services such as personal care.[15]

FULL EFFECTS OF MEDICARE WAIVERS NOT YET KNOWN; PRELIMINARY ANALYSIS INDICATES MEDICARE FEE-FOR-SERVICE TELEHEALTH WAIVERS INCREASED UTILIZATION AND ACCESS

CMS Has Issued Hundreds of Medicare Waivers During the COVID–19 Pandemic

According to the CMS Accomplishment Report, as of January 2021, CMS had issued over 130 blanket Medicare waivers nationwide since the start of the pandemic. The blanket waivers cover flexibilities for hospitals, skilled nursing facilities, home health agencies, and hospices, among others. They also cover flexibilities for providers, including licensing and enrollment, to the extent these flexibilities are consistent with applicable State laws, State emergency preparedness plans, and State scope of practice rules. For example, CMS waived or modified certain telehealth provisions to increase access to services and give providers more flexibility in treating beneficiaries.

In addition to blanket waivers of statutory requirements, CMS also reported that as of January 2021, it had issued over 100 Medicare waivers under its authority to waive or modify its policies or regulations in response to the pandemic. CMS has since made some of these waivers permanent.[16] Table 1 provides examples of changes that CMS approved, including under blanket waivers.[17]

Table 1: Examples of Medicare Waivers CMS Approved, Since March 13, 2020

Waiver	Changes
Increased capacity	• Expand hospital capacity—for example, hospitals may provide patient care at nonhospital buildings or spaces provided that the location is approved by the State, and hospitals may treat patients in their own homes.[a] • Allow hospitals to set up alternative screening sites on campus to perform medical screening examinations as a triage function.[b] • Waive sanctions for certain referrals that would otherwise violate the Physician Self-Referral law that generally prohibits a physician from making referrals for certain health-care services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies.[c]
Workforce expansion	• Expedite process for provider enrollment in Medicare, including expediting pending or new applications and waiving certain criminal background checks. • Allow physicians whose privileges to practice at a hospital will expire to continue practicing at the hospital and allowing new physicians to begin practicing before full approval.
Reducing administrative burdens	• Temporarily eliminate certain reporting and other paperwork requirements that providers must complete to be paid by Medicare, such as program audits that may require additional information from providers.

[15] Under section 1915(c) of the Social Security Act, the Secretary of HHS may waive requirements that States offering home- and community-based services offer comparable benefits statewide and to all eligible beneficiaries, and that they use a single standard for eligibility.

[16] For example, in December 2020, CMS announced it was permanently adding certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic.

[17] For more information on all COVID–19 related waivers approved by CMS, *see* Centers for Medicare and Medicaid Services, *Coronavirus Waivers and Flexibilities,* accessed May 11, 2021, *https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.*

Table 1: Examples of Medicare Waivers CMS Approved, Since March 13, 2020—Continued

Waiver	Changes
Expansion of telehealth services	• Allow telehealth services to be provided nationwide, rather than only in certain locations. • Allow beneficiaries to receive, and providers to furnish, telehealth services from any setting, including beneficiaries' and providers' homes. • Allow additional types of providers, such as physical and occupational therapists, to furnish telehealth services. • Temporarily add over 146 new telehealth services. • Allow certain services to be furnished using audio-only technology such as telephones, instead of interactive systems involving video technology.

Source: GAO analysis of Centers for Medicare and Medicaid Services (CMS) information. | GAO–21–575T

[a] Hospitals typically must meet certain requirements to participate in Medicare, including providing services within their own buildings.

[b] By law, any Medicare-participating hospital with a dedicated emergency department must provide a medical screening examination and, if necessary, stabilizing treatment to any individual who arrives in its emergency department for examination or treatment, regardless of the ability to pay for the services.

[c] Entities that submit claims for services furnished pursuant to a prohibited referral are subject to financial sanctions.

Full Effects of Medicare Waivers Are Not Yet Known

Information on the full effects of Medicare waivers and flexibilities is not yet available. However, in its Accomplishment Report, CMS provided information on certain flexibilities in January 2021. For example:

- **Expansion of hospital capacity.** CMS reported that the waiver permitting hospitals to use non-hospital buildings and spaces to be used for patient care and quarantine sites (subject to State approval), has expanded access to care during the pandemic. For example, according to CMS, as of January 2021, 116 facilities in Texas were enrolled as hospital sites under a waiver that allowed ambulatory care centers and freestanding emergency centers to enroll as hospitals—thus increasing access to care. Additionally, CMS reported as of January 7, 2021, it had approved 63 hospitals in 21 States nationwide to participate in the waiver that allowed hospitals to treat patients in their own homes.[18]
- **Workforce expansion.** CMS reported that the removal of certain barriers regarding licensure and scope of practice has expanded the provider workforce enabling health professionals to provide services they were otherwise not eligible to provide, subject to State law. For example,
  - Certain non-physician practitioners such as nurse practitioners and physician assistants can supervise the performance of diagnostic tests, subject to State law.
  - Occupational therapists from home health agencies can now perform initial assessments on certain homebound patients, allowing home health services to start sooner and freeing home- health nurses to do more direct patient care.

However, the Accomplishment Report did not contain information on the extent to which these added flexibilities have resulted in greater access to services for Medicare beneficiaries.

CMS's Accomplishment Report also did not contain information on the effects of other flexibilities—including waivers granting provider enrollment flexibilities or waivers that reduced administrative burdens—on Medicare services during the pandemic. In future work, we will examine the impact of these and other waivers and flexibilities that HHS issued in response to the pandemic.

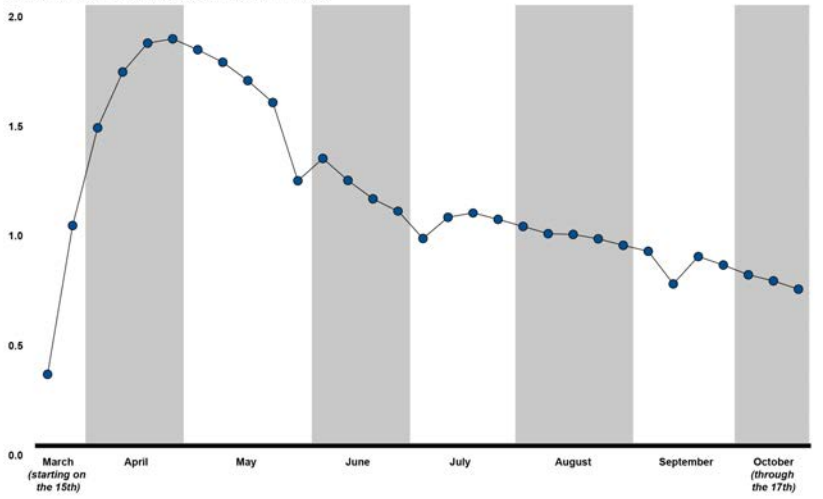
[18] These include six health systems with extensive pre-pandemic experience providing acute hospital care at home—Brigham and Women's Hospital (Massachusetts); Huntsman Cancer Institute (Utah); Massachusetts General Hospital (Massachusetts); Mount Sinai Health System (New York City); Presbyterian Healthcare Services (New Mexico); and UnityPoint Health (Iowa).

Medicare Telehealth Waivers Increased Utilization and Access

As we reported in November 2020, Medicare telehealth waivers resulted in increased utilization of telehealth services, and provided beneficiaries access to services that would not have otherwise been available during the early days of the COVID–19 pandemic. However, the long-term effect of these waivers on spending and quality of care is not yet known.[19] In addition, we reported that careful monitoring and oversight is warranted to prevent potential fraud, waste, and abuse that can arise from these new waivers. Existing research and preliminary observations from our ongoing work indicate the following effects of telehealth waivers on service utilization and access to care.

Available analysis from the CMS Accomplishment Report indicates that over the first 8 months of the pandemic, utilization of telehealth services in Medicare FFS sharply increased from about 325,000 services in mid-March to a peak of nearly 1.9 million services in late-April.[20] Utilization then dropped to about 1.3 million services by the beginning of June, and generally continued to slowly drop through mid-October, as shown in figure 2.[21]

Figure 2: Medicare Weekly Utilization of Telehealth Services from March 15 through October 17, 2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-575T

Note: The data for this analysis are based on Medicare fee-for-service claims submitted through 11/13/2020. These figures include telehealth services as well as other services such as virtual check-ins and e-visits, which collectively CMS defines as telemedicine. Virtual check-ins are short patient-initiated communications with a health care practitioner through different technologies including by phone or video. E-visits are non-face-to-face patient-initiated communications through an online patient portal. Medicare covered and paid for virtual check-ins and e-visits prior to the pandemic.

[19] *See* GAO–21–191.

[20] The data for this analysis are based on Medicare FFS claims submitted through November 13, 2020. These figures include telehealth services as well as other services such as virtual check-ins and e-visits, which collectively CMS defines as telemedicine. Virtual check-ins are short patient-initiated communications with a health-care practitioner through different technologies including by phone or video. E-visits are non-face-to-face patient-initiated communications through an online patient portal. Medicare covered and paid for virtual check-ins and e-visits prior to the pandemic.

[21] CMS did not provide data on corresponding utilization of in-person services for all services furnished via telehealth during this time. An analysis of telehealth utilization of primary care services from the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation showed similar trends in telehealth utilization. Their analysis also showed that while telehealth primary care services were peaking from mid-March through mid-April, in-person services were precipitously dropping during this time, and that the peak in telehealth services was not sufficient to offset the drop in in-person services. *See* Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of COVID–19 Pandemic* (Washington, DC: July 28, 2020).

This utilization varied by the type of service, the specialty of the provider, and the telehealth modality (audio-video or audio only). For example, CMS reported that nearly 40 percent of beneficiaries receiving office visits received them through telehealth compared to nearly 60 percent for mental health services. CMS also reported that internists and family practitioners furnished about one-quarter of their services through telehealth compared to virtually none for other specialties. In addition, CMS reported that many (89 out of 146) of the newly available types of telehealth services could be furnished through landline phones.

Moreover, CMS reported that telehealth waivers played a critical role in maintaining access to services when beneficiaries and providers were concerned about the transmission of COVID–19. For example, before the pandemic, approximately 13,000 beneficiaries in Medicare FFS had received telehealth services in a week, compared to almost 1.7 million in the last week of April. CMS also reported that there was some variation in the levels of access among various groups of beneficiaries utilizing telehealth services. For example, a slightly higher proportion of beneficiaries below the age of 65 received a telehealth service, compared to groups aged 65 and over; the proportion of beneficiaries receiving telehealth services in urban areas was slightly higher than in rural areas; but the proportion of beneficiaries utilizing telehealth was similar across racial and ethnic groups. (See fig. 3.)

Preliminary observations from our interviews with groups representing providers and beneficiaries confirmed flexibilities enabled beneficiaries to continue accessing care. Specifically, representatives we interviewed from two provider groups said providers quickly adopted and furnished telehealth services in the early days of the pandemic, but as patients became more comfortable coming into the office or clinic, in-person appointments resumed. Representatives from one provider group also told us that they relied more heavily on audio-only or phone visits rather than video visits in the early days of the pandemic and switched later on to offering only in-person or video visits. Interviews with two groups representing beneficiaries indicated that telehealth flexibilities have enabled beneficiaries to access care from home during the pandemic, as well as the ability to seek care in a timely manner, reduce travel time, and triage their health issues to determine if an in-person visit is needed.

However, as we noted in our June 2020 report, telehealth waivers may not alleviate all access concerns.[22] Further, a recent study found that more than 26 percent of Medicare beneficiaries lack digital access at home in 2018, making it unlikely that they could have video-based telehealth visits with clinicians.[23] The proportion of beneficiaries in this study who lacked digital access was higher among those with low socioeconomic status, those 85 years or older, and in communities of color. Preliminary observations from our beneficiary and provider group interviews is consistent with these findings. For example, representatives from the two beneficiary groups and three groups representing providers told us that some beneficiaries were unable to access telehealth services due to lack of technology or broadband needed for a telehealth visit or they did not understand how to use the technology.

Furthermore, the quality of telehealth services provided to Medicare beneficiaries has not yet been fully analyzed, and evidence from the few existing studies is inconclusive. According to MedPAC, some researchers have concluded that, in addition to increasing access to care, telehealth can also improve the quality of care.[24] Other researchers caution that the convenience of telehealth could harm the quality of patient care.[25] CMS officials told us in February 2021 that they are still exploring how to measure the quality of care when services are delivered via telehealth.

---

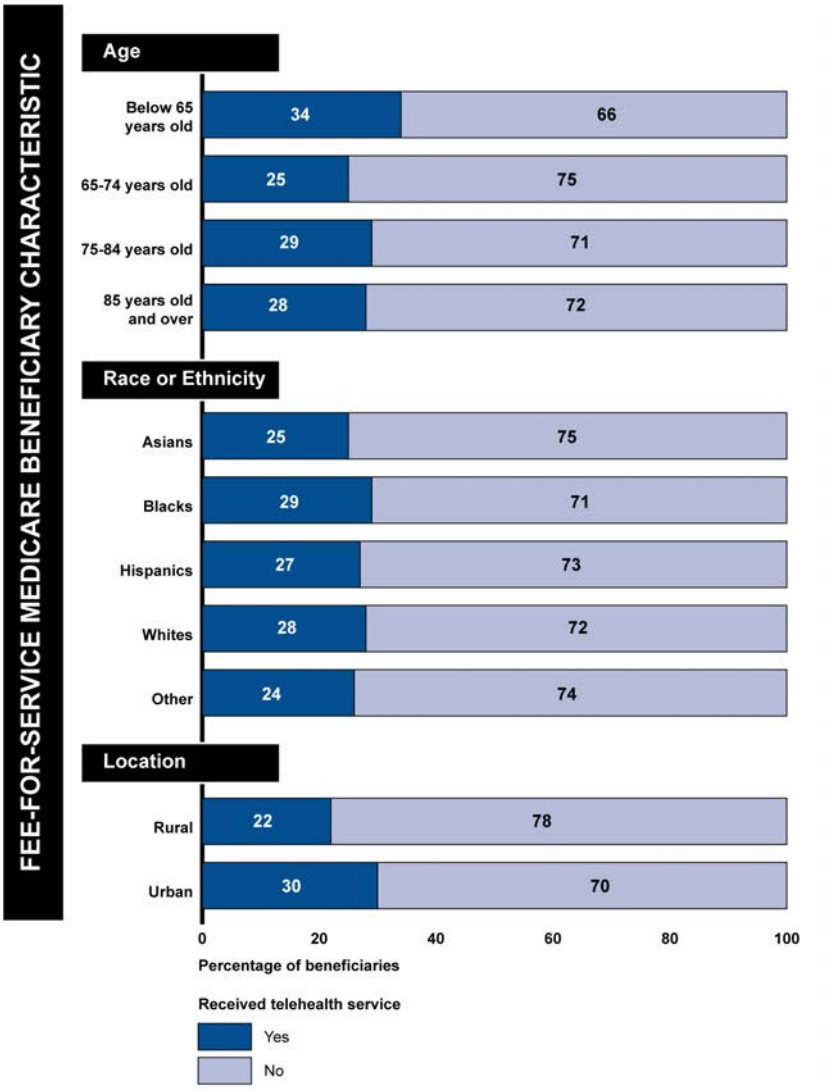
[22] *See* GAO–20–625.

[23] Eric Roberts and Ateev Mehrotra, "Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine," *The Journal of American Medical Association Internal Medicine,* vol. 180, no. 10 (2020): pp. 1386–1389.

[24] For example, in 2018 MedPAC reported that telestroke services both expanded access to care and likely improve the quality of care because the timeliness of stroke treatment could be improved. MedPAC, Report to Congress: Medicare Payment Policy (March 2018): 496.

[25] For example, a 2015 study of patients receiving treatment for acute respiratory infections found that physicians providing care through telehealth prescribed more expensive antibiotics that could increase antibiotic resistance in patients than antibiotics prescribed by physicians providing in-person care. *See* L. Uscher-Pines, et al., "Antibiotic Prescribing for Acute Respiratory Infections in Direct-to-Consumer Telemedicine Visits," *JAMA Internal Medicine,* vol. 175, no. 7 (2015).

Figure 3: Percentages of Medicare Fee-for-Service Beneficiaries Receiving Telehealth Services, by Beneficiary Characteristics, March 17 through June 13, 2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-575T

Note: These figures include telehealth services as well as other services such as virtual check-ins and e-visits, which collectively CMS defines as telemedicine. Virtual check-ins are short patient-initiated communications with a health-care practitioner through different technologies including by phone or video. E-visits are non-face-to-face patient-initiated communications through an online patient portal. Medicare covered and paid for virtual check-ins and e-visits prior to the pandemic.

TEMPORARY STATE MEDICAID FLEXIBILITIES AIMED TO ADDRESS OBSTACLES TO BENEFICIARY CARE, PROVIDER AVAILABILITY, AND PROGRAM ENROLLMENT; EFFECTS NOT FULLY KNOWN

CMS-approved Medicaid waivers and flexibilities in all States were aimed at addressing obstacles that affect beneficiary care and provider availability, among other areas. In December 2020, CMS reported that the agency had approved more than 600 different Medicaid waivers, State plan amendments, and other flexibilities to offer States flexibility in responding to the COVID–19 pandemic. Some of the Medicaid flexibilities focused on facilitating beneficiary access to care and beneficiary safety. For example, CMS approved flexibilities regarding the provision of long-term services and supports to beneficiaries who receive care in facilities or in their homes and who were particularly vulnerable to exposure and disease. Other flexibilities focused on ensuring provider availability, such as allowing licensed out-of-State providers to enroll in a State's Medicaid program. (See table 2.)

Table 2: Examples of State Medicaid Waivers and Flexibilities Approved by CMS, March 2020 to May 2021

Focus	Specific State Flexibilities Approved
Beneficiary care and safety	• Forty-three States suspended fee-for-service prior authorizations, which are used to demonstrate compliance with coverage and payment rules before beneficiaries can obtain certain services, rather than after the services have been provided.[a] • Forty-nine States extended the dates for reassessing and reevaluating beneficiaries' needs, which are normally required for beneficiaries to retain eligibility for some home- and community-based services.[b] • Fifty States permitted virtual evaluations, assessments, and person-centered planning for beneficiaries receiving long-term services and supports normally conducted in person.[b] • Fifty-one States issued program guidance to expand coverage and access to telehealth services.[c] • Nine States allowed early refills for most medications.[c]
Provider availability	• Fifty-one States waived some requirements to allow licensed out-of-State providers to enroll in their programs to maintain provider capacity.[a, d] • Twelve States modified facility requirements to allow services to be provided from practitioner's location via telehealth.[c] • Fifty-one States waived certain provider screening and enrollment requirements during the pandemic.

Source: GAO analysis of Centers for Medicare and Medicaid Services (CMS) information complied by Kaiser Family Foundation, Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID–19, accessed May 10, 2021, *https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/*. | GAO-21-575T

Note: For purposes of the table, States include the 50 States and the District of Columbia.

[a] States received approval under section 1135 of the Social Security Act, which authorizes the Secretary of Health and Human Services to temporarily waive or modify certain Federal health-care program requirements, including Medicaid requirements, to ensure that sufficient health-care items and services are available to meet the needs of enrollees when both a public health emergency and a disaster or emergency have been declared.

[b] States received approval to make changes to their section 1915(c) home- and community-based services waivers under an Appendix K amendment in order to respond to the emergency.

[c] States received approval to revise policies in their Medicaid State plan related to eligibility, enrollment, benefits, premiums and cost sharing, and payments. To make these changes, States must submit a State Plan Amendment to CMS for approval.

[d] States approved to temporarily enroll licensed out-of-State providers must follow certain requirements, which include screening providers to ensure they are enrolled in the Medicaid program and licensed in the State relating to their Medicaid enrollment. Waiver of these Federal requirements does not affect State or local licensure requirements.

Among these flexibilities, we have reported that efforts to remove obstacles to beneficiary access to care, such as the use of telehealth, were among the most important during the COVID–19 pandemic.[26] A Medicaid official we interviewed in one State said that flexibilities permitting virtual evaluations provided Medicaid beneficiaries with an added sense of security and safety while providing needed care. We have ongoing work examining States' experiences using waivers to maintain safe access to home- and community-based services. To reduce in- person contact between

[26] *See* GAO–21–387.

beneficiaries and providers, CMS has approved waivers allowing family to become paid caregivers. In addition, waivers have been used to make retainer payments to certain providers to support and maintain the provider network.

In addition to waivers, recent statutory changes have aimed at maintaining Medicaid enrollment. For example, the Families First Coronavirus Response Act provided a temporary increase in the Federal Government's matching rate for States' and territories' spending for Medicaid services for all qualifying States through the end of the quarter in which the public health emergency, including any extensions, ends. To receive the increased matching rate, States and territories were required to meet certain conditions, such as maintaining Medicaid enrollment for certain beneficiaries through the end of the month in which the public health emergency ends.[27] In March 2021, we reported that from February 2020 through August 2020, Medicaid enrollment increased by 5.6 million, or 9 percent.[28]

Some preliminary effects of CMS-approved waivers and flexibilities and other flexibilities States permitted through law are known. CMS has reported an increase in telehealth utilization since the pandemic began—in particular, soon after the national emergency was declared. CMS has also reported variation in the use of telehealth across States and across ages within States.[29] As an example of this variation, in January 2021, a North Carolina Medicaid official reported that beneficiaries in urban geographies were more likely to use services delivered via telehealth than beneficiaries in rural geographies.

PROGRAM INTEGRITY, BENEFICIARY HEALTH AND SAFETY, AND EQUITY ARE AMONG CONSIDERATIONS FOR THE CONTINUED USE OF WAIVERS AND FLEXIBILITIES IMPLEMENTED DURING THE PANDEMIC

The waivers and flexibilities implemented in Medicare and Medicaid during the COVID–19 pandemic likely benefited providers and beneficiaries, yet determining whether—and if so, how—to continue them post-pandemic warrants consideration. CMS has made some Medicare waivers permanent, and, based on interest from policymakers and stakeholders, is considering doing so for other waivers. With respect to Medicaid, CMS has set an end date for some of the waivers and flexibilities and has issued guidance to States in December 2020 on resuming normal Medicaid operations after the end of the public health emergency.[30] In light of these impending decisions, our past work and the work of others suggest there are several issues, including program integrity, beneficiary health and safety, and equity, to consider.

Potential for increased spending. As we have previously reported, telehealth and other waivers pose risks of increased spending in both programs. Specifically,

- Recent data from the CMS Accomplishment Report indicates telehealth services continued as in-person visits began to ramp up in the third quarter of 2020. This suggests that increased demand for telehealth may continue even after the pandemic—an important consideration given payment incentives that may result from paying the same for telehealth and in-person services. One provider group that we interviewed also noted that these incentives may be particularly relevant for specialties that can provide and be paid for both in-person and additional telehealth services they generate compared to other procedure-based specialties that receive more global payments regardless of the number of visits they generate.
- The temporary waiver of sanctions for certain referrals that would otherwise violate the Physician Self-Referral Law may increase the potential for in-

[27] Specifically, States must provide continuous coverage to Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination, through the end of the month in which the public health emergency ends, among other requirements. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the State.

[28] *See* GAO–21–387.

[29] *See* CMS, *Medicaid and CHIP COVID–19 Summaries, Preliminary Medicaid and CHIP Data Snapshot of Services through July 31, 2020,* accessed May 10, 2021, *https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf.*

[30] *See* CMS, *RE: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID–19 Public Health Emergency* (Baltimore, MD: December 22, 2020).

creased spending in both programs given our prior work indicating that providers who self-refer tended to use more health-care services.[31]

Program integrity. Both the Medicare and Medicaid programs are on GAO's High-Risk List, in part due to concerns about fraud, waste, and abuse.[32] Increased program spending, the lack of complete data, and suspensions of some program safeguards increase these risks. For example:

- CMS lacks complete data to determine the telehealth modality being used (audio only or audio-video technology) or if services are originating from providers' and beneficiaries' homes, important information to consider in light of the aforementioned payment incentives and that the quality of telehealth services has not yet been fully analyzed.
- The non-enforcement of certain privacy and security rules to allow for telehealth flexibility raises concerns about the transmission of medical information over potentially insecure systems.[33]

In our ongoing work, CMS officials have noted oversight activities related to program integrity. As examples:

- CMS is using its Fraud Prevention System to identify potentially inappropriate Medicare claims for telehealth services prior to payment and to flag providers with suspicious billing patterns through post- payment screens.
- CMS is conducting and updating program integrity risk assessments for all Medicaid waivers and flexibilities issued as a result of the pandemic.

Beneficiary health and safety. Providing services while limiting beneficiary exposure to COVID–19 has been a difficult balance for CMS and states—and telehealth has been a large part of these efforts. The pandemic has also given rise to new levels of need for behavioral health care—both mental health and substance use disorders—while behavioral health service providers reported increasing demand and decreasing staff size.[34] Extending or ending waivers and flexibilities may affect beneficiary health and safety in unknown ways.

- In Medicare, we have previously reported that the effect of COVID–19 related waivers on quality of care is not yet known. We also noted earlier that the quality of telehealth services has not been fully analyzed, and evidence from the few existing studies is inconclusive.
- In Medicaid, preliminary data from CMS show outpatient mental health services for adults age 19 to 64 declined starting in March and continuing through July—despite CMS approving waivers and flexibilities to help ensure the availability of care.
- Expedited processes for provider enrollment, including waivers of normal screening and criminal background checks, could affect the quality of care provided to beneficiaries in both programs.

Issues of equity. We have previously reported that communities of color have been disproportionately affected by COVID–19 in terms of cases reported, hospitalizations, deaths, and rates of testing and vaccinations.[35] Disparate effects from COVID–19 extend to beneficiaries' receipt of services, as well. As we noted earlier, beneficiaries in urban areas received or were more likely to use telehealth services than beneficiaries in rural areas both in Medicare and in one State's Medicaid pro-

---

[31] GAO, *Medicare Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary,* GAO–14–270 (Washington, DC: April 30, 2014); GAO, *Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny,* GAO–13–525 (Washington, DC: July 19, 2013); GAO, *Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer,* GAO–13–445 (Washington, DC: June 24, 2013); GAO, *Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny,* GAO/HEHS–95–2 (Washington, DC: October 20, 1994).

[32] GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas,* GAO–21–119SP (Washington, DC: March 2, 2021).

[33] The HHS Office of Civil Rights (responsible for enforcing certain regulations relating to privacy and security of protected health information) stated that it would exercise enforcement discretion and not impose penalties for noncompliance with regulatory requirements during the pandemic.

[34] GAO, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID–19 Pandemic,* GAO–21–437R (Washington, DC: March 31, 2021).

[35] For example, Non-Hispanic black persons were hospitalized at almost 3 times the rate of non-Hispanic white persons when adjusting for age, and their death rates were 1.4 times higher than non-Hispanic white persons. *See* GAO–21–387.

gram. To ensure that all beneficiaries receive the best care possible, how waivers and flexibilities in both programs account for equity is an important consideration.

In summary, my testimony highlighted the various flexibilities and waivers implemented during the COVID–19 pandemic and provided preliminary information on how these flexibilities have likely benefitted providers and beneficiaries. Continuing these flexibilities after the public health emergency declarations end could increase certain risks to the Medicare and Medicaid programs. Careful consideration of these benefits and risks will be key to determining the path forward, especially given that both programs are on GAO's High-Risk List. We look forward to working with Congress as we continue our oversight of the Federal response to the COVID–19 pandemic.

Chairman Wyden, Ranking Member Crapo, and members of the committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

QUESTIONS SUBMITTED FOR THE RECORD TO JESSICA FARB

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. In your written testimony, you noted that the quality of telehealth services has not been fully analyzed.

What kind of information does GAO or CMS need to paint a complete picture of care quality when it comes to telehealth?

Answer. We will report on CMS's progress on this topic in our ongoing work on Medicare and Medicaid telehealth services, which we expect to issue in late 2021 and early 2022, respectively. As we reported in our testimony, CMS officials told us in February 2021 that they are still exploring how to measure the quality of telehealth services. Several organizations have been involved in developing quality measures for services delivered via telehealth. For example, in 2017 the National Quality Forum (NQF) developed a framework for measuring the quality of telehealth services, through a project funded by CMS. In January 2021, NQF announced that CMS had tasked it with updating the framework in light of the recent uptick in telehealth use.

Question. In your written testimony, you noted a couple of instances where the COVID–19 flexibilities benefit different populations disproportionately. Telehealth, for example, was utilized more by urban populations than their rural counterparts. One of the flexibilities enabled providers to deliver services within their scope of practice that they're normally not eligible to provide to Medicare beneficiaries. Typically, we see these scope expansions as disproportionately benefitting rural areas where provider shortages are more acute.

Has GAO found any patterns in the benefits of these scope expansions?

Answer. As we reported in our testimony, CMS provided certain Medicare scope of practice flexibilities during the pandemic to allow health professionals to provide services that they were not otherwise permitted to provide. For example, CMS allowed certain nonphysicians to supervise the performance of diagnostic tests that they were otherwise not eligible to provide, as permitted under State law. CMS data show that the proportion of beneficiaries in rural areas using telehealth significantly increased from October 2019 through June 2020. It is not clear how much of this increase was due to expansion of scope of practice versus lifting of other restrictions, such as allowing beneficiaries to receive services at home. In our ongoing work, we will report how these flexibilities affected beneficiary access to services in rural areas during the public health emergency.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. During the pandemic, telehealth has been an essential tool to get children the care that they need while minimizing risk. Although telehealth under Medicare has been a focus, close to 40 million children are enrolled in Medicaid.

What are the main policy changes we need to ensure this broader use of telehealth can be continued beyond the pandemic for children?

Answer. We have not done work specific to the broader use of telehealth for children. CMS-approved Medicaid waivers and flexibilities in all States were aimed at

addressing obstacles that affect beneficiary care and provider availability, among other areas. Among these flexibilities, we have reported that efforts to remove obstacles to beneficiary access to care, such as the use of telehealth, were among the most important during the COVID–19 pandemic. The temporary authorities CMS has approved will terminate based on the conclusion of the public health emergency unless the States make certain temporary changes permanent, for example, by submitting a State plan amendment for CMS's review and approval. We will continue to monitor CMS and State actions on temporary authorities, including in our ongoing work examining telehealth in Medicaid during COVID–19, which we expect to issue in early 2022.

Question. During COVID–19, many States adopted temporary changes to their telehealth policies, such as expanding the scope of services and providers able to furnish telehealth, relaxing of licensure requirements and modifying reimbursement policies. Many States legislatures have also begun the work to adopt more permanent telehealth policy changes.

How can the Federal Government best support State Medicaid programs in their efforts to expand telehealth?

Are there Medicaid supports, incentives, and learnings that Federal policymakers could provide'?

Answer. Medicaid allows significant flexibility for States to design and implement their programs. For example, States have the option to determine: whether to cover services provided through telehealth; which types of services provided through telehealth to cover, as long as such telehealth providers are recognized and qualified according to Medicaid statute and regulation; and how much to pay providers for services delivered through telehealth, as long as such payments do not exceed other program requirements.

Since the beginning of the COVID–19 pandemic, CMS created and released four templates to help States obtain Federal waivers and assist them in identifying other authorities to implement program flexibilities more efficiently. In our ongoing work examining telehealth in Medicaid during COVID–19, CMS officials have described efforts to share practices with States, for example through technical advisory group calls and Medicaid Integrity Institute offerings. We will continue to monitor these efforts through our ongoing work.

Question. COVID–19 has introduced additional stress and trauma for children and families. Telehealth, and particularly audio-only telehealth has been a crucial tool to connect children and adolescents to needed mental health-care services.

How can telehealth be best utilized to meet kids' mental health-care needs, and can you speak to the use of audio-only telehealth specifically?

Answer. We have not reviewed how telehealth can best be utilized to meet children's mental health needs. According to preliminary data from CMS, through October 31, 2020, primary, preventive, and mental health service use declined among children under age 19 starting in March 2020. The agency also noted that of all services examined in their analysis, the smallest rebound between March and October 2020 has been the mental health service use rates. Our ongoing work examining telehealth in Medicaid during COVID–19 will review selected States' considerations for delivering services via telehealth after the end of the public health. emergency, including via audio-only telehealth modality. As part of that ongoing work, CMS officials told us that the agency is monitoring services delivered via telehealth by modality, and that for services delivered via live audio/video, the agency is also examining monthly utilization of certain behavioral health services.

Question. As State Medicaid programs look at expanding their use of telehealth, it is particularly important that vulnerable populations like children are not negatively impacted. Policies must be looked at through a health equity lens, considering access to reliable and affordable broadband services, access to devices that support HIPAA-compliant telehealth platforms and coverage policies.

How can Medicaid programs work to ensure telehealth policies are equitable for children and mitigate potential inequities that may arise?

Answer. We have not conducted work on how to ensure telehealth policies are equitable for children and mitigate potential inequities across the Medicaid beneficiary population. However, as part of our ongoing work examining telehealth in Medicaid during COVID–19, we will continue to monitor CMS and State telehealth policies. As noted in the testimony statement, to ensure that all beneficiaries receive the best

care possible, how waivers and flexibilities account for equity is an important consideration.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. The COVID–19 pandemic laid bare the deep systemic inequities that exist in our Nation's health system. Telehealth creates opportunities to combat racial disparities. But, if policymakers fail to center health equity in their discussions around expanding telehealth and making pandemic-era flexibilities permanent, future telehealth policies could exacerbate inequity.

Ensuring that patients receive health services in a language they can understand is critical to maximizing health outcomes, and studies show that language-concordant care "enhances trust between patients and physicians, optimizes health outcomes, and advances health equity for diverse populations."[1]

What specific steps, if any, did CMS take to ensure that telehealth services provided during the pandemic were offered in languages that patients could understand?

Were these steps sufficient in ensuring that patients with limited English proficiency could access high-quality care during the pandemic?

What information, if any, exists on improvements that could be made to telehealth regulations (both generally and regarding flexibilities offered during the pandemic) to improve patient access to language-concordant services?

Answer. During the pandemic, CMS compiled a variety of resources on telehealth for minority populations, including individuals with limited English proficiency. For example, CMS developed a telehealth guide for health-care providers that included considerations for providing telehealth to special populations, including non-English speakers.[2] We have not assessed the effectiveness of these resources in ensuring access to care for these individuals, but equitable access to care will continue to be an important consideration in our work on delivery of services to Medicare and Medicaid beneficiaries during the pandemic, which we expect to report on in late 2021 and early 2022, respectively.

Question. The COVID–19 pandemic exacerbated substance use disorder across the country, with impacts disproportionately felt by communities of color.[3] In your testimony, you noted that preliminary Medicaid data "show outpatient mental health services for adults age 19 to 64 declined" from March through July 2020, "despite CMS approving waivers and flexibilities to ensure the availability of care." Medicare data on behavioral health was not yet fully analyzed or conclusive.

What information, if any, exists explaining why Medicaid (and to the extent data has become available, Medicare) mental health visits declined, despite efforts to expand access to services via telehealth and other flexibilities?

What lessons should policymakers take from this episode to app y to future efforts to expand access to mental health services during public health crises?

Answer. We do not have information explaining why Medicaid mental health visits declined for either population during this time frame. As you noted, preliminary CMS data show that Medicaid outpatient mental health services for adults age 19 to 64 declined from March through July 2020. In addition, preliminary CMS data through October 31, 2020 show that mental health service use also declined among children under age 19 starting in March 2020.

Some of our ongoing work could also provide additional information about efforts to expand behavioral health services to Medicaid beneficiaries. In addition to our work examining Medicaid telehealth services during COVID–19, we are also exam-

---

[1] BMC Medical Education, "The power of language-concordant care: A call to action for medical schools," Rose L. Molina and Jennifer Kasper, November 6, 2019, doi: 10.1186/s12909–019–1807–4.

[2] *See,* U.S. Department of Health and Human Services, *Stay Safe: Getting the Care You Need at Home,* Woodlawn, MD: revised May 2020, accessed June 9, 2021, available at *https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumerresources/c2c-covid-19-resources;* and U.S. Department of Health and Human Services, *Telehealth for Providers: What You Need to Know,* Woodlawn, MD: revised March 2021, accessed June 14, 2021, available at *https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf.*

[3] *Mass.gov,* "Opioid-related overdose deaths rose by 5 percent in 2020," May 12, 2021, *https://www.mass.gov/news/opioid-related-overdose-deaths-rose-by-5-percent-in-2020.*

ining State demonstrations that have established certified community behavioral health clinics, including steps States have taken to assess the effects of the demonstration on the health outcomes of beneficiaries, including beneficiaries with substance use disorders.

With respect to Medicare, telehealth for mental health care may be showing promise for beneficiaries. Specifically, CMS data show that 60 percent of beneficiaries receiving mental health services received them through telehealth between March 17th and June 13, 2020. In our ongoing work, we are examining trends in beneficiary use of Medicare services in 2019 and 2020, including by service type, such as mental and behavioral health services.

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. The improper payment rates in Medicare (6.27 percent in FFS, 6.78 percent in MA) are the lowest in nearly a decade, whereas the Medicaid improper payment rate has ballooned (21.36 percent).[4] Bringing the Medicare improper payment rate down over the years was surely not an easy feat. Given the propensity for our Federal health-care programs to be susceptible to waste, fraud, and abuse, policymakers and Federal agencies must continue to take action to safeguard these programs. The Medicare Payment Advisory Commission (MedPAC) previously noted that telehealth could enhance risks for fraud, waste, and abuse in Medicare, and the Commission recommended that the Centers for Medicare and Medicaid Services (CMS) implement additional safeguards to curb the potential for telehealth-related fraud and waste following the public health emergency.[5]

What features of the Medicare and Medicaid programs make telehealth services susceptible to fraud, waste, and abuse? Which feature has the greatest potential for such behavior?

Does CMS have the tools and resources necessary to expand telehealth services or provide flexibilities in a manner that does not exacerbate existing vulnerabilities in the Medicare and Medicaid programs?

Answer. With respect to telehealth in the Medicare program, as we reported in our testimony, the suspension of some program safeguards-such as the non-enforcement of certain privacy and security rules to allow for telehealth flexibility-can increase these vulnerabilities. Telehealth waivers can also increase spending if these services are furnished in addition to in-person services. As noted in our testimony, assessing the impact of some flexibilities will be challenging because CMS lacks complete data—for example, with respect to the telehealth modality being used (audio-only or audio-video technology). In the Medicaid program, one-third of improper payments are related to States' noncompliance with provider screening and enrollment requirements-an area where flexibilities have been increased, and oversight decreased.[6]

Question. Your testimony noted that CMS is conducting program integrity risk assessments for all of pandemic-related waivers and flexibilities in the Medicaid program.

Has the Department of Health and Human Services established a timeline or plan for the completion of these integrity risk assessments?

Answer. According to CMS officials, the risk assessments are an ongoing process and may be updated, for example, when certain risk mitigation strategies are implemented. In April 2021, CMS officials said that the agency was developing a webinar and toolkit for States to conduct risk assessments. We will continue to monitor these actions as part of our ongoing work examining telehealth in Medicaid during COVID–19.

---

[4] "2020 Estimated Improper Payment Rates for Centers for Medicare and Medicaid (CMS) Programs," CMS, November 16, 2020, *https://www.cms.gov/newsroom/fact-sheets/2020-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs.*

[5] "Telehealth in Medicare After the Coronavirus Public Health Emergency," Medicare Payment Advisory Commission (MedPAC), *http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch14_sec.pdf?sfvrsn=0.*

[6] GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas,* GAO–21 119SP (Washington, DC: March 2, 2021).

Question. Your testimony also noted that CMS currently lacks data on certain aspects of telehealth visits that could be important in determining the quality outcomes of telehealth services.

What data is needed in order to measure the effects of telehealth services on patient outcomes? Has the Department of Health and Human Services established a timeline or plan for developing these type of measures?

Answer. As reported in our testimony, regarding Medicare, CMS lacks complete data to determine the telehealth modality being used (audio-only or audio-video technology) or if services are originating from providers' and beneficiaries' homes—important information to consider in light of the fact that the quality of telehealth services has not yet been fully analyzed. As part of our ongoing work examining telehealth in Medicaid during COVID–19, CMS officials told us that the agency is monitoring services delivered via telehealth by modality, and that for services delivered via live audio-video, the agency is also examining monthly utilization of certain services.

Several organizations have been involved in developing quality measures for services delivered via telehealth. For example, in 2017, the National Quality Forum (NQF) developed a framework for measuring the quality of telehealth services through a project funded by CMS and was tasked with updating this framework in January 2021, in light of the recent uptick in telehealth use. As we reported in our testimony, CMS officials told us in February 2021 that they are still exploring how to measure the quality of telehealth services. We will report on CMS's progress on this topic in our ongoing work on Medicare and Medicaid telehealth services, which we expect to issue in late 2021 and early 2022, respectively.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Throughout the public health emergency, the Centers for Medicare and Medicaid Services (CMS) issued over 200 waivers under Medicare and approved more than 600 waivers and other flexibilities under Medicaid. While some of the regulations waived are specifically for responding to a pandemic, ensuring patient safety, controlling costs, and maintaining program integrity its clear innovation and common sense ideas in our health-care system have been stifled too often by Federal regulations. For example, CMS permanently added certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic. Some regulations play an important role in protecting safety and maintaining program integrity but others may stifle good ideas.

Is health care too regulated that it's stifling good ideas?

Should executive agencies sunset regulations in the future to enable more innovation in health care?

Answer. CMS issued hundreds of waivers in the Medicare and Medicaid programs to ensure beneficiary access to services during the pandemic. We reported in our testimony that telehealth waivers in particular were instrumental in providing safe access to services that beneficiaries would otherwise not have had. In addition to implementing rapid innovations through waivers and flexibilities, as we reported in March 2018, CMS is also testing new approaches to health-care delivery and payment in both programs through its Center for Medicare and Medicaid Innovation Center, and, as of March 1, 2018, had implemented 37 models to reduce spending and improve the quality of care.[7]

Our prior work examining States' views on the impact of Federal Medicaid policies on their programs also highlights key considerations with respect to any potential changes to program oversight. In this work, States identified a range of Federal laws, regulations, and procedures that affected their ability to efficiently administer their Medicaid programs. In considering potential Federal actions to address these challenges, we identified a series of tradeoffs and considerations, including (1) targeting Federal oversight to critical areas, such as to reduce improper payments or to manage other program risks; (2) having accurate and complete data on key measures, such as beneficiary access, service use, and related costs, to inform any potential change; and (3) balancing States' ongoing efforts to waive statutory require-

[7] GAO, *CMS Innovation Center: Model Implementation and Center Performance,* GAO–18–302 (Washington, DC: March 26, 2018).

ments with an appropriate level of oversight, as historically we have identified multiple instances where improved oversight of such efforts was warranted.[8]

Question. At the beginning of the public health emergency (PHE), Congress provided the Health and Human Services (HHS) Secretary with authority to waive Medicare requirements for telehealth payment during the PHE. This allowed more than 140 telehealth services to be provided that previously were not allowed or were limited. Some limitations included a lack of payment parity, geographic limitations on where services are provided, and restrictions on audio-only telehealth services. Similar flexibilities were granted to States under Medicaid. Most of these flexibilities will be go away once the PHE ends. MedPAC reports "there is not yet evidence on how the combination of telehealth and in-person care affects quality and costs in the Medicare program."

Your written testimony mentioned that the "Medicare and Medicaid programs are on GAO's high-risk list" when it comes to telehealth "in part due to concerns about fraud, waste, and abuse." While the public health emergency is still in place, what program integrity measures should CMS put in place to stop these high-risk activities?

Answer. As reported in our testimony, telehealth services can pose heightened program integrity risks to the Medicare and Medicaid programs stemming from increased program spending, the lack of complete data, and suspens1dns of some program safeguards. Our ongoing work on Medicare telehealth services, which we expect to issue in late 2021, will examine the telehealth-related vulnerabilities CMS has identified and control activities the agency has put in place to address them.

We also reported in our testimony that CMS is conducting and updating program integrity risk assessments for all Medicaid waivers and flexibilities issued as a result of the pandemic. According to CMS officials, the risk assessments He an ongoing process and may be updated, for example, when certain risk mitigation strategies are implemented. In April 2021, CMS officials said that the agency was developing a webinar and toolkit for States to conduct risk assessments. We will continue to monitor these actions as part of our ongoing work examining telehealth in Medicaid during COVID–19, which we expect to issue in early 2022.

Question. Your written testimony mentioned that the "quality of telehealth services has not been fully analyzed." What quality metrics should GAO and Congress be using?

Answer. We will report on CMS's progress on this topic in our ongoing work on Medicare and Medicaid telehealth services. CMS has tasked the National Quality Forum with updating its framework for assessing the quality of telehealth services, and in February 2021, CMS officials told us that they are still exploring these measures.

Question. Is GAO looking at the Medicare Advantage telehealth experience prepandemic and throughout the pandemic to inform its recommendations? If so, what kind of data does GAO have and how is it using that data to inform recommendations?

Answer. Our ongoing work on Medicare telehealth services focuses on the fee-for-service program through data analysis and interviews with selected payer and other stakeholders. To the extent these interviews provide insights into telehealth services in the Medicare Advantage program, we will discuss these in our ongoing work.

Question. Expanding Medicare FFS telehealth after the PHE ends should consider implications of federalism including scope-of-practice, medical malpractice, and credentialing and licensing. What other federalism considerations should Congress take into account when determining telehealth expansion in Medicare FFS?

Answer. We have no plans at this time to explore these issues in our ongoing work on Medicare telehealth services.

---

[8] GAO, *Medicaid: State Views on Program Administration Challenges,* GAO–20–407 (Washington, DC: April 30, 2020).

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. Before coming to the Senate, I had the privilege of practicing medicine in Wyoming. Rural health care faced challenges prior to the pandemic. In particular, we know since 2010 more than 135 rural hospitals have closed.

In the Senate, I am proud to help lead the bipartisan Rural Health Caucus. This group is committed to ensuring patients in rural America can get access to the care they need.

Can you specifically discuss the changes in Federal health-care policy that you believe have helped rural providers the most during this pandemic?

Can you please discuss any specific changes that Congress should consider to better support rural health-care providers?

Answer. As we noted in our testimony, Medicare telehealth waivers enabled beneficiaries in both rural and urban areas to receive care from their home. A July 2020 Issue Brief from the Assistant Secretary for Planning and Evaluation indicated that utilization of telehealth in rural areas increased significantly between March and April 2020.[9] However, as we also noted in our testimony, disparate effects from COVID–19 extend to beneficiaries' receipt of services. Beneficiaries in urban areas received more telehealth services or were more likely to use telehealth services than beneficiaries in rural areas both in Medicare and in one State's Medicaid program. Additionally, providers face challenges offering telehealth services due in part to limited patient access to broadband Internet. Specifically, in March 2021, we reported that as of February 18, 2021, the Federal Communication Commission's COVID–19 Telehealth Program had disbursed $143.2 million in awards to eligible providers, including funding targeted towards patient care in rural populations.[10] While we have not assessed the changes that helped rural providers the most during the pandemic, we have reported on rural health care in our ongoing COVID–19 reporting, for example, on Provider Relief Fund allocations and disbursements to rural health-care facilities and Veterans Health Administration outreach to rural veterans.[11] We will continue to monitor beneficiaries' receipt of services in urban and rural areas as part of our ongoing work examining telehealth in both programs during COVID–19, which we expect to issue in late 2021 and early 2022, respectively.

Question. Prior to the pandemic, I introduced bipartisan legislation with Senator Tina Smith, which among other things, would allow Rural Health Clinics (RHCs) to provide more telehealth services.

I was pleased that Congress through the CARES Act authorized both Rural Health Clinics and Federally Qualified Health Centers to furnish telehealth services to Medicare beneficiaries during the public health emergency.

Can you discuss the importance of Rural Health Clinics and Federally Qualified Health Centers continuing to provide telehealth services after the public health emergency has ended?

Answer. As we noted in our testimony, CMS waived or modified certain telehealth provisions to increase access to care and give providers more flexibilities in treating beneficiaries. We also noted in our testimony that telehealth has been a major part of efforts to provide services while limiting beneficiary exposure to COVID–19, and that extending or ending waivers and flexibilities may affect beneficiary health and safety in unknown ways. We will continue to monitor utilization of telehealth services, including telehealth services utilized by geographic location, as part of our ongoing work examining Medicare telehealth waivers.

Question. My wife Bobbi and I are passionate about improving access to mental health services. This pandemic has clearly impacted the mental, as well as the physical health of our Nation.

---

[9] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of COVID–19 Pandemic* (Washington, DC: July 28, 2020). ASPE reported that the proportion of weekly rural primary care visits delivered via telehealth increased from virtually none prior to the pandemic to about 25 percent mid-April before gradually decreasing to about 10 percent by May.

[10] GAO, *COVID–19: Sustained Federal Action Is Crucial as Pandemic Enters Its Second Year,* GAO–21–387 (Washington, DC: March 31, 2021).

[11] For example, *see* GAO, *COVID–19: Opportunities to Improve Federal Response and Recovery Efforts,* GAO–20–625 (Washington, DC: June 25, 2020); GAO, *COVID–19: Urgent Actions Needed to Better Ensure an Effective Federal Response,* GAO–21–191 (Washington, DC: November 30, 2020); and GAO–21–387.

For people living in rural America, getting help from a mental health provider was challenging before the pandemic. This is why Senator Stabenow and I have long supported professional counselors and marriage and family therapists participating in Medicare. We believe that increasing the number of mental health providers able to care for our Nation's seniors is an important priority.

Please discuss how telehealth has impacted the ability of patients to receive mental health services during the pandemic.

Can you please identify ways Congress can improve access to mental health services, including expanding the number of providers that can participate in Medicare?

Answer. Access to mental health services remains a growing concern as the pandemic continues. As we noted in our testimony, in Medicaid, preliminary data from CMS show outpatient mental health services for adults age 19 to 64 declined starting in March and continuing through July—despite CMS approving waivers and flexibilities to help ensure the availability of care. In March 2021, we reported on longstanding concerns about the availability of behavioral health treatment, particularly for low-income individuals.[12] Evidence collected during the pandemic suggests the prevalence of behavioral health conditions has increased, while access to in-person behavioral health services has decreased. In our March 2021 report, we reiterated a 2019 recommendation that the Federal agencies involved in the oversight of mental health parity requirements evaluate the effectiveness of their oversight efforts. As of March 2021, the agencies had not yet implemented this recommendation.

Telehealth may help provide access to mental and behavioral health services for beneficiaries. In our March 2021 report, we reported that the increased use of and payment for telehealth has had a positive effect during the pandemic, leading to improved access to behavioral health services for some patients and resulting in fewer missed appointments, according to most stakeholders. Further, CMS data show that 60 percent of Medicare beneficiaries receiving mental health services received them through telehealth between March 17th and June 13, 2020. We will continue to monitor utilization of telehealth services, including mental and behavioral health services, as part of our ongoing work examining Medicare telehealth waivers.

PREPARED STATEMENT OF NARAYANA MURALI, M.D., BOARD MEMBER, AMERICA'S PHYSICIAN GROUPS; AND EXECUTIVE DIRECTOR, MARSHFIELD CLINIC

Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. My name is Dr. Narayana Murali, and I serve as the executive vice president of care delivery and chief strategy officer of the Marshfield Clinic Health System. I also serve as the executive director of Marshfield Clinic, headquartered in Marshfield, WI. It is my honor to be here today to discuss this important topic.

It is my privilege to testify on behalf of America's Physician Groups and myself. APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care to nearly 45 million patients. It is the vision of APG's member organizations to transition from the fee-for-service (FFS) reimbursement system to a value-based system where physician groups are held accountable for the cost and quality of care they provide to their patients. APG's preferred model of capitated, delegated, and coordinated care, eliminates incentives for waste associated with Fee for Service reimbursement. I am here to make the case for permanently supporting the telehealth flexibilities created in during the PHE, with some refinements.

Since the outset of the pandemic, APG members in all 50 States have risen to the challenge presented by COVID–19. Our members have been at the forefront of caring for patients, as well as the communities we serve from coast to coast. The challenges have been immense, and the risks associated with COVID–19 remain serious today. However, the lessons and experiences we have gained—as difficult as it has been at times—can serve as opportunities to embrace changes, so we can continually improve services we provide to our patients and communities. This is especially true when it comes to the waivers and flexibilities made available to address the Nation's current public health emergency (PHE). The widespread adoption and utilization of telehealth services in a variety of health-care settings have been life-

---

[12] GAO, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID–19 Pandemic,* GAO–21–437R (Washington, DC: March 31, 2021).

lines to patients, ensuring access and continuity of care during some of the darkest days of the pandemic when alternatives were non-existent. This is particularly true for those physician groups that have moved away from FFS (where earnings are tied to volume of services rendered) *and* are participating in models of care where the provider takes partial or full financial risk for quality, outcomes and total cost of care (degree of risk may be shared with a health plan or fully absorbed by the provider—globally capitated contracts).

I joined the Marshfield Clinic in 2006 as a nephrologist, having practiced and furthered my education in India, Australia, and the United States. I did an internal medicine residency at Mayo School of Graduate Medical Education, a National Institutes of Health-sponsored Clinician Investigator Training Program and fellowship in kidney disease at the Mayo Clinic College of Medicine, Rochester, MN. I serve as the prime site principal investigator of the Wisconsin Consortium for the All of Us Research Program, a historic effort to gather data from one million or more people living in the United States to accelerate research, improve health, and deliver precision medicine. In addition, I serve as the secretary of American Physicians Group, the vice chair of the governing council of the Integrated Physician and Practice Section of the American Medical Association, and on several other not-for-profit boards. As a physician with decades of experience treating patients and navigating the health-care system, I would like to especially commend Congress and the various relevant Federal agencies for their efforts to address the struggles health-care providers and organizations have alike faced during the COVID–19 pandemic. Yes, we have all come a long way and yet much work remains to be done.

Marshfield Clinic Health System (MCHS), which Marshfield Clinic is a part of, is an integrated health system serving northern, central, and western Wisconsin. We are one of the Nation's largest fully integrated systems serving a predominantly rural population. Our 1,400 physicians and providers accommodate 3.5 million patient encounters each year across our 10 hospitals and over 60 ambulatory clinical sites. Our primary service area encompasses over 80 percent of the rural population of the State of Wisconsin. In fact, over half of our 60+ facilities are located in communities of less than 2,000 people. We are the largest provider of primary and specialty care in our region. As stewards of our communities and to what we call home along with our patients, we have been committed to community engagement activities that support the rural and underserved communities. We are a teaching health system, providing over 1,300 students with over 2,300 educational experiences throughout our system. The Marshfield Clinic Research Institute is the largest not for profit, private medical research institute in Wisconsin with more than 30 Ph.D. and M.D. scientists and 150 physicians engaged in medical research.

As a fully integrated health system, MCHS has a rich legacy of over 104 years and a long history of providing accessible, affordable and high quality, compassionate health care. A third of the counties we serve have less than two workers per Medicare beneficiary, and our patients are older, sicker and poorer than average in the State of Wisconsin and the Nation. Forty-two percent of the children in our primary service area are eligible for reduced or free school lunches.

Telehealth at MCHS did not have its genesis in the pandemic. It has been a foundational element in our clinical delivery of care for rural Wisconsin. In fact, we have used telehealth services since 1997, and it has become an important resource to care for patients in often remote and distant locations throughout our service area, which is approximately 45,000 square miles, just bigger than the State of Maine. In 2019, by our estimates use of telehealth saved our patients over 1.2 million driving miles. For older and sicker patients who cannot transport themselves, this is very impactful. To this, add the inclement weather and the challenges of harsh and cold winters. Additionally, in rural areas few, if any, public transportation systems serve as safety net for our patients. A critical lever we have leveraged to manage the cost of care for our patients and communities is our full risk, globally capitated arrangements with our not for profit Security Health Plan, and other models of risk based arrangements with payers in the private and governmental markets. Capitated arrangements have allowed us to innovate, invest and implement effective systems of care for our patients while also passing on the benefits in terms of lower premiums and additional benefits such as hearing aids and spectacles. These programs have improved outcomes, reduced costs and waste, and ensured high-quality and accessible health care. Presently, Marshfield serves 68,224 patients in a globally capitated, full risk arrangement. We also serve another 51,131 patients on value-based contracts.

Relying on the knowledge gleaned from our several decades' long history of utilizing telehealth services in our clinical care models, and our present experience of responding to COVID–19, I would like to share the following perspectives and substantiate why these are relevant for your consideration.

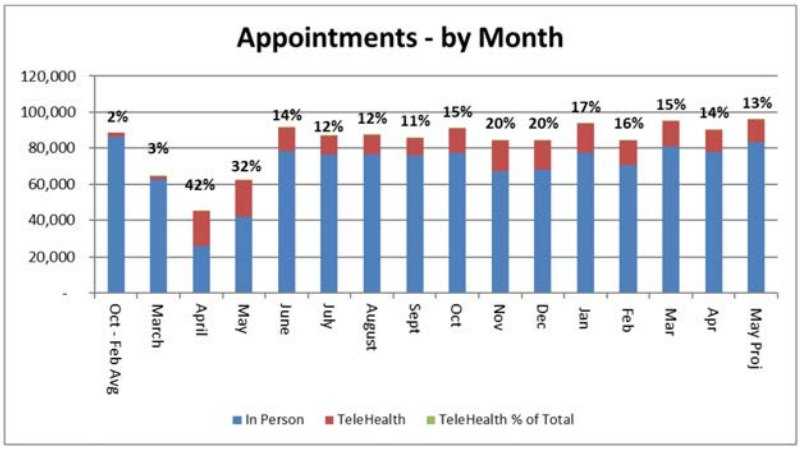
1. Telehealth adoption has increased exponentially. With the Federal waivers and commercial insurance coverage expansion during the PHE, almost 20 percent of ambulatory care can be safely provided through telehealth.
2. Expanded utilization of telehealth by baby boomers and senior citizens has resulted in improved patient access, increased convenience, and appropriate care albeit with less than robust, integrated platforms. Creating such platforms within the framework of existing health care and EHR systems can reduce overall cost of health care.
3. Blanket telehealth waivers issued in response to the pandemic have enabled the industry to continue its population health and health promotion initiatives and provide innovative programs such as Hospital Without Walls.

As we look forward to the next phases of the pandemic response and the return to whatever our new paradigm will be, embracing telehealth and stopping its backslide is critical. I urge you and your colleagues to fully support and implement effective and responsible policy that ensures continued accessibility to high-quality telehealth services that benefits patients, and their overall health.

PATIENT BEHAVIOR AND PREFERENCES, AN MCHS SNAPSHOT, AND AN APG VIEW

Since COVID 19, patient preferences on how they choose to engage with physicians and Health systems has forever changed. In MCHS, we serve around 100,000 outpatients a month with some cyclical drop in Wisconsin winters. Those appointments have declined to about 90,000 outpatients a month during the PHE. In entire year of 2019, we registered about 12,500 telehealth encounters, with about 200 clinicians providing telehealth services in any given month.

In 2020, across all demographies, telehealth visits skyrocketed from a pre-pandemic average of about 2 percent of visits a month, by 21-fold in April 2020. Within 4 weeks of the pandemic, MCHS was averaging 3,000 telehealth visits per week, and by week 8, we were delivering over 6,500 telehealth and phone care visits per week. During the time our centers were closed, telehealth and phone care services were able to provide access to 22 percent of our normally expected patient volume. Overall, in 2020, MCHS provided 240,000 telehealth and telephone encounters. All 1,400 physicians have been trained to provide this service.



In the last 4 months, telehealth visits have plateaued to an average of 15.5 percent. In certain specialties, such as Behavioral health, 30 to 32 percent of our patients use telehealth or "phone only" visits.

In discussions with my APG colleagues and several health system leaders across the nations, we all agree there has been a decline in telehealth numbers. **Observational evidence suggests this 15–16 percent fraction of "telehealth and**

phone visits" over all appointments per month are a reflection of a new steady state for consumer behavior across the Nation. Baby boomers have increasingly adopted telehealth visits, as have many of our octogenarian parents.

PATIENT EXPERIENCE, LOYALTY, AND DIRECT-TO-CONSUMER MODELS

Patients seem to be willing to switch to telehealth as tolerance to waiting for appointments decreases. With increased access to convenient care, patient satisfaction in the care they receive from their physicians has also increased. In a survey of our patient population, Marshfield Clinic found that 68 percent of respondents reported being "highly satisfied" or "satisfied" with their virtual visit. **The most common reason given by patients for frustration with their telehealth visit was poor quality of Internet connection.**

Removal of geographic site origination and other burdensome regulatory burden would improve access to care. Our child psychologist in Lake Hallie, WI had to move to Colorado because of family commitments. With the low availability of skilled providers to cover these patients we worked with the State of Wisconsin for approval of telehealth services and invested in a telehealth room in Lake Hallie. Patients were offered the option to continue or switch to new provider. In two years, only one patient opted for a different provider. He sees about 1,200 encounters annually.

DIGITAL DIVIDE (LACK OF BROADBAND ACCESS)

Phone-only telehealth services have been critical to delivering health care to the underserved, rural, and racial minorities. *Even a year into the pandemic, meeting the regulatory expectations of audio-video visits for risk adjustment in rural Wisconsin has been challenging.* In April 2021, 57.6 percent of the 12,299 telehealth/phone patient appointments used "phone only" care. Our patients, who are old, have chronic illness sit in the parking lots of our schools and clinics to access broadband Wi-Fi that they lack at home for telehealth services. It is sad how little we, as one of the most developed nations in the world, are able to support our old, poor, needy and sick.

According to the Federal Communications Commission, 19 million Americans lack access to fixed broadband service at threshold speeds—and 14.5 million of those residents are reside in rural settings.[1] According to one study, during the pandemic, Federally Qualified Health Center audio-only ("phone") visits accounted for 65.4 percent for all primary care visits and 71.6 percent of behavior health visits.[2] Centers for Medicare and Medicaid Services (CMS) estimates up to 30 percent of visits during the pandemic have been audio-only.[3] Rural residents should not be disadvantaged in accessing telehealth just because of where they live.

TRAVEL FOR HEALTH CARE AND ITS ECONOMIC IMPACT

The economic impact on patient families of saved miles and time cannot be lost upon us. Our three pediatric neurologists are the only physicians with the subspecialty skills to see complicated neurological patients across a 45,000 square mile service area. In order for a child with well controlled epilepsy, the parent or parents are compelled to take time off from work, often for a whole day, all for a 30-minute physician visit that can be done over telehealth or telephone. *This is a wasteful exercise of time, money, and resources. This child is an example of the 20 percent of medical care that is well suited for virtual care.*

Other such visits that are well suited for telehealth include follow-up visits, teledermatology, provider-to-provider consulting in subspecialty care, second opinions for highly specialized counseling, and radiology opinions. The benefits of reducing unnecessary travel, lost days of production for the family, and improved access to care along with downstream reduction in urgent and emergency care utilization are all important drivers of reducing cost of care and improving patient experience.

---

[1] *https://www.fcc.gov/reports-research/reports/broadband-progress-reports/eighth-broadband-progress-report.*

[2] Uscher-Pines L, et al. "Telehealth Use Among Safety-Net Organizations in California During the COVID–19 Pandemic." *JAMA.* 2021;325(11):1106–1107.

[3] Verma, S. "Early Impact of CMS Expansion of Medicare Telehealth During COVID–19." Health Affairs Blog 2020. *https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.*

GEOGRAPHIC LIMITATION AND IMPROVING ACCESS TO APPROPRIATE HEALTHCARE IN RURAL AMERICA

Overcoming geographic isolation through telehealth in rural America has critical relevance. There is limited access to public transportation, and long drive times to avail medical care. This is further compounded in winter when the roads are treacherous with black ice or travel is blinded by blowing winds and snow.

A story that tugs at my heart is that of a 67-year-old diabetic woman who traveled 200 miles to see me, four times a year to titrate medications and optimize her health. In 2007, MCHS provided me the ability to provide virtual care, do a heart and lung and physical exam over video, review her vital signs with the assistance of a nurse, review her lab tests and arrange for diuretic infusions when her heart failure worsened. For 13 years, every year she has sent me a Christmas card and even now, when I no longer see her.

INCENT INVESTMENTS FOR INCREASED PHYSICIAN ADOPTION

In the wake of the pandemic, physicians have rapidly adapted to the new paradigm of care. The additional waivers and regulatory changes surrounding telehealth services have been vital in creating pathways for organizations facing financial peril to be creative and expand access to care.

The present state involves working simultaneously with an electronic health record (EHR), a video platform, and a chat function with their medical teams to coordinate scheduling, lab tests and diagnostics, educating patients how to switch on their cameras, educating themselves in performing a good virtual physical exam and good "web-side" manners.

Substantial investments in infrastructure are needed to ensure physicians can provide high quality, cost-effective, increased access to care through telehealth services. As patients become increasingly adroit with technology and physicians with telehealth workflows, access to critically needed services such as behavioral health, primary, and specialty care would also increase.

ACUTE CARE WITHOUT WALLS

Since 2016, MCHS has provided, hospital-level care in patients' homes *through use of telehealth, in-home nursing visits, and virtual visits by hospitalists.* We treat over 100 acute care conditions such as asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease (COPD) safely at home with proper monitoring and treatment protocols.[4]

Our research highlighted in the August 15, 2019, *New England Journal of Medicine Catalyst*[5] and those of others have demonstrated high rates of patient satisfaction and improved outcomes, and meaningful reductions in costs. As an author of this study, I will be the first to admit that the best place for a patient to recover is where they are most comfortable—and that is not in a hospital room in many instances.

- Our patients had 44 percent fewer 30-day readmissions, and a 50-percent reduction in emergency department visits than Security Health Plan members within the same group of DRGs who were treated in the hospital.
- HRC patients had 37 percent shorter length of stay, compared with historical data from SHP members within our diagnosis-related groups. (Length of stay for HRC patients was measured as number of days in the "acute" phase.)
- Patient satisfaction was greater than 90 percent, based on the number of top-box responses for all questions administered via the HRC program patient satisfaction survey.
- The health plan saved approximately 15–30 percent per episode, when compared to our historical baseline costs.

In late 2020, MCHS with bipartisan support from the congressional delegation that represents our service territory was granted a Section 1135 waiver from CMS to more broadly implement the Acute Hospital Care at Home program. MCHS, was one of the first nine, health-care institutions in the country granted this waiver by

[4] Centers for Medicare and Medicaid Services. (2020, November 25). CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID–19 Surge [press release]. Retrieved from: *https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge.*

[5] *NEJM Catalyst*, "No Place Like Home: Bringing Inpatient Care to the Patient," Narayana Murali and Travis Messina. *https://catalyst.nejm.org/no-place-home-recovery-care.*

CMS. MCHS was approved four hospital sites by CMS for Acute Care at Home, during the COVID pandemic. This waiver allowed us to expand our Hospital at Home, and has increased our capacity for the care of patients during the COVID–19 pandemic, providing greater flexibility and reducing the burden on providers caring for the most acutely sick patients.

RECOMMENDATIONS

In response to the committee's request, below are our recommendations.

I. Allow Acute Care Without Walls flexibilities to extend beyond the PHE waiver

Even in rural areas, this model has successfully improved access and outcomes. While the CMS allowed a blanket waiver to permit the expanded use of this program for the duration of the PHE, we continue to gain data and experience to improve the program. We hope and strongly urge that Congress recognize the success of these programs, and ensure these programs can continue to grow and increase access beyond the PHE.

II. Eliminate origination site and geographic limitations

a. These limitations are outdated based on our experience with the present waivers and can no longer be justified as guard rails to protect against fraud, waste, and abuse.
b. By creating certainty that telehealth will continue to be reimbursed by Federal health-care programs, Congress will give providers the certainty they need, to invest in the technology infrastructure, software and practice redesigns necessary to make telehealth part of their standard business operations. A lack of certainty could create new disparities among providers, and result in uneven access for patients.

III. Support and ensure access to reliable broadband

It is imperative to invest in broadband technology to close the digital divide and ensure living in rural communities is not a barrier to accessing telehealth.

IV. Allow phone-only telehealth services for Medicare Advantage risk adjustment until we overcome the challenges of Internet access

The disparities in broadband access are exacerbated in rural, underserved and minorities. In fact, over half of our telehealth visits with our patients have been phone-only because of limited access to broadband, smart phones, or tablets. Medicare Advantage has allowed both audio and audio/video telehealth services. Audio-only (phone) has not been allowed for risk adjustment, which impairs appropriate funding for health-care delivery to the most vulnerable—an impact that will ultimately affect future Medicare member benefits and premium, given restrictions to formally document real risks is not true reflection of no risk. Our APG members agree that barriers that discourage patient participation through phone, when access to broadband is unavailable, prevent patients from receiving necessary care, and ultimately expose organizations that are in the capitated, value-based models to greater financial peril.

V. Ensure payment parity

In order to guarantee that clinicians and systems have the appropriate incentives to invest in telehealth services and capabilities, Congress must ensure payment parity between in-person and virtual visits. Allowing for expanded telehealth without the guarantee of payment parity will create another barrier to adoption, limit overall uptake by providers, and stagnate access to this important treatment mechanism for patients. Congressional action on this front will also send an important message to commercial payers to guarantee parity across insurance markets.

VI. Reduce administrative burden on providers

First off, every effort possible should be made to harmonize statutes and regulations at the Federal, State, and local levels to promote the continued adoption and utilization of telehealth. For example, Congress should explore the establishment of a form of blanket patient consent to facilitate the provider connecting with them via the 2-way video method that the patient is most comfortable with. Congress must also work in concert with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to reduce burdensome regulations that inhibit the expansion of telehealth to smaller physician practices that reduce the ability of clinicians to focus on their most important task: serving their patients.

VII. Protect patient data while fostering innovation and access

As patient satisfaction rises with the increased usage of telehealth services, creating a care environment that best serves patients and their needs is paramount. HIPAA waivers have been helpful in providing care and allowing patients (senior patients especially) to use compliant platforms they are familiar with. However, I am aware that some of these non-HIPAA compliant applications and platforms may compromise security and thus, it will be important to weigh the benefits of expanding access via the use of consumer-based technology versus potential privacy and security risks. All payers should be encouraged to align payment policies and coding requirements in order to ensure a seamless system of care that works in a coordinated manner across all providers and organizations.

VIII. Support integrating telehealth in EHR platforms

Congress should consider supporting regulations and incentives for integrating telehealth in Electronic Health Record Platforms.

I would again like to thank Chairman Wyden, Ranking Member Crapo, and the rest of the committee for granting me this opportunity to share these observations and recommendations with you during this hearing. We look forward to continuing to work with you on this very important issue and advancing America's health-care system.

QUESTIONS SUBMITTED FOR THE RECORD TO NARAYANA MURALI, M.D.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. During the pandemic, telehealth has been an essential tool to get children the care that they need while minimizing risk. Although telehealth under Medicare has been a focus, close to 40 million children are enrolled in Medicaid.

What are the main policy changes we need to ensure this broader use of telehealth can be continued beyond the pandemic for children?

Answer. Thank you for your question. You are right that while the focus of much our discussion centers around issues related to Medicare, we must focus on ensuring patients' access to telehealth services no matter what type of insurance coverage they use. When it comes to Medicaid, there are particular rules pertaining to what services can be provided, and by what type of provider. As telehealth becomes more ubiquitous in the delivery of care, Medicaid coverage of telehealth services should grow as well. A patient's access to telehealth should not be based on what type of insurance coverage they have. This includes the expansion of the CPT codes where telehealth is an option for Medicaid enrollees, both in managed care and traditional fee-for-service reimbursement arrangements.

There are also a number of State-level issues that will have to be addressed on a case-by-case basis. A good example of this was the passage of Wisconsin 2019 Act 56, which mandated parity in coverage for telehealth services for Medicaid enrollees.

Additionally, patients must not be precluded from accessing telehealth due to lack of access to technology. This includes providing supports to ensure that individuals can use technology that allows for video visits, and that they have access to reliable Internet service. The truth of the matter is that while we take access to broadband coverage and smart phones for granted, many Americans, and especially those who rely on Medicaid, do not actually have access to these conveniences of every day life. Nineteen million Americans lack access to fixed broadband service at threshold speeds—and 14.5 million of those residents are reside in rural settings. And, many of our Medicaid patients cannot afford smart phones, or the service to use them. As a result, CMS should consider creating technology vouchers and reduced-cost broadband as part of coverage, especially for chronic conditions.

Question. During COVID–19, many States adopted temporary changes to their telehealth policies, such as expanding the scope of services and providers able to furnish telehealth, relaxing of licensure requirements and modifying reimbursement policies. Many States legislatures have also begun the work to adopt more permanent telehealth policy changes.

How can the Federal Government best support State Medicaid programs in their efforts to expand telehealth?

Answer. First and foremost, the Federal Government should continue to support the flexibilities to Medicaid programs that have been granted throughout the pan-

demic. While vaccinations are readily available and we are all trying to find ways to return to normal, we must realize that we are going to be dealing with the fallout of this pandemic for a very long time. As a result, States and Medicaid providers need time to recover from the pandemic and adequately prepare for the move away from the current flexibilities.

CMS needs to develop and implement effective lines of communications with State Medicaid programs about future changes in the program. Furthermore, State Medicaid programs must undertake initiatives now to ensure that when the pandemic flexibilities expire that Medicaid enrollees are not all of a sudden unable to access telehealth services. This is an issue of equity and access.

Further, providers need clarity about the scope and parameters of what is allowed under Medicaid when it comes to telehealth services so they can adequately plan and implement changes to their service models. Unnecessary and arbitrary obstacles to telehealth will serve as a disincentive to providers and patients, and result in missed opportunities to provide high-quality accessible health care, no matter the patient's coverage.

Question. Are there Medicaid supports, incentives, and learnings that Federal policymakers could provide?

Answer. Honestly, the ability to develop Medicaid programs that meet the unique needs of the patients we care for is the most important tool Federal lawmakers could provide. It is just a fact that the needs of patients in north central Wisconsin will be different than those of residents in Texas, Florida, or even Iowa for that matter. However, everything possible should be done to prevent arbitrary obstacles from getting in the way, like access to broadband and flexibility in how patients access care.

Question. COVID–19 has introduced additional stress and trauma for children and families. Telehealth, and particularly audio-only telehealth has been a crucial tool to connect children and adolescents to needed mental health-care services.

How can telehealth be best utilized to meet kids' mental health-care needs, and can you speak to the use of audio-only telehealth specifically?

Answer. Telehealth has the great potential to increase access and utilization of mental health services for children enrolled in Medicaid. This is something we must embrace. The pandemic has been catastrophic in terms of mental health for large segments of society, but especially children. Children in Medicaid have long been challenged to access mental/behavioral health services. For children in rural settings like Marshfield Clinic' service area, access is even more challenging because a lack of providers. However, throughout the pandemic we have been able to access care through video visits, and many instances through audio-only visits when they cannot take advantage of video visits. This has been an important tool to ensure access to vital mental health services, especially when children face serious mental health challenges resulting from the disruptions of the pandemic. Congress should ensure that CMS maintains the telehealth flexibilities that allow Medicaid enrollees, especially children the ability to access mental health services even after the end of the public health emergency.

An important component to the delivery of this care is the use of audio-only visits. These visits routinely are the only way children can access mental health services in some rural areas that lack access to reliable broadband, or the patients and their families may not have access to video-enabled phones/computers. Additionally, audio-only visits help maintain regular and consistent engagement between patient and provider. And, phone-only visits are also great tools for check-ups in between regular appointments, especially in acute situations.

Question. As State Medicaid programs look at expanding their use of telehealth, it is particularly important that vulnerable populations like children are not negatively impacted. Policies must be looked at through a health equity lens, considering access to reliable and affordable broadband services, access to devices that support HIPAA-compliant telehealth platforms and coverage policies.

How can Medicaid programs work to ensure telehealth policies are equitable for children and mitigate potential inequities that may arise?

Answer. You concern about the expansion of telehealth services exacerbating health disparities is certainly valid. First and foremost, we must remember that telehealth is best integrated into a full spectrum of services available to all patients, based on their needs and unique circumstances in consultation with their medical

provider. An individual should not be precluded from a particular care because of their type of insurance coverage.

Medicaid programs must make efforts to ensure that access to reliable broadband is not an obstacle to accessing telehealth services. This is not just the issue of having broadband available. It also means being able to afford broadband. Broadband services, no matter whether a patient lives in a rural, urban or even suburban setting can be expensive. Affordability must be taken into account. Medicaid could consider providing broadband subsidies for enrollees, especially children because of the added value of supporting their educational pursuits, just like transportation subsidies.

And, continuing to allow for phone-only will be an important bridge to ensure care is accessible, no matter the circumstances of the patient. In the end, it will always be necessary for a provider to make the final decision on the best way to treat their patient, but they should not be precluded because of arbitrary obstacles like access to smart technology like phones or tablets, or broadband access.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. We have seen licensure limits substantially restrict access to cross-State medical care during this unprecedented COVID–19 emergency period. To maximize the utility of telehealth options and ensure provider accountability, some experts have suggested that States should do more to ensure mutual licensing reciprocity in the post-pandemic environment.

I am a cosponsor of Senator Murphy's Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168/H.R. 708)—a narrowly tailored bill to enable providers licensed in good standing in one State to treat patients in any State for the duration of the COVID–19 Public Health Emergency.

How have health systems and patients benefited from State licensing reciprocity during the COVID19 public health emergency?

Answer. You are certainly correct that State licensing reciprocity was an important tool to ensure access during the height of the pandemic. The greatest benefit was in patients being able to access high-quality care without unnecessary delays or obstacles.

This reciprocity was especially important for rural providers such as Marshfield Clinic Health System. Our model is to bring as much care as close to home as possible for our patients. However, as a rural provider, recruiting and retaining talent can be difficult. According to a recent study, less than 5 percent of current medical students want to practice care in a town smaller than 50,000 people.

During the pandemic, we were able to use licensing reciprocity to engage physicians in high-demand/need areas more quickly via telehealth, and to bring in necessary staff to bridge gaps in coverage. A perfect example of this is during a significant surge of COVID–19 patients in the Midwest, we were able to secure staffing support from the Federal Emergency Management Administration and the U.S. Department of Defense. The staff that was assigned to our facilities were able to expedite their licensure through reciprocity flexibility. This meant they were not delayed in getting into clinical settings where they could provide much need support and relief to our permanent staff.

Workforce is a major issue at all levels for rural medical providers, and reciprocity was an important tool we could use to take care of our patients. And to be frank with you all, after the harrowing last year and a half, I suspect that the healthcare sector is going to be dealing with long-term staffing challenges. This will necessitate us to be creative and nimble in developing solutions that are not always easy, or quick. Continued reciprocity flexibility will help us recruit and on-board staff at multiple levels that could lead to delays in patient care.

Question. I recently reintroduced the Home Health Emergency Access to Telehealth (HEAT) Act with Senators Collins and Shaheen. This bill would allow Medicare home health providers to be reimbursed for the telehealth services during a public health emergency. I also have heard from other home-based care providers, like hospice and palliative care as well as home-based primary care about the importance of telehealth during the emergency and into the future as services in the home and community continue to grow.

Could you talk about your experiences using telehealth to supplement care for the populations you take care of?

Answer. Telehealth at MCHS did not have its genesis in the pandemic. It has been a foundational element in our clinical delivery of care for rural Wisconsin. In fact, we have used telehealth services since 1997, and it has become an important resource to care for patients in often remote and distant locations throughout our service area, which is approximately 45,000 square miles, just bigger than the State of Maine. In 2019, by our estimates use of telehealth saved our patients over 1.2 million driving miles. For older and sicker patients who cannot transport themselves, this is very impactful. To this, add the inclement weather and the challenges of harsh and cold winters. Additionally, in rural areas few, if any, public transportation systems serve as safety net for our patients.

During the peak of COVID, we converted about 35 percent of our out-patient visits to telehealth visits, about 6,000 visits per week. And we leveraged the flexibilities granted by CMS to provide as much care as possible remotely, including inpatient level care of patients at home, mental and behavioral health services, rehabilitation and physical therapy services and even chronic care management to just to name some of the categories of care we transition to virtual platforms. Anecdotally, patients have had positive experiences and come to realize that the best place to heal or recuperate is their own home, not in a hospital bed. It has also been a chance for us as a system to reevaluate some of the services we provide and think more creatively. And, as a physician myself, I will admit that the pandemic forced many providers to reevaluate their preconceptions about what they could do via telehealth and what they have to do as part of an in-person clinical visit. It will take time to fully adjust our clinical approach and our operations as a health-care system. But telehealth is here to stay and has the chance to make a huge positive difference in the lives of our patients.

Palliative care and hospice care are some of our most sacred duties as physicians to our patients and their loved ones. Even before the COVID–19 pandemic, MCHS was committed to using new models of care to provide comfort and support to patients throughout their care journey. Our model of home-based care, Home Recovery, has been deployed to assist patients in these circumstances. This is especially important in rural areas where palliative care and hospice facilities are less common. Additionally, because of longer distances between home and facility, virtual care cuts down on the stress to the patient, as well as burdens to their families/caregivers. And virtual care in these settings routinely allows for more fulsome discussion with families and the patients about their wishes, and gives greater peace to all involved.

Continuing to allow for these types of services through telehealth and other virtual platforms will go a long way to ensuring all patients can go through this type of care with dignity. For the last 3 years MCHS has been at the forefront of delivering a large spectrum of services that are traditionally only offered as inpatient services to our patients in the comfort of their home. This experience has demonstrated that patients routinely prefer to be at home, and that outcomes at home are usually much better than in a hospital setting. That is because patients are most comfortable where they live. We should continue to expand on the opportunity to bring care to the homes of patients leveraging technology and telehealth, and when that is not possible to deliver it close to home at the best facility for the patient and their families. That will make a difference in the experience for all involved, the patient, their family and the provider.It is an exciting potential, and one that we should all work together to realize in the coming months and years.

The number one barrier during this time was lack of technology in people homes and lack of sufficient broadband. About 65 percent of our telehealth visits during COVID were audio-only, underscoring both the importance of phone care continuing to maintain access to patients as well as the need to continue advancing broadband expansion. Congress must also do everything to ensure that a person's health-care coverage does not dictate the type of care they receive. There must be parity when it comes to access to telehealth services.

Question. What lessons from the pandemic would you like to see brought forward into the future of care for home health, hospice, palliative, and other home-based care providers?

Answer. Telehealth has the ability to improve outcomes, increase access and satisfaction for patients in all settings, and reduce health-care disparities. Some of the

most important lessons gleaned confirmed long-held ideas about the potential of telehealth to improve the care we provide our patients.

Telehealth can increase access, improve outcomes and patient satisfaction. Keep in mind, the cost of health care is not limited to the bill from a doctors' office. Patients often take time off of work, often unpaid, to drive up to 3 hours to receive care. Telehealth can increase access by allowing patient to present closer to home and this reduces their cost of accessing care.

Telehealth has an important role to play in a comprehensive approach to care delivery, especially as we promote the move from volume to value. More frequent low-acuity contact with your provider is better than less frequent high-acuity contact. And, telehealth can be integrated to comprehensive care that includes auxiliary services like case management, physical or occupational therapy and even palliative care.

Telehealth should continue to be an option for all patients, regardless of their location or the type of insurance they have. The site of service and geographic limitations that have been the hallmark of telehealth reimbursement policy in Medicare are outdated. They do not serve the best interests of the patients or the programs. While it is important to come up with a comprehensive system to monitor and track utilization of telehealth services, arbitrary limits will cause us to regress from the progress we have made. The ones that will ultimately pay the price for that lack of foresight will not be decision-makers, but instead patients and their loved ones.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Throughout the public health emergency, the Centers for Medicare and Medicaid Services (CMS) issued over 200 waivers under Medicare and approved more than 600 waivers and other flexibilities under Medicaid. While some of the regulations waived are specifically for responding to a pandemic, ensuring patient safety, controlling costs, and maintaining program integrity its clear innovation and common sense ideas in our health-care system have been stifled too often by Federal regulations. For example, CMS permanently added certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic. Some regulations play an important role in protecting safety and maintaining program integrity but others may stifle good ideas.

Is health care too regulated that it's stifling good ideas?

Answer. Health-care regulation is not keeping up with technology and science. As a result, patients and providers are stuck in a system that is behind the times and not adequately harnessing all the innovation that is occurring throughout health care. And we are missing out on taking advantage of the potential fields like artificial intelligence and data analytics have to deliver new and improved care to our patients and communities.

Good ideas are being brought to life each and every day. The real challenge is implementing them in a way that can have a meaningful impact on patients and their health-care providers, and the health system in general in any timely and useful way. A perfect example of this has been the long-time desire to promote a health-care system where value is rewarded over pure volume. This catch-phrase has seemingly been around for decades. But, it is hard to say we are much further along our journey from volume to value than when we started.

For decades, American Physicians Group has been promoting capitated care. This model has been demonstrated to be in the best interests of providers, payers and patients. Experience during the pandemic has born this out. As decreased volumes imperiled providers reliant on fee-for-service revenues, while many providers in capitated arrangements were able to manage the ups and downs more effectively.

Regulatory frameworks should not be focused on what is allowed or not allowed. Instead, it should be focused on giving practitioners guidelines to achieve a shared goal like promoting value-based care, and then allow stakeholders (including providers, payers, technologists and leaders) the ability to create systems that they think will work best for their patients and communities.

It is hard to imagine creating a universal health-care model that works as effectively in Marshfield, WI as it would in Laredo, TX, New York City, or even Manhattan, KS. We should be focusing on creating a regulatory system that lets providers

tailor a system to the needs of their patients and communities, and promotes utilizing the best available technology and data to promote a culture of health and well-being.

Question. Should executive agencies sunset regulations in the future to enable more innovation in health care?

Answer. The current health-care regulatory framework is a hindrance to the development and implementation of innovative models of care. We should reorient our approach to the regulatory system. Instead of overly prescriptive, or restrictive, regulations that do nothing to advance a culture of health, we should create a framework that allows providers, innovators and patients the power to create systems that are functional and effective in delivering care for all patients.

When health-care leaders are conceptualizing new models of care and implementing new technology for their patients, they look for certainty. They need to know that what they are envisioning will be permitted well into the future. Potentially sunsetting, or requiring regulations to be renewed, could actually have the unintended consequence of creating uncertainty and cool the embrace of new technology and methods. Of the 18,000 or so regulations defined in the Code of Federal Regulations, sunsetting all regulations (SUNSET rule published in the Federal Register on November 4, 2020, 85 Fed. Reg. 70096) without adequate review by the impacted stakeholders would likely have far-reaching economic impact and even greater impact on the ability to provide care due to regulatory uncertainty it will create for insurance providers and patients. During the pandemic, it would divert vital resources from HHS, away from providing needed support at the worst of times. Therefore while there are regulations that need change, the how, what, and when matters so as not to throw out the baby with the bath water. Instead of automatically sunsetting regulations, agency leadership should reframe how they construct proposed regulations and regulatory guidance to foster innovation.

Unnecessary or overly burdensome regulations certainly need to be addressed. The experience we have had during the pandemic when regulatory flexibility was exercised appropriately is a great illustration. The quality of care a patient received did change from all indications, and these flexibilities allowed providers to think of new approaches to new and old problems. Creating an environment that fosters growth and innovation is imperative to improve the health and well-being of our patients and communities.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. Before coming to the Senate, I had the privilege of practicing medicine in Wyoming. Rural health care faced challenges prior to the pandemic. In particular, we know since 2010 more than 135 rural hospitals have closed.

In the Senate, I am proud to help lead the bipartisan Rural Health Caucus. This group is committed to ensuring patients in rural America can get access to the care they need.

Can you specifically discuss the changes in Federal health-care policy that you believe have helped rural providers the most during this pandemic?

Answer. Thank you, Senator, for your focus on the important topic of how to support rural health-care providers. Even before the onset of the pandemic, rural health-care providers were struggling financially. This is the result of the unique challenges associated with delivering medical care to rural communities.

By far, the expansion of telehealth services has made a huge difference for rural health-care providers. The suspension of geographic restrictions and site of service rules were a lifeline to patients during the darkest periods of the pandemic. When we had to curtail in-person care, telehealth became an important lifeline for our providers, and more importantly for our patients. For example, we went from doing about 200 telehealth visits per month before the beginning of the pandemic, to about 6000 visits per week in the spring of last year.

And one of the most important lessons for providers and patients from the pandemic is the breadth and depth of services that can be provided via telehealth services. It is not just routine clinical visits, but behavior health and substance abuse support, physical therapy, pre-operative and post-operative appointments, and so much more. The expansion of the types of services allowed to be done through tele-

health was vital to its broad acceptance at the outset of the pandemic, and even now.

Furthermore, allowing audio-only telehealth visits was vital for a number of our patients, especially those in rural areas that do not have access to reliable broadband, or may not be comfortable with technology because of their age.

Question. Can you please discuss any specific changes that Congress should consider to better support rural health-care providers?

Answer. First and foremost, Congress must understand that the model to deliver care in rural areas is just plain different than those in more urban settings. As a result, as changes are made to the way reimbursement occurs, or rules about operations of facilities, the unique impacts on rural operations must be considered. And, it has to be acknowledged that the finances of rural health-care providers are routinely much more precarious than more populated areas. And, we have to understand that the population we serve is different as well. Rural residents on average are older, sicker, and poorer than their more urban counterparts. In some of the counties we serve, there are less than two workers per every Medicare beneficiary, so our payer mix is very different than a health system in suburban Washington, DC. Lastly, it should be remembered that access to care is an equity issue for rural residents as well. A person should not be limited in their medical options just because of where they choose to live.

Achieving a high-functioning rural health-care ecosystem requires supporting and strengthening the programs that work well for rural residents. One such program is Rural Health Clinics. This program can help ensure access to care when otherwise it would not be economically feasible. However, recent changes to reimbursement at RHCs could restrict their growth moving forward, which is dangerous for rural communities. A new provision passed in December would cap reimbursement rates at newly created RHCs. This significant change came as a surprise to many in the rural health community, and has imperiled plans across the country to create RHCs in areas of significant medical need, including some of the areas we serve at MCHS.

In the context of RHCs and telehealth, the long-standing limitation of providing telehealth services external to the RHC is overly burdensome and creates an unfair obstacle to accessing care. Before the waivers for COVID–19, a provider in an RHC could not connect to a facility outside of the RHC to render service. Clinicians would be required to use space specifically carved out of the RHC to have telehealth visits with outside clinicians. Further, restrictions on telehealth services at Federally Qualified Health Centers are unnecessary and again create an unjustifiable barrier to accessing care for those patients who rely on FQHCs for their care.

Beyond these concrete examples, the issue of workforce is one of the most pressing for our system, and providers across the country. In the last 16 months, our frontline staff have truly embodied the moniker they were given as Healthcare Heroes. However, we are not facing challenges from burnout. And, this has to do with every level of employee, from frontline staff in the ICUs, to technologists and administrative staff who have been doing more than their fair share at work, while at the same time having to change their lives at home. This is a burgeoning problem that has no quick solution. Recruitment and retention in rural areas is always more difficult because of the unique circumstances of living in smaller communities, and the overall lack of a ready labor pool.

Question. Prior to the pandemic, I introduced bipartisan legislation with Senator Tina Smith, which among other things, would allow Rural Health Clinics (RHCs) to provide more telehealth services.

I was pleased that Congress through the CARES Act authorized both Rural Health Clinics and Federally Qualified Health Centers to furnish telehealth services to Medicare beneficiaries during the public health emergency.

Can you discuss the importance of Rural Health Clinics and Federally Qualified Health Centers continuing to provide telehealth services after the public health emergency has ended?

Answer. You are absolutely right to highlight the importance of RHCs and FQHCs in rural health care. For many rural communities that do not have a full hospital, RHCs and FQHCs are patients' only consistent connection to care. Every effort should be made to ensure that the restrictions to telehealth services at RHCs and FQHCs that were in place before the pandemic are not reinstated when the public health emergency ends. Otherwise, there will be an unfair difference in access based

on where individuals access their care. This is wrong and unnecessary. Patients should be able to get the best care possible, no matter where they get their care, in consultation with their clinician.

Question. My wife Bobbi and I are passionate about improving access to mental health services. This pandemic has clearly impacted the mental, as well as the physical health of our Nation.

For people living in rural America, getting help from a mental health provider was challenging before the pandemic. This is why Senator Stabenow and I have long supported professional counselors and marriage and family therapists participating in Medicare. We believe that increasing the number of mental health providers able to care for our Nation's seniors is an important priority.

Please discuss how telehealth has impacted the ability of patients to receive mental health services during the pandemic.

Answer. The COVID–19 pandemic has demonstrated the importance of access to mental health services for all Americans, and the challenges that occur when we cannot meet those needs.

A vast majority of behavioral health services are uniquely suited for telehealth. In fact, at MCHS, the behavioral health service line was the only group to experience an increase in volume in 2020. We saw an increase of approximately 20 percent in utilization and appointments. Further, we saw a decrease in no-show appointments, and greater adherence to a course of treatment. This is accentuated in rural areas where access to mental health services is more limited due to a dearth of providers, and because of the usually extra-long distances patients are sometimes required to travel to seek care.

Telehealth has served as an important bridge to ensure patients have access to care, and as a way to address a chronic shortage of access to mental health services in rural areas. A case in point is research we have done about mental health and farmers. MCHS in partnership with the National Farm Medicine Center published an article in the *Journal of Agromedicine* in September 2020 after recognizing that we were seeing an increase in farmers receiving behavioral health services, a notoriously difficult population to engage in BH services, largely due to stigma. Farmers reported that not having to present in a facility where others were waiting in a waiting room was a significant reason they didn't previously request care.

And I agree with you that we have to expand the types of providers eligible to provide mental health services in Medicare. Doing so will not only address access issues, but also ensure that patients can get the right type of care.

Question. Can you please identify ways Congress can improve access to mental health services, including expanding the number of providers that can participate in Medicare?

Answer. First and foremost, Congress must recognize that telehealth will continue to play a vital role to ensuring access to mental health services. It pales in comparison to the suffering many people have dealt with through this pandemic, but the emergence of telehealth as an important part of the continuum of care, especially in behavioral health, must be embraced and supported with the appropriate policy changes moving forward.

Geographic restrictions and site of service regulations for behavioral health services in Medicare must be rescinded. The pandemic has shown that care can be effective care through telehealth and it should be available to all patients, no matter where they live and where they get their care.

Furthermore, Congress can move forward with incentives for States to implement responsible and effective licensing rules that allow for delivery of telehealth services across State lines in selected fields, like mental health. This will mean that patients would have access to these important services no matter where they live. And, it would also fill in coverage gaps, especially in rural areas, where it is hard to recruit and retain trained mental health professionals. Lastly, it is important to ensure that there are a variety of providers eligible to provide services in the Medicare program, including licensed clinical social workers, family counselors and other nonphysician providers.

Question. I was interested in your testimony where you discussed the need to reduce the administrative burdens on health-care providers.

I agree telehealth is transforming the way we are providing care. However, in Wyoming, most of our providers are part of smaller hospitals and practices. We need to make sure government regulation is not making it more difficult for these providers to serve their patients.

Can you discuss specific ways Congress can reduce the administrative burden in providing care through telehealth?

Answer. We must create an environment that supports delivery of high-quality care and does not unnecessarily burden patients or providers. As the use of telehealth continues to expand, CMS must simplify the process for coding and billing of telehealth services. Complexity will serve as a deterrent for providers and their offices to wholly embrace telehealth. Also, CMS should approach telehealth through the lens of maximizing the categories of providers eligible to provide care through telehealth services. This includes advanced practice clinicians, as well as medical students with appropriate supervision. The future of health care will include telehealth, and we are doing a disservice to patients and future clinicians if we fail to provide appropriate training in how to provide care in this medium.

Further, CMS should ensure that there is parity for Medicaid enrollees when it comes to telehealth services. Providers and their staff should not have to sift through different regulations to understand what services a patient is eligible for based on their insurance coverage. We cannot allow a tiered system to emerge. And, we must figure out a framework that allows for appropriate care across borders, especially in high priority fields like behavioral health.

Question. Wyoming has many passionate advocates supporting both hospice and palliative care. These folks are committed to ensuring patients have the highest quality of life and are able stay out of the hospital and with their families. This is why I help lead the bipartisan Comprehensive Care Caucus. Our mission is to improve both palliative and hospice care for patients.

Answer. Palliative care and hospice care are some of our most sacred duties we have as physicians to our patients, and their loved ones. Even before the COVID–19 pandemic, MCHS was committed to using new models of care to provide comfort and support to patients throughout their care journey. Our model of home-based care, Home Recovery, has been deployed to assist patients in these circumstances. This is especially important in rural areas where palliative care and hospice facilities are less common. Additionally, because of longer distances between home and facility, virtual care cuts down on the stress to the patient, as well as burdens to their families/caregivers. And virtual care in these settings routinely allows for more fulsome discussion with families and the patients about their wishes, and gives greater peace to all involved.

Continuing to allow for these types of services through telehealth and other virtual platforms will go a long way to ensuring all patients can go through this type of care with dignity. For the last 3 years MCHS has been at the forefront of delivering a large spectrum of services that are traditionally only offered as inpatient services to our patients in the comfort of their home. This experience has demonstrated that patients routinely prefer to be at home, and that outcomes at home are usually much better than in a hospital setting. That is because patients are most comfortable where they live.

We should continue to expand on the opportunity to bring care to the homes of patients leveraging technology and telehealth, and when that is not possible to deliver it close to home at the best facility for the patient and their families. That will make a difference in the experience for all involved, the patient, their family and the provider. It is an exciting potential, and one that we should all work together to realize in the coming months and years. To achieve this grand goal, we must allow programs like the Hospital Without Walls and other flexibilities to remain intact and to establish new policies that promote home- based care. It will also be necessary to educate providers, payers, and patients about the best practices in delivering care this way, and how it benefits all parties involved.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

When COVID–19 hit, it was no longer safe to meet face to face, take a bus to the doctor's office, or even walk into the hospital for care. Congress, Federal agen-

cies, and health-care providers had to act fast with bold changes to prevent a dramatic disruption of health care in America.

This morning's hearing is an opportunity to talk about the changes that ought to stick around post-pandemic, and there's no better example than telehealth. Right at the top, I want to thank Senator Crapo for proposing a hearing on this vital topic, where there's a big opportunity for the two sides to work together.

The telehealth challenge has always been about balancing the speed and efficiency of new technologies with the need for health-care quality and accountability. During the pandemic, some patients have felt like they had to jump through too many hoops to get access to telehealth. My view is, as a general proposition, patients ought to have telehealth available as an option after seeing a provider for the first time.

In some cases, the right approach might be to give the green light for telehealth from the beginning. I hope today the committee is able to discuss how to go about striking that balance after a year of telehealth experience during the pandemic.

Last year, in the CARES Act, Congress allowed health-care providers in Medicare to offer telehealth services to all seniors, regardless of whether they lived in the biggest city or the smallest rural town. That brought badly needed health-care safely into the homes of tens of millions of seniors nationwide.

The CARES Act also allowed Federally Qualified Health Centers, including community health centers and Rural Health Clinics, to receive Medicare payment for telehealth services, allowing more health-care providers to help meet the overwhelming demand for remote health services.

Fortunately, the Finance Committee had already paved the way for a lot of these changes, which means they were a lot easier to adopt. Telehealth has been a Finance Committee priority for years, particularly when it's part of the effort to update the Medicare guarantee.

For many years, the Congress fell behind in terms of recognizing the transformation of this flagship health-care program. When the Medicare program was designed, it was built to cover acute conditions—broken ankles under Medicare Part A, bouts of the flu under Part B. Modern-day Medicare is about cancer, diabetes, heart disease, and more of the chronic health conditions that are a lot more complicated and more expensive to treat. Telehealth is going to be a bigger part of that transformation going forward.

The CHRONIC Care Act, passed by this committee in 2017, marked the very first time seniors could get telehealth at home for kidney disease. The law also made it easier to use telehealth to diagnose and treat strokes. It allowed more flexibility for Medicare Advantage plans and Accountable Care Organizations. When the pandemic hit, CMS already had a head start for telehealth.

Federal agencies also took advantage of existing law to allow providers to care for their patients in fresh ways. For example, certain hospital doctors and nurses were able to travel out into their communities and provide services at home that would typically be reserved for inpatient care.

Others were able to set up temporary spaces like tents near hospitals themselves. That wasn't allowed in ordinary times pre-pandemic. These steps have increased capacity, kept patients safe, and helped maintain care.

Today the committee will hear from physicians and hospitals who have been on the front lines, as well as health policy experts. They have seen how these fresh approaches transformed care. In my view, there is bipartisan interest in building on the changes that worked well for both seniors and providers.

That bipartisan work has already begun. At the end of last year, Congress passed legislation that allowed all seniors in Medicare to receive mental health services via telehealth, including at home. My view is, mental health services ought to be available via telehealth for all Americans. That provision was part of a bill I authored that would also permanently allow telehealth for routine health-care visits in Medicare, known as evaluation and management services. I'm going to keep working to make that a reality.

So there's a lot for the committee to discuss today. I'd like to welcome the witnesses, and again I want to thank Ranking Member Crapo for his partnership on this bipartisan issue.

Medicare Payment Advisory Commission (MedPAC)
425 I Street, NW, Suite 701
Washington, DC 20001
202–220–3700
https://www.medpac.gov/

Michael E. Chernew, Ph.D., Chair • Paul B. Ginsburg, Ph.D., Vice Chair
James E. Mathews, Ph.D., Executive Director

Statement of Michael E. Chernew, Ph.D., Chair

The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (Pub. L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health-care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly. The Commission would like to thank Chair Wyden and Ranking Member Crapo for the opportunity to submit a statement for the record today.

The Congress and the administration granted temporary modifications to Medicare policies to enable providers, health plans, and others to effectively respond to the coronavirus pandemic. While many of these actions have been helpful in addressing the short-term issues presented by the pandemic, continuing those changes indefinitely would have drawbacks. Therefore, policymakers should be cautious about extending them beyond the duration of the public health emergency (PHE) or other scheduled expiration date.

Introduction

The Commission acknowledges the catastrophic consequences the coronavirus pandemic has had on all Americans and the health-care delivery system. Medicare beneficiaries are at particular risk of developing COVID–19, and those over 65 years old are more likely to suffer complications and die compared to those who are younger and have fewer comorbidities. Non White beneficiaries have faced disproportionately high rates of mortality due to COVID–19, reflecting, in part, longstanding inequities in the health-care system. The Commission also recognizes the heroic work performed by the nation's health-care workers, who have been on the front lines of this health crisis for more than a year, and thanks them for their tireless dedication and service.

The coronavirus pandemic has put our nation's health-care system under enormous strain. Starting in March of last year, cases of patients infected with the coronavirus began to rise sharply at institutional settings, like hospitals and nursing homes. Hospital emergency rooms and intensive care units were regularly filled with patients affected by the pandemic, and beneficiaries in nursing homes have accounted for a disproportionate share of fatalities from COVID–19.

Meanwhile, the volume of ambulatory care services furnished to Medicare beneficiaries dropped sharply last spring as patients delayed or avoided care, and access to some services was curtailed to avoid spreading the disease. The number of ambulatory care services furnished to Medicare beneficiaries in the spring of 2020 was about half of the volume of the same services furnished during the same period the year before. The sudden decline in service volume during this period placed many providers under financial stress and may have put patient health and well-being at risk.

Actions Taken to Modify Medicare Policies in Response to the Public Health Emergency

As the coronavirus emerged in the U.S. and our health-care system confronted extraordinary challenges, the Secretary of Health and Human Services first declared the public health emergency in January 2020.[1] Starting in March 2020, CMS and the Congress made numerous changes to Medicare policies and granted regulatory flexibilities aimed at helping health-care providers respond to the pandemic. We ap-

[1] Under section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. On January 31, 2020, the Secretary first determined the existence of a coronavirus PHE since January 27, 2020, based on confirmed cases of COVID–19 in the U.S. Since then, the coronavirus PHE has been renewed five times, most recently on April 15, 2021, and is scheduled to expire on July 20, 2021 (Office of the Assistant Secretary for Preparedness and Response 2021).

plaud CMS and policymakers for acting rapidly to provide a comprehensive array of policy modifications and flexibilities during an unprecedented time.

According to a report from the Commonwealth Fund, the administration and Congress modified more than 200 Medicare program policies and requirements between January and July 2020 (Podulka and Blum 2020). In addition, CMS has been issuing subregulatory flexibilities to providers and plans since the PHE began. Some of these measures have been phased out, but many of these temporary policy changes are scheduled to remain in effect for the duration of the PHE.

In general, the steps taken by CMS and the Congress are time limited and intended to support providers in diagnosing and treating COVID–19 patients by reducing or eliminating certain regulatory requirements and enabling providers to treat Medicare beneficiaries under social distancing protocols. The regulatory and legislative changes fall into nine broad categories (Podulka and Blum 2020):

- Alternative care sites.
- Benefits and care management.
- Conditions of participation.
- Expanded testing.
- Payment systems and quality programs.
- Provider capacity and workforce.
- Reporting and audit requirements.
- Safety requirements.
- Telehealth.

A plurality of the regulatory changes eased some provider eligibility requirements. Regulatory waivers allowed providers to furnish services outside the state where they are enrolled and permitted beneficiaries to receive care in settings other than acute care hospitals (*e.g.,* homes and skilled nursing facilities) to allow for surge capacity in those hospitals. Some of the changes suspended audits and quality reporting requirements or granted more flexibility over which measures to report. CMS has also expanded access to telehealth services in a variety of ways, including temporarily eliminating geographic restrictions on where such services can be provided and expanding the types of services that can be furnished remotely.

Although the pandemic-related policy changes and flexibilities have touched almost every part of the Medicare program, I want to focus on two areas where the changes are especially important: telehealth and post-acute care.

Telehealth: The changes made to Medicare's telehealth coverage and payment policies enabled more types of services to be furnished remotely to more Medicare beneficiaries. These changes contributed to a substantial increase in the number of Medicare-covered services furnished via remote technologies, which helped to offset the decrease in in-person clinician visits.

Post-acute care: CMS modified numerous post-acute care (PAC) policies and requirements to preserve hospital capacity for beneficiaries with COVID–19. These actions enabled inpatient rehabilitation facilities and long-term care hospitals to treat certain hospital-level patients that do not meet certain requirements for these PAC settings and, in some cases, be paid the higher PAC-level payments. These waivers also extended skilled nursing facility coverage to beneficiaries who normally would not qualify.

The temporary waivers and other policy changes gave providers the flexibility to maintain access to care under social distancing guidelines and helped providers to respond to surges in COVID–19 cases by providing capacity beyond the acute care setting. These have been important tools for providers during the pandemic, but policymakers would be remiss in thinking that the extending these measures has only the potential for good. The underlying policies and regulations that have been waived or altered are designed to protect beneficiaries, support program integrity, and minimize potential overuse and misuse based on the incentives of the payment systems. As decisions are made about which pandemic-related measures should be continued, policymakers need to account for the fact that not all actors in the health-care system are well-intentioned, and remain vigilant in protecting the Medicare program, beneficiaries, and taxpayers.

Telehealth

Medicare coverage of telehealth services before the PHE was limited by statute under the physician fee schedule (PFS). Before the PHE, Medicare covered telehealth services if they were provided to beneficiaries who received the service at a clinician's office or certain health-care facilities (known as "originating sites") lo-

cated in a rural area, with some exceptions.[2] Medicare has historically been cautious about covering telehealth services because of uncertainties about the impact of telehealth on total spending, quality, and program integrity.

Prior to the PHE, the Commission evaluated the use of telehealth in the Medicare program and whether telehealth services covered under commercial plans should be incorporated into the Medicare fee-for-service (FFS) program (Medicare Payment Advisory Commission 2018). Our analysis of a sample of commercial insurers found a lack of uniformity in how these insurers covered telehealth services. Consequently, we did not make recommendations about covering specific telehealth services in Medicare. Instead, the Commission recommended that policymakers should use a set of principles (access, quality, and cost) to evaluate individual telehealth services before covering them in Medicare.

To increase access to care and help limit community spread of COVID–19 during the PHE, Medicare temporarily expanded coverage of telehealth under the PFS to all Medicare beneficiaries, including telehealth visits provided to patients at home (Table 1).

Table 1. Selected Temporary Telehealth Expansions to the Physician Fee Schedule During the Public Health Emergency

	Pre-PHE	During the PHE
Who can receive telehealth services?	Clinicians can provide telehealth services to Medicare beneficiaries in certain originating sites in rural areas (*e.g.,* a clinician's office or hospital but not the beneficiary's home).	Clinicians may provide telehealth services to Medicare beneficiaries outside of rural areas and in the patient's home.
Which types of telehealth services does Medicare pay for?	Limited set of services (does not include audio-only E&M visits).	CMS pays for over 140 additional services (*e.g.,* emergency department visits, radiation treatment management). CMS allows audio-only interaction for some of the telehealth services and covers audio-only E&M codes.
How much does Medicare pay for telehealth services?	PFS rate for facility-based services (less than the nonfacility rate).	PFS rate is the same as if the service were furnished in person (facility or nonfacility rate, depending on the clinician's location). Same for audio-only visits.
What are the costs to beneficiaries?	Standard cost sharing.	Clinicians are permitted to reduce or waive cost sharing.

Note: PHE (public health emergency), E&M (evaluation and management), PFS (physician fee schedule). Under the PFS, clinicians who provide services in facilities such as hospitals receive a lower payment rate (the facility rate) than clinicians who provide services in offices (the nonfacility rate).

During the PHE, demand for telehealth services soared as providers and beneficiaries sought to reduce the risk and spread of infection by avoiding in-person visits. According to an analysis of FFS Medicare claims data from the first 6 months of 2020 and the first 6 months of 2019, there were 8.4 million telehealth services paid under the PFS in April 2020, compared with 102,000 in February 2020 (Medicare Payment Advisory Commission 2021). The number of telehealth services declined to 5.6 million in June 2020, as the number of in-person services began to re-

[2] Medicare pays for some telehealth services outside of rural areas and in any location, including a patient's home, including telehealth services for substance use disorders, for end-stage renal disease patients receiving home dialysis, and for mental health conditions (if the physician or practitioner has furnished an in-person service to the individual within the 6 months prior to the first time they furnish the telehealth service, and during subsequent periods that the Secretary would determine). Medicare also covers telehealth services to treat patients with a stroke in hospitals in urban and rural areas.

bound. During the first 6 months of 2020, 10.3 million beneficiaries in FFS Medicare (32 percent of the total) received at least one telehealth service, compared with 134,000 beneficiaries during the first 6 months of 2019. The share of all primary care services conducted by telehealth rose dramatically from less than 1 percent in January 2020 to 47 percent in April.[3] The share declined to 31 percent in May and 18 percent in June as in-person primary care services rebounded. The Commission will analyze more recent claims data over the next year.

Rationale for Telehealth Expansion and Potential Safeguards

During the past year, the Commission discussed whether the temporary telehealth expansions should continue in Medicare after the PHE. Many providers and beneficiaries have described the benefits of increased access and convenience from telehealth during the PHE. Advocates of telehealth services support making the temporary expansion of telehealth in Medicare permanent after the PHE. They assert that these services can expand access to care, increase convenience to patients, improve quality, and reduce costs relative to in-person care. However, there is a risk that under FFS Medicare, telehealth services could supplement—rather than substitute for—in-person services, thereby increasing spending for Medicare and patients (Ashwood et al. 2017, Mehrotra et al. 2020). Telehealth could lead to higher volume if telehealth providers induce demand for their services, if the greater convenience of telehealth leads beneficiaries to use telehealth services more frequently than in-person services, or if additional in-person follow-up visits are required. Although there are some clinical trials comparing telehealth and in-person care, there is not yet evidence on how the combination of telehealth and in-person care affects quality of care and outcomes.

Expanding telehealth services also raises program integrity concerns. Telehealth companies have been involved in several large fraud cases, resulting in billions of dollars in losses for Medicare. For example, the Department of Justice (DOJ) recently charged defendants—including telemedicine companies—with submitting false and fraudulent claims worth more than $4.5 billion to federal health programs and private insurers (Department of Justice 2020). Telehealth technology makes it easier to carry out fraud on a large scale because clinicians employed by fraudulent telehealth companies can interact with many beneficiaries from different parts of the country in a short amount of time. In addition, if beneficiaries become more comfortable receiving care by telehealth, they might become more vulnerable to being exploited by companies that pretend to be legitimate telehealth providers.

In considering a permanent expansion of telehealth, it is important to balance the potential of telehealth to improve beneficiaries' access to care with the risk of higher spending due to overuse, while ensuring that beneficiaries receive high-quality care. In our March 2021 report to the Congress, we present a policy option for expanding FFS Medicare's coverage of telehealth services after the PHE (Medicare Payment Advisory Commission 2021). In developing this policy option, we maintain our previous recommendation that policymakers should use the principles of access, cost, and quality to evaluate individual telehealth services before covering them under Medicare.

Under this policy option, policymakers should continue some telehealth expansions for a limited duration following the end of the PHE (*e.g.,* one to two years) to gather more evidence about the impact of the telehealth expansions on total spending, access, patient experience, and outcomes of care. Policymakers should use this evidence to inform any permanent changes. First, Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location. Second, Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit. Third, to improve access to those without the capability to engage in a video visit from their home, Medicare should temporarily cover certain telehealth services when they are provided through an audio only interaction if there is potential for clinical benefit.

Other telehealth policies that were adopted during the PHE should end when the PHE ends. First, Medicare should return to paying the fee schedule's facility rate for telehealth services instead of paying either the facility or nonfacility rate, as it

[3] Primary care services include the following PFS services: office/outpatient evaluation and management (E&M) visits, home E&M visits, E&M visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care), audio-only E&M visits, chronic care management, transitional care management, Welcome to Medicare visits, annual wellness visits, e-visits, and advance care planning services.

does during the PHE. CMS should also collect data from practices and other entities on the costs they incur to provide telehealth services and make any future changes to telehealth payment rates based on those costs. We expect the rates for telehealth services to be lower than rates for in-person services because services delivered via telehealth likely do not require the same practice costs as services provided in a physical office. Although telehealth may require upfront investments in technology and training, in the long run the marginal cost of a telehealth service should be lower than that of an in-person service (Mehrotra et al. 2020).

In addition, Medicare should require the same share of beneficiary cost sharing for telehealth as it does for in-person service after the PHE. Because telehealth services are more convenient for beneficiaries to access, they have a higher risk of overuse than in-person services, particularly in the context of a fee-for-service payment system in which providers have a financial incentive to bill for more services. Requiring beneficiaries to pay a portion of the cost of telehealth services would help reduce the possibility of overuse.

After the PHE, CMS should implement other safeguards to protect the Medicare program and its beneficiaries from unnecessary spending and potential fraud related to telehealth, including:

- Applying additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians;
- Requiring clinicians to provide an in-person, face-to-face visit before they order high-cost durable medical equipment or high-cost clinical laboratory tests; and
- Prohibiting "incident to" billing for telehealth services provided by any clinician who can bill Medicare directly.

In future work, we will continue to monitor beneficiaries' and providers' experiences with telehealth in Medicare and the use of telehealth during the PHE. We plan to continue exploring trends in telehealth use and spending using more recent Medicare claims data. This summer, we will ask clinicians and Medicare beneficiaries about their use of telehealth during focus groups, and we will ask beneficiaries and privately insured individuals about their use of telehealth during our annual telephone survey. In addition, we continue to meet with telehealth companies and other stakeholders and will regularly inform the Congress of our work.

Post-Acute Care

Institutional post-acute care (PAC) settings-skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs)-provide care to patients who need skilled institutional care to recuperate and regain function, typically following an acute care hospital stay. The Medicare program maintains separate conditions/requirements of participation and coverage rules and uses setting-specific prospective payment systems (PPSs) to pay for stays in each setting. Distinct facility and patient requirements help ensure that care provided in each setting is consistent with Medicare coverage rules and help control unnecessary spending for care in high-cost settings when patients' conditions do not warrant this level of care.

During the PHE, CMS used its emergency and other waiver authority to modify numerous policies and requirements intended to preserve hospital capacity for beneficiaries with COVID–19 (Centers for Medicare and Medicaid Services 2021b). Waivers allowed IRFs and LTCHs to be paid the higher-level payments for some cases that do not qualify as IRF or LTCH stays, and they extended SNF coverage to beneficiaries who normally would not qualify for SNF stays. The SNF, IRF, and LTCH facility and patient requirements and PHE-related waivers are summarized below.

Skilled nursing facility requirement. Beneficiaries who need daily, short-term skilled nursing or rehabilitation care on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in SNFs. By limiting coverage to post-hospital "skilled" services, the program extends coverage for services similar to those provided to hospital inpatients, but at a lower level of care, and effectively excludes long-term care, which is not a covered Medicare benefit.

Skilled nursing facility waiver. During the PHE, CMS is waiving the requirement for a three-day prior hospitalization for coverage of a SNF stay for beneficiaries who experience dislocations or were otherwise affected by COVID–19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, CMS authorizes renewed SNF coverage without first having to start a new benefit period. These waivers allowed facilities to "skill in place" beneficiaries who required skilled care without having to transfer them to a hospital for a three-day hospital stay and

helped retain hospital capacity for COVID–19 patients. CMS estimated that about 16 percent of SNF admissions in fiscal year 2020 used a waiver, and the majority of those were attributed to the waived prior hospital stay requirement (Centers for Medicare and Medicaid Services 2021b).

Inpatient rehabilitation facility requirements. After an illness, injury, or surgery, some beneficiaries need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. For a facility to receive payment as an IRF, 60 percent of its admissions must be for one of 13 conditions that typically require intensive rehabilitation therapy (referred to as the "60-percent rule"). To qualify for admission to an IRF, a beneficiary must be able to tolerate and benefit from intensive therapy, typically defined as three hours of therapy a day at least five days a week (referred to as the "3-hour rule"). These Medicare requirements help ensure that only the most appropriate patients are eligible to receive care at this relatively costly setting, given that many beneficiaries are able to receive care at lower-cost settings.

Inpatient rehabilitation facility waiver. CMS is allowing IRFs to exclude from the calculation of their compliance with the 60-percent rule those patients who were admitted in response to the PHE. CMS is also waiving the three-hour therapy rule, as required by Section 3711(a) of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. These waivers effectively allow IRFs to admit patients who would not normally qualify for IRF care and provide additional hospital beds for surge capacity in communities that need it. These cases may be paid the IRF PPS rates in freestanding IRFs in areas experiencing a surge during the PHE.[4]

Long-term care hospital requirements. Some patients with profound debilitation of multiple systems, frequently with ongoing respiratory failure, receive care in an LTCH. To be paid at the higher standard Medicare LTCH payment rate, a case must immediately follow an acute care hospital stay, not be a psychiatric or rehabilitation case, and the preceding hospital stay must include three or more days in an intensive care unit or the LTCH case must include mechanical ventilation services for at least 96 hours. If these requirements are not met, cases are paid at a lower "site-neutral" rate. In addition, to qualify for Medicare payment as an LTCH, a facility must have an average length of stay greater than 25 days for Medicare cases paid the LTCH PPS standard payment rate. Finally, if less than 50 percent of Medicare discharges qualify for the standard LTCH PPS rate, the facility is to be paid under the acute care hospital PPS until that share reaches 50 percent or higher. As with Medicare's IRF requirements, LTCH criteria were implemented to ensure that Medicare does not pay the high LTCH rates for lower-acuity cases that can be cared for in other, lower-resource intensive settings.

Long-term care hospital waiver. Consistent with section 3711(b) of the CARES Act, all cases admitted are being paid the LTCH payment rate, even those that normally would not qualify for the higher LTCH rate, for the duration of the PHE. In addition, all cases will be counted as discharges paid the LTCH PPS rate for purposes of calculating an LTCH's share of Medicare discharges that qualify for the standard LTCH PPS rate. In addition, CMS waived the 25-day average length-of-stay requirement to participate in the LTCH PPS when an LTCH admits or discharges patients to meet the demands of the PHE. These waivers enable LTCHs to treat a broad mix of patients, including overflow short-term acute care hospital patients, and be paid LTCH payment rates.

Waived PAC Criteria Should Be Reinstated When the Public Health Emergency Ends

The waivers of facility and patient requirements for SNFs, IRFs, and LTCHs are examples of policy changes that provide flexibility to expand capacity and reduce patient transfers for the duration of the PHE. The waivers allowed providers to be paid for Medicare patients that would not ordinarily qualify for payment in those settings or to be paid higher rates for those patients during the PHE, but there are compelling reasons to reinstate these waived requirements after the PHE is over. Making these changes permanent would roll back gains in defining appropriate use

[4] A state (or region, as applicable) that is experiencing a surge means a state (or region, as applicable) that satisfies all of the following, as determined by applicable state and local officials: (1) all vulnerable individuals continue to shelter in place, (2) individuals continue social distancing, (3) individuals avoid socializing in groups of more than 10, (4) non-essential travel is minimized, (5) visits to senior living facilities and hospitals are prohibited, and (6) schools and organized youth activities remain closed (Centers for Medicare and Medicaid Services 2021a).

of costly settings and expose the Medicare program to increased spending. For example, until 2016, the lack of meaningful criteria for LTCH use resulted in admissions of less-complex patients who could be cared for appropriately in lower-cost settings. The Commission and CMS had long been concerned that caring for lower-acuity patients in LTCHs increased spending without demonstrable improvements in quality or outcomes (Medicare Payment Advisory Commission 2020). When "site-neutral" payments for less-complex patients were implemented starting in 2016 and LTCHs received lower acute hospital rates for these cases, providers responded by reducing the number of site-neutral cases treated in LTCHs (Medicare Payment Advisory Commission 2021).

Studies of the impact of eliminating the SNF prior-hospitalization requirement (along with other changes) under the Medicare Catastrophic Coverage Act suggest that spending would increase substantially without the three-day rule to act as a guardrail for program spending (Aaronson et al. 1994, Laliberte et al. 1997, Office of Inspector General 1991). To balance the objectives of updating the policy to reflect current hospital practices yet protect the Hospital Insurance Trust Fund, in 2015 the Commission recommended that the three-day policy be revised to allow up to two days spent in outpatient observation status to count toward the three-day prior hospitalization requirement (Medicare Payment Advisory Commission 2015). When the three day hospital stay waiver is lifted, the Congress should revise it to allow two of the days in observation status to count towards meeting the required three-day stay.

While Medicare permitted the SNF three-day stay requirement to be waived for entities participating in bundled payment demonstrations, some entities did not take advantage of this flexibility (Dummit et al. 2018, Lewin Group 2019, The Lewin Group 2020). Similarly, not all Next Generation ACOs elected to waive the three-day stay requirement (NORC at the University of Chicago 2020). However, since these bundled payment entities and ACOs are at full risk, this experience may not be relevant to entities operating under traditional FFS Medicare. This is because they already have a financial incentive to control the total cost of care to Medicare, unlike providers not at financial risk under traditional Medicare.

In 2016, the Commission recommended design features of a unified payment system for post-acute care that would pay for PAC services based on patient characteristics and needs, rather than setting (Medicare Payment Advisory Commission 2016). Later, it outlined a patient centered approach to align regulatory requirements so that providers would face similar regulatory requirements for treating similar patients (Medicare Payment Advisory Commission 2019). Until a uniform payment system is implemented and regulatory requirements are aligned, institutional PAC settings' patient and facility criteria provide important program safeguards against paying for unnecessary care and help ensure that care provided in costly, intensive settings is targeted to patients who can benefit from that level of care.

Policymakers Should Be Cautious About Making Current Flexibilities and Policy Modifications Permanent

It is important to keep in mind the reasons that policies and rules in place prior to the pandemic exist. Many of the Medicare policy changes made in response to PHE affect important beneficiary protections, as well as measures designed to deter fraud, overuse, or inappropriate spending. The intended effects of the regulatory flexibilities and other changes to Medicare's policies are to maintain beneficiary access to needed services and help the health-care system to respond to the pandemic, but these flexibilities can also have negative effects. For example, waiving conditions of participation can expand access and minimize provider burden, but looser regulations may also negatively affect quality of care and quality of life for patients and put Medicare at higher risk for waste and fraud by creating opportunities for those who wish to exploit the program to do so.

If it is determined that any temporary policy changes are leading to poor health outcomes, patient harm, or increases in fraud and abuse, policymakers should take immediate action to curtail those flexibilities prior to the end of the PHE. Likewise, some of the temporary policy changes that were viewed as necessary during the worst days of the PHE—such as increased payment rates for certain services—may no longer be needed as the effects of the pandemic wind down.

In other cases, decisions about whether to extend or make permanent policy modifications after they are scheduled to expire should be made based on evaluation of data collected not only during the pandemic, but also during more typical circumstances. That being said, we do not yet have reliable information about how policy modifications and flexibilities granted during the PHE have affected health sta-

tus, access, spending, program integrity, and other important considerations. Furthermore, findings on the effects of policy changes based on data collected during a pandemic may not be generalizable to the post-pandemic environment. For instance, the impact of the modifications that increased use of telehealth on quality and cost of care are largely unknown and will take time to fully analyze, and findings from 2020 could be shaped by factors that may not be applicable after the pandemic.

Conclusion

MedPAC recognizes the tremendous challenges the coronavirus pandemic has imposed on beneficiaries, providers, and the rest of the health-care system. We applaud the quick and decisive actions taken by the Congress and CMS aimed at maintaining access to care and enabling an effective response to the public health emergency. In general, the Commission has been supportive of the temporary waivers, flexibilities, and other changes to Medicare policies implemented during the PHE. We are supportive of continuing some of the telehealth expansions for a limited time, beyond the PHE, provided that adequate oversight and protections are in place to protect the Medicare program and beneficiaries. We would not advise extending the PAC waivers beyond the PHE.

The Commission is also supportive of efforts by this Committee and others to review the changes and make determinations about which, if any, flexibilities and policy changes should be continued, and which should be reinstated once the PHE ends. We realize many stakeholders see the benefits of less regulatory oversight and expanded coverage of services like telehealth, along with other pandemic-related policy changes, and wish to see them made permanent. But the Commission is concerned about the implications of indefinitely continuing Medicare policy modifications and flexibilities that were granted in direct response to the unique circumstances of the coronavirus pandemic. There are trade-offs to extending PHE-related modifications, and the benefits of continuing these changes must be weighed against the potential drawbacks, including substantial spending and program integrity implications.

Although we are concerned about the potential for some of the waivers and coverage expansions to lead to overuse of services and reductions in quality of care, these modifications may not have the same drawbacks when implemented in alternative payment arrangements to traditional FFS where an entity is at financial risk for the cost and quality of care. In fact, many existing Medicare alternative payment models (APMs) contain waivers and flexibilities similar to those granted during the PHE. As noted earlier, many APMs permit beneficiaries to receive care in a SNF without a preceding three-day inpatient hospital stay, and there are fewer restrictions on telehealth compared to traditional FFS. The Commission is hopeful that the continued development of such models can help facilitate more flexibility for providers and expanded coverage of technologies such as telehealth, while minimizing the negative behaviors.

In closing, MedPAC urges the administration and the Congress to carefully consider how making waivers permanent will affect the quality of care beneficiaries receive, the willingness of providers to continue to participate in the Medicare program, and the already challenging issues of fiscal solvency and Medicare program integrity. The Commission plans to continue to follow the status of the temporary policy changes and waivers granted during the PHE and will be closely monitoring their impact on the program. Ultimately, all decisions about whether to continue these measures beyond the PHE should balance the benefits of expanding access to care and reducing administrative burden with the need to minimize the potentially negative effects that the rules and policies were originally designed to prevent.

References

Aaronson, W.E., J.S. Zinn, and M.D. Rosko. 1994. The success and repeal of the Medicare Catastrophic Coverage Act: A paradoxical lesson for health-care reform. *Journal of Health Politics, Policy and Law* 19, no. 4 (Winter): 753–771.

Ashwood, J.S., A. Mehrotra, D. Cowling, et al. 2017. Direct-to-consumer telehealth may increase access to care but does not decrease spending. *Health Affairs* 36, no. 3 (March 1st): 485–491.

Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2021a. Medicare and Medicaid programs, Basic Health Program, and Exchanges; additional policy and regulatory revisions in response to the COVID–19 public health emergency and delay of certain reporting requirements for the Skilled Nursing Facility Quality Reporting Program. Interim final rule with comment period. *Federal Register* 85, no. 90 (May 8): 27550–27629.

Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2021b. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the Quality Reporting Program and Value-Based Purchasing Program for federal fiscal year 2022. Proposed rule. *Federal Register* 86, no. 71 (April 15): 19954–20022.

Department of Justice. 2020. National health-care fraud and opioid takedown results in charges against 345 defendants responsible for more than $6 billion in alleged fraud losses. News release. September 30th, *https://www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants.*

Dummit, L., G. Marrufo, J. Marshall, et al. 2018. *CMS Bundled Payments for Care improvement Initiative Models 2–4: Year 5 evaluation and monitoring annual report.* Falls Church, VA: The Lewin Group.

Laliberte, L., V. Mor, K. Berg, et al. 1997. Impact of the Medicare Catastrophic Coverage Act on nursing homes. *Milbank Quarterly* 75, no. 2: 203–233.

Lewin Group. 2019. *CMS Comprehensive Care for Joint Replacement Model: Performance year 2 evaluation report—Appendices.* Falls Church, VA: The Lewin Group, *https://downloads.cms.gov/files/cmmi/cjr-secondannrpt-app.pdf.*

Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Mehrotra, A., B. Wang, and G. Snyder. 2020. Telemedicine: *What should the post pandemic regulatory and payment landscape look like?* Issue brief. New York, NY: The Commonwealth Fund.

NORC at the University of Chicago. 2020. *Second evaluation report technical appendices: Next Generation Accountable Care Organization Model evaluation.* Report prepared by staff from NORC at the University of Chicago for the Center for Medicare and Medicaid Innovation, Bethesda, MD: NORC.

Office of Inspector General, Department of Health and Human Services. 1991. *Influences on Medicare's skilled nursing facility benefit,* Washington, DC: OIG.

Office of the Assistant Secretary for Preparedness and Response, Department of Health and Human Services. 2021. Renewal of determination that a public health emergency exists, *https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-l5April2021.aspx.*

Podulka, J., and J. Blum. 2020. *Regulatory changes to Medicare in response to COVID–19.* Issue brief, Washington, DC: Commonwealth Fund, *https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/regulatory-changes-medicare-response-covid-19.*

The Lewin Group. 2020. *CMS Comprehensive Care for Joint Replacement Model: Performance year 3 evaluation report.* Falls Church, VA: The Lewin Group, Abt Associates, GDIT, and Telligen, *https://innovation.cms.gov/data-and-reports/2020/cjr-thirdannrpt.*

COMMUNICATIONS

ADVENTIST HEALTH

May 26, 2021

Senator Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

Senator Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

RE: Mayo Clinic Statement for the Record for the Committee hearing entitled: "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned," May 19, 2021

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of Adventist Health and the patients we serve, thank you for holding the May 19, 2021 hearing on "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." We commend the committee for addressing this important issue and analyzing critical lessons learned from the hospital and patient perspectives. We look forward to supporting the evolution and advancement of health-care flexibilities today and post-pandemic.

Adventist Health is a faith-based, nonprofit integrated health system serving more than 80 communities in California, Hawaii, and Oregon. Adventist Health provides compassionate care in 23 rural and urban safety net hospitals. We operate the largest network of rural health clinics in California, with more than 20 percent of California's Rural Health Clinics as a part of the system. Our rural Health Clinics (RHCs) provide care to about 315,000 individuals who mostly live in medically underserved communities.

Adventist Health is transforming the health-care experience, shifting from providing care to focusing on the overall health of the communities it serves. This includes embracing technology that makes care more convenient and accessible. The beginning of 2020 introduced a disruption that has created more opportunities for virtual visits, which are an essential component of health-care innovation that have proven to be a lifeline during the COVID–19 pandemic. This innovative approach also offers insights on the virtual hospital of the future. In May of 2020, Adventist Health created a new care model that is reshaping the way acute care is delivered to the system's communities. Hospital@Home, in collaboration with Medically Home Group, Inc. and Huron, is a virtual hospital that harnesses virtual and telemedicine technologies proven successful in hospitals for the last decade, to provide care in a patient's home.

Telehealth services, like those provided by Hospital@Home, are more convenient and accessible than traditional office visits and can greatly benefit populations who find it difficult to manage their health-care needs in person. Our virtual visits provide crucial access to care for high-risk patients who need to stay home to protect themselves, both during public health crises and in normal times. Our telehealth services also provide vital access for patients in rural communities, where in-person clinic visits may require extraneous time and effort to schedule and attend. Virtual visits are also an essential way for patients to receive mental and behavioral health-

care services that are increasingly necessary for whole-person care, but often difficult to access. Telehealth services are an important way for traditionally disadvantaged patient populations to easily connect to primary as well as specialty care providers that may not be accessible in person. It has been a critical lifeline for the patients and communities we proudly serve.

The past year has demonstrated the undeniable value of virtual care. However, much work remains to be done to ensure the continued growth of telehealth and preserving beneficiary choice in how care is furnished. Expedient action from Congress is essential to permanently establish the flexibilities granted to CMS during the COVID–19 pandemic and to subsequently authorize CMS to build out an accompanying regulatory framework.

Virtual Care at Adventist Health

During the pandemic, Adventist Health's clinical and digital teams provided essential remote care through 300,000 telephone and video visits. Through our virtual care we have seen a decrease in missed visits, our patient satisfaction rates have increased and we are able to create access points to our most vulnerable populations where we otherwise would not have.

Hospital@Home

In one of the most significant developments in remote care, in May of 2020, Adventist Health launched its Hospital@Home program to furnish acute-level services to patients in their home. Adventist Health's Hospital@Home serves patients in 7 locations throughout California and Oregon. The program has served hundreds of patients, delivering complex comprehensive acute care to qualifying patients in their homes. These services, provided in person and virtually, include infusions, nursing care, medications, laboratory and imaging services, and rehabilitation services from a network of registered nurses, community paramedics, and an ecosystem of support team members—all under the clinical direction of credentialed board certified hospitalists in Adventist Health command centers.

The availability of an acute care option at home was a critical tool in the pandemic response and Adventist Health's hospitals are approved participants under the CMS Acute Care at Home (CMS ACH) program announced in November 2020.

Our model counters isolation created by the COVID–19 pandemic and allows family members to be at a patient's bedside in their home, while helping hospitals balance the increased demand for hospital beds. The Adventist Health Hospital@Home care model is applied in emergency medicine, acute level COVID–19 care, and for patients with infections and chronic disease exacerbation (*e.g.,* CHF, COPD). This broad spectrum of applications unlocks patients' homes as a meaningful addition to flexible medical care capacity and supports greater health system resiliency, while meeting the needs and wants of patients who prefer to be cared for at home or in a home-like setting. The CMS ACH waiver expires at the end of the PHE, and it is essential that Congress act to extend the current waivers to enable Medicare beneficiaries to continue to access safe and effective acute-level care in the comfort of their home.

Since launching Hospital@Home in May 2020, Adventist Health has been collecting and analyzing data on Hospital@Home's impact on patient care, experience, acuity, readmission rates, and mortality. To date, Adventist Health has cared for over 500 patients and has had over 3,000 patient days, with promising data. For Adventist Health patients receiving care in the Hospital@Home program, the 30-day hospital readmission rate is 43.4% lower than the comparable population in the same timeframe within Adventist Health's traditional (brick and mortar) hospital practice.

To assess 2020 patient satisfaction, data collected using inpatient HCAHPS surveys have been generated for Hospital@Home patients, resulting in top decile scores for overall rating – 89.4% (n=53) – and would recommend – 87% (n=46).

Recommendations for Health Care Flexibilities

Adventist Health supports keeping these important flexibilities in place so that we can ensure that our forward momentum is built upon and that the significant investments in telehealth infrastructure and accessible patient care are maintained.

- **Geographic and originating site restrictions.** Before the pandemic, Medicare required that a patient either live in a rural or certain health professional shortage area or only use telehealth at an approved originating site, such as a hospital or physician's office. Together, these restrictions functionally prevented beneficiaries from accessing telehealth at home. Only about 2 percent of

beneficiaries reside in zip codes that meet the traditional geographic and originating site criteria.

- **FQHC and RHC expansion.** Without making permanent the COVID–19 regulatory flexibility, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will not be allowed to serve as distant site telehealth providers. This prevents low-income and geographically isolated individuals from utilizing accessible points of care for telehealth visits, creating barriers to affordable treatment for the populations who often need it most.
- **Qualifying providers.** When the PHE ends, CMS would currently have to revert to policies that restrict the types of providers that can deliver reimbursable virtual care to Medicare beneficiaries. Commonly accessed providers like physical therapists, occupational therapists and speech language pathologists would no longer be able to bill for telehealth services.
- **Audio-Only Services.** Audio-only services are critically important for many populations. Technology challenges, such as access to Internet/broadband and low digital literacy, is a telehealth barrier for 64% of patients. These patients require audio-only services to meet their unique needs.
- **Hospital Without Walls.** Acute Hospital Care at Home waivers mitigate the residual impacts of COVID–19 on public health and encourage broader adoption of providing patient centered health-care services in the home.

Thank you again for holding this important hearing. We look forward to continuing to work with Congress and HHS to ensure that access and quality care are available to our patients and our communities during and beyond the PHE, as well as to further provide groundwork for greater innovations in health-care delivery for the future.

Sincerely,

Scott Reiner, CEO

ADVOCATE AURORA HEALTH

June 2, 2021

Hon. Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Hon. Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Written Testimony Submitted to the Senate Committee on Finance for the May 19, 2021 Hearing Record, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of Advocate Aurora Health (Advocate Aurora), thank you for holding a hearing on May 19, 2021 titled, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." We are grateful for your leadership on—and attention to—this important topic. We appreciate the opportunity to submit this statement for the hearing record and thank you in advance for your consideration of our recommendations for how to sustain the gains made in telehealth deployment during the Public Health Emergency (PHE), fully harness the potential telehealth holds for tackling many of the challenging health-care issues facing our nation, including how to increase access to quality care, lower costs, eliminate health-care disparities, and address socioeconomic determinants of health (SDOH), such as lack of safe, reliable transportation.

Our clinicians feel strongly that telehealth, remote patient monitoring, and other health technology together are a powerful set of tools that can help expand access to care for rural and underserved communities, such as South Chicago and inner-city Milwaukee. For many patients, having the option to engage with a clinician via telehealth offers them a convenient clinical option as it eliminates the need for transportation, parking, and childcare and reduces absences from school or work. Further, for some patients with mobility challenges, disabilities, or other special needs, such as autism, telehealth and remote care can provide a more effective, less burdensome, and less stressful clinical care experience.

As enumerated further below, Advocate Aurora has appreciated the waivers and flexibilities afforded to clinicians during the PHE, and in particular, the waivers associated with telehealth have supported our ability to maintain continuity of care for a significant number of our patients and to expand access to care to traditionally underserved individuals and communities. As we begin to emerge from the PHE, it will be imperative that we retain the advances in telehealth. We thank you in advance for your consideration of our recommendations and requests with respect to making the PHE telehealth and related changes permanent.

Overview of Advocate Aurora

Advocate Aurora is a leading employer in the Midwest with more than 75,000 team members, including more than 22,000 nurses and the region's largest employed medical staff and home health organization. The system serves nearly 3 million patients annually; across both Illinois and Wisconsin, in particular, we serve an estimated 695,000 Medicare beneficiaries and more than 485,000 individuals with Medicaid coverage.

With more than 500 sites of care, Advocate Aurora is engaged in hundreds of clinical trials and research studies, and is nationally recognized for its expertise in cardiology, neurosciences, oncology, and pediatrics. The organization contributed $2.2 billion in charitable care and services to its communities in 2019. Advocate Aurora brings its strengths, assets, and commitment to delivering value and outcomes to individuals, families, and communities throughout Illinois and Wisconsin.

Advocate Aurora also serves as a transformative leader and strong partner with the federal government in the journey from volume to value. The Centers for Medicare & Medicaid Services in 2020 announced that Advocate Aurora Health's three affiliated Accountable Care Organizations (ACOs) combined saved taxpayers $87.5 million through the Medicare Shared Savings Program, the most of any integrated system in the country.

Advocate Aurora and Telehealth

Advocate Aurora has long been engaged in the provision of care through telehealth, as it is an important tool in reaching rural and underserved communities, including individuals with special needs, such as people who are deaf and hard-of-hearing. For example, we are proud that more than 15 years ago we were the only Chicago area provider to offer tele-psychiatry visits using videoconferencing and clinicians who speak American Sign Language (ASL) to deaf and hard-of-hearing patients who were living in southern Illinois. These patients had unmet mental health needs but there were no providers in the community who spoke ASL and an audio-only visit is ineffective and inappropriate. By offering video-tele-psychiatry with ASL speakers, patients could access the specialty care they needed without the burden of having to travel. Since that time, we have significantly expanded our telehealth and digital medicine offerings in Illinois and Wisconsin.

We connect to our patients through videoconferencing, remote monitoring, electronic consults, and wireless communications and we deploy these technologies to provide primary, urgent care, and specialty services. The strategic utilization of telehealth—both prior to and during the PHE—allows us to offer patients an important, safe, and convenient care option.

Advocate Aurora Telemedicine ED Triage

For example, prior to the PHE, we successfully implemented remote video monitoring technology to help reduce overcrowding at Aurora Sinai Medical Center's Emergency Department (ED) in Milwaukee, Wisconsin, one of our busiest EDs. This telemedicine program allows patients to be seen initially by an Advocate Aurora clinician via video when they arrive, with a nurse at the patient's side. By having additional clinicians available via telemedicine—with triage assistance and on-site clinician support—patients are seen by a clinician faster and, in turn, they experience a reduced time to diagnoses and quicker initiation of treatment.

- The program has helped to reduce door-to-provider times from 60 minutes to about 10 minutes, on average.
- The average length of stay has declined by 40 minutes.
- The leave-without-being-seen rate has plummeted from 8% to 2%.
- Overcrowding in the ED has decreased significantly.

Advocate Aurora's Experience with Telehealth During the PHE

We are eager to sustain the recent advances made in the utilization and adoption of telehealth; while the advantages and power of telehealth have been known for decades, the importance of virtual care has become profoundly clear in the past year

during the PHE. Starting in March 2020, providers and patients alike sought ways to interact that reduced their risk of exposure to COVID–19. Many physicians and Advance Practice Clinicians (APCs) could not be in the office or at the hospital due to COVID–19 restrictions but could still see patients through virtual care. Telehealth helped reduce unnecessary patient and provider exposure to COVID–19 and allowed us to preserve scarce PPE during shortages.

Moreover, many patients, including home care patients, were fearful of seeing their care providers in person but were eager to engage in a visit through audio or video means. Further, as noted earlier, many patients have mobility issues, disabilities, transportation challenges, or home, work, or school obligations that make traveling to an office, clinic, or hospital campus extremely burdensome even in non-pandemic times. With vast disruption with public transportation systems and patients experiencing greater stress overall, telehealth allowed us to provide convenient, continuity of care for our patients across the care spectrum—primary, specialty, post-acute, chronic disease management, etc.

Advocate Aurora's behavioral health-care physicians and APCs in particular have noticed a significant reduction in canceled or missed appointments and high patient satisfaction levels among patients using tele-behavioral health services. Our behavioral health patients consistently gave high daily ratings to virtual treatment with an average rating of 8.7 out of 10. When questioned about future preferences, 72% of patients either preferred virtual to in-person treatment or were neutral. Across the Advocate Aurora system, 90% of patients were satisfied after virtual visits and likely to use virtual visits again. Further, 91-93% found it either easy or very easy to interact with their provider via video.

In 2019 and before the pandemic, an estimated 300 Advocate Aurora physicians and APCs performed 13,026 virtual health visits. By the end of 2020, Advocate Aurora's virtual care program:[1]

- Provided a total of 876,000 virtual visits to 507,375 unique patients;
- Reached a diverse patient population: 17% Black/African American, 10% Hispanic or Latino; and 3% Asian;
- Experienced most demand (45%) within primary care with Family Practice providers accounting for 27% of visits and Internal Medicine providers comprising 18% of visits, while Behavioral Health services were 14% of visits, followed by Cardiology at 6%;
- Delivered care to patients in 15 states; and
- Had a payer mix of 32% Medicare, 12% Medicaid, 51% commercial insurance, and 5% self-paying patients or another payer source.

Advocate Aurora Supports Making Permanent the PHE-Related Telehealth Policy Changes

Advocate Aurora very much appreciates the changes that both the Centers for Medicare and Medicaid Services (CMS) and Congress have made since the start of the PHE to ensure that patients can receive care via telehealth, should they so choose. We enumerate below a number of the flexibilities and waivers currently available that we respectfully request be made permanent. We understand that some of the waivers and flexibilities can be made permanent under existing CMS authority, while others require Congressional action. We urge you and your colleagues to work with CMS to ensure all of these policies are made permanent so patients can continue to benefit from what telehealth offers them. Specifically, we ask that you continue to allow:

- All patients, irrespective of their geography (*e.g.,* rural) and physical location (*e.g.,* home), to receive telehealth services in the location of their choosing.
- Medicare to pay for telehealth services at the same rate as in-office visits for all diagnoses.
- Practitioners to provide telehealth services to both new and established Medicare patients.

We appreciate that audio-only telehealth was an important focus during the hearing. Audio-only telehealth flexibilities have allowed our clinicians a convenient and effective way to maintain and expand access to care during the pandemic. Currently these audio-only visits represent approximately 35% of our total virtual health consults, providing care to 285,601 unique patients. Audio-only visits experienced most demand from our Family Practice providers (18%) and Internal Medicine pro-

[1] Advocate Aurora's virtual care services are comprised of Quick Care, E-Visits, telephonic, and virtual clinic visits.

viders (18%) followed by our Behavioral Health, Oncology and Cardiology specialists. 45% of our patients receiving audio-only virtual visits are covered by Medicare, 12% by Medicaid while 36% are covered by commercial insurance with the remainder receiving coverage from self-pay or some other source. We strongly support policymakers continuing to allow:

- Practitioners to provide audio-only telephone evaluation and management visits for new and established patients; this is especially important for patients who may not have Internet access or a smart phone.
- Practitioners licensed in one state to be reimbursed for services provided to Medicare beneficiaries in another state and reduction of burdens preventing reciprocity in state licensures.
- Practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists to provide—and be reimbursed for—telehealth, virtual check-ins, e-visits, and telephone calls to patients.
- Practitioners to provide a greater range of services to beneficiaries via telehealth, including ED visits.
- Medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), to be performed via telehealth.

Further, we very much appreciate that CMS and the Office of Inspector General at the Department of Health and Human Services (HHS) have offered relief from enforcement of Stark Self-Referral and Anti-Kickback laws during the PHE. As you know, while well intended when they were designed, the nature of health-care delivery has changed significantly in the decades since these laws were passed and their implementing regulations promulgated. We urge that many of these flexibilities be made permanent so that patients can have access to the technologies they need to benefit from advances in virtual care. We are concerned that underserved and vulnerable patient populations may not have access to the needed technologies primarily used for telemedicine, including broadband Internet access and smartphones, yet providers cannot provide financial help so patients can secure these needed tools.

Without a permanent change, hospitals face significant legal risk if they want to provide a subsidy to their physicians to purchase telehealth technologies, like specialized tablets to perform remote patient monitoring, or if they want to give patients, free of cost or at reduced prices, devices such as wearable "stethoscopes," blue-tooth enabled-digital blood pressure cuffs, or a virtual care kit for a home examination. Patients who cannot afford the out-of-pocket costs for these devices, apps, etc. will be unable to benefit from innovative, patient-centered virtual care. This further exacerbates inequities and health disparities, and prevents physicians and APCs from being able to address many SDOH. We appreciate the recent changes CMS and HHS have made to the Stark and Anti-Kickback regulations but we urge federal policymakers to further modernize these outdated laws and regulations so that underserved and vulnerable patients can have access to the care and tools they need and deserve.

Summary

Again, we thank you for the opportunity to submit this statement for the hearing record and we stand ready to work with you to ensure that the advances made in leveraging telehealth are maintained so we can continue to improve and transform health care in America, particularly for our most vulnerable patient populations. To that end, we urge you and your colleagues to make permanent the PHE-related telehealth waivers and flexibilities.

On behalf of Advocate Aurora's physicians, nurses, other health professionals and associates, and the patients, families, and communities we serve, thank you for your leadership and commitment to ensuring that we as a nation sustain the gains made in expanding access to care via telehealth and other virtual care offerings. We look forward to working with you throughout the 117th Congress to improve the health and well-being of the communities we serve.

Sincerely,

Meghan Woltman
Chief Government Affairs Officer

ALLIANCE FOR CONNECTED CARE
1100 H Street, NW, Suite 740
Washington, DC 20005
https://connectwithcare.org/

The Alliance for Connected Care appreciates the opportunity to submit testimony for this hearing examining COVID–19 health-care flexibilities. The Alliance for Connected Care (the Alliance) is an advocacy organization dedicated to facilitating the delivery of high-quality care using connected care technology. Our members are leading health care and technology companies from across the health-care spectrum, representing insurers, health systems, and technology innovators. Our Advisory Board includes more than 30 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 Alliance will focus comments on (1) Research and evidence we have gathered thus far; (2) recommendations for future telehealth expansion that Congress should consider—including steps to ensure equitable access; and (3) Recommendations for telehealth "guardrail" provisions that Congress should consider to prevent fraud, waste and abuse in the health-care system.

While we prefer the implementation of permanent policies described in our recommendations below, the Alliance supports a two-year clean extension of telehealth flexibilities exercised during the COVID–19 pandemic, including 1834(m) Medicare telehealth waivers, a safe harbor for employer-subsidized telehealth for people with Health Savings Account eligible High-Deductible Health Plans, and the flexibility for Critical Access Hospitals to continue to bill telehealth as they have during the pandemic. We want policymakers to feel comfortable that access to telehealth services in Medicare will not negatively impact health-care quality, or the federal budget. Therefore, we recommend Congress wait to make permanent policy until more peer-reviewed research has been published, government studies—such as the study underway by AHRQ—have been completed, the Office of the Inspector General has examined the level of fraud in telehealth during the Public Health Emergency, and when we have observed what the use of telehealth during "normal times."

Telehealth Research and Evidence

We have a unique opportunity afforded by the PHE to understand the effects of telehealth on clinical practice—and to make direct apples-to-apples comparisons across service modality. The sudden shift to virtual services generated fee-for-service (FFS) data and empirical provider and patient experience that didn't exist prior to the pandemic. This data is just now being understood, and peer-reviewed studies and reports are forthcoming. We believe it is essential to take this new evidence into account when writing permanent laws especially given that pre-pandemic telehealth studies were either narrowly-focused or relied on inferences on the impact of Medicare using commercial or Veterans Affairs data.

The COVID–19 pandemic has resulted in drastic increases in telemedicine utilization, introducing millions of Americans to a new way to access health-care. Data from the Centers for Disease Control and Prevention (CDC) finds that during the period of June 26—November 6, 2020, 30.2 percent of weekly health center visits occurred via telehealth. In addition, preliminary data [1] from the Centers for Medicare and Medicaid Services (CMS) show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE. Finally, an HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicare fee-for-service (FFS) telehealth report [2] found that from mid-March through early July more than 10.1 million traditional Medicare beneficiaries used telehealth, including nearly 50 percent of primary care visits conducted via telehealth in April vs. less than 1 percent before the COVID–19 pandemic. In addition to providing a lifeline to continuity of care, it is important to note that the net number of Medicare FFS primary care in-person and telehealth visits combined remained below pre-pandemic levels. As in-person care began to resume in May, telehealth visits dropped to 30 percent but there was still no net visit increase. We infer this and other data showing that as in-person visits increased, telehealth visits decreased, that there was a substitution

[1] *https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.*
[2] *https://aspe.hhs.gov/sites/default/files/private/pdf/263866/hp-issue-brief-medicare-telehealth.pdf.*

effect. A claims-based analysis[3] suggests that approximately $250 billion in health care spend could be shifted to virtual care in the long term—roughly 20 percent of all Medicare, Medicaid and commercial outpatient, office and home health spend. The effects of the COVID- 19 pandemic on patients seeking or avoiding care still need further analysis, but these data suggest that telehealth substituted for in-person care without increasing utilization.

In addition to telehealth largely substituting for in-person care, policymakers should consider telehealth's ability to increase efficiencies and improve access where barriers to care exist. COVID–19 has dramatically heightened awareness of existing health disparities and made the call to address these longstanding issues more urgent. Transportation is just one example of a barrier to care that telehealth can alleviate. Transportation barriers are regularly cited[4] as barriers to access, particularly for low-incomes or under/uninsured populations—leading to missed appointments, delayed care, and poor health outcomes. In a 2018 proposed rule,[5] CMS estimated that telemedicine is saving Medicare patients $60 million in travel time, with a projected estimate of $100 million by 2024 and $170 million by 2029. CMS also noted that these estimates tend to underestimate the impacts of telemedicine. Higher projections estimate $540 million in savings by 2029.

The experience during COVID–19 has pushed forward a revolution in consumer attitudes toward virtual care. Polling data from the University of Michigan[6] showed that one in four older adults had used telemedicine during the first three months of the pandemic, compared to just 4% in 2019. The same poll showed that 64% of those surveyed in June 2020 were comfortable with using videoconferencing technology for any purpose, up from 53% in May 2019.

Top Telehealth Priorities

- *Remove geographic and originating site restrictions on telehealth in Medicare.* The COVID–19 pandemic has clearly demonstrated the need for telehealth in rural areas, in urban areas, at work, at school, at home and many other locations. These provisions are obsolete and outdated and should be removed from statute entirely. The location of the patient should not matter for telehealth—only the quality of the care being delivered.
    - Please note that the removal of the originating site construct, a relic from an era in which telehealth was an office-to-office interaction, is better policy that the addition of the home as a site for telehealth services or a waiver of these restrictions.[7]
- *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, 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.
- *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. Please note that Critical Access Hospitals (CAHs) are sometimes omitted from this list, but are a crucial component of a health-care system able to reach all Medicare beneficiaries and must be able to directly bill for telehealth services as a distant site provider.
- *Make permanent the Health and Human Services (HHS) emergency waiver authority for virtual care* so that it can be quickly leveraged during future emergencies. Telehealth has maintained critical connections between patients and

---

[3] *https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality?_lrsc=a92397a2-f826-4e32-863b-4f1f467784d1&cid=other-soc-lke.*

[4] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/#:%7E:text=Transportation%20barriers%20are%20often%20cited,and%20thus%20poorer%20health%20outcomes.*

[5] *https://www.govinfo.gov/content/pkg/FR-2018-11-01/pdf/2018-23599.pdf.*

[6] *https://labblog.uofmhealth.org/rounds/telehealth-visits-skyrocket-for-older-adults-but-concerns-and-barriers-remain.*

[7] The Alliance strongly supports the *Telehealth Modernization Act (H.R. 1332),* introduced by Senators Tim Scott and Brian Schatz, which would eliminate the originating site construct completely.

health-care practitioners during the pandemic, and should be enabled for a future wildfire, flood, hurricane, or other emergency.

- *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 receive cost-free or discounted telehealth and remote care services prior to the patient reaching their deductible. According to the Bureau of Labor Statistics (BLS), only 15 percent of workers employed in the private sector participated in an HDHP in 2010. By 2018, that number had risen to 45 percent. With significant numbers of American workers now relying on coverage through account-based plans, policymakers can meaningfully expand access to care by permanently allowing first-dollar coverage of virtual care under HDHPs.
- *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 [8] 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.
- *Fund a comprehensive study of telehealth during the COVID–19 pandemic using claims data and qualitative interviews with providers and patients who used telehealth during the pandemic.* The study should to answer specific questions critical to future telehealth decision-making by Congress and regulators at CMS. Suggested priorities include:
    1. Is telehealth being adequately leveraged to address health disparities, and what policies could Congress or HHS enact to ensure telehealth is a tool to increase access to those most in need of health care?
    2. To what extent are Medicare telehealth services during the PHE replacing in-person care?
        - How often to telehealth services require a follow-up in person visit and how often are they fulfilling patient needs?
        - Is the availability of telehealth increasing utilization, and if so, are they primary care or preventative services with the potential to prevent a more costly encounter downstream?
    3. Are there specific, high-cost areas of the Medicare program that might lower long-term costs through telehealth utilization?
        - Are care coordination codes that have been shown to improve care such as 99495 and 99496 being used more frequently during virtual care?
        - Has the shift to using telehealth to manage lower acuity conditions in skilled nursing facilities prevented unnecessary transfers to hospitals?
    4. To what extent have CMS permissions for virtual/remote supervision of health-care professionals been utilized during the COVID–19 pandemic? Have these permissions resulted in patient harm? How have health-care providers expanded their capability and capacity using this tool during the PHE.
    5. In addition to HHS investigations of fraud and abuse, what has been the health-care provider, patient, and health plan experience with fraud perpetrated through virtual tools during the PHE?
- *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

[8] *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf.*

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. *(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. 1395jjj(f) if directing the use of authority instead would keep the score down)*

- *Allow the Centers for Medicare and Medicaid Services 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.
- *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.
- *Expand the mandate of the Office for the Advancement of Telehealth at HRSA and require it to develop tools and resources on telehealth* services that can be distributed to small health-care practices, patients, and consumer organizations. Additionally, explore partnerships with leading consumer and patient organizations to educate seniors about telehealth services, including the use of technology and how to verify the identity of a health-care provider.
- *Encourage CMS to continue facilitating greater use of remote patient monitoring (RPM) technology through policy,* including ongoing flexibility for allowing acceptance of patient-reported data for scales up to meet connected device requirements.

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, as Congress created in the Consolidated Appropriations Act, 2021 (Pub. L. 116–260) 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.

We are pleased to note that on February 26, 2021, OIG Principal Deputy Inspector General Grimm issued a statement[9] to this effect—differentiating between fraud perpetrated through virtual tools and telehealth fraud.

> We are aware of concerns raised regarding enforcement actions related to "telefraud" schemes, and it is important to distinguish those schemes from telehealth fraud. In the last few years, OIG has conducted several large investigations of fraud schemes that inappropriately leveraged the reach of telemarketing schemes in combination with unscrupulous doctors conducting sham remote visits to increase the size and scale of the perpetrator's criminal operations. In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. We will continue to vigilantly pursue these "telefraud" schemes and monitor the evolution of scams that may relate to telehealth.

Recommendations

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.

- *Enhance the ability of HHS to fight fraud in Medicare through new resources and capacity*
  - Provide additional funding for OIG to strengthen existing fraud, waste, and abuse mechanisms that have already been proven successful in fighting fraud perpetrated through virtual tools. The House Ways and Means minority staff has proposed workable text to this effect that we support.
  - We also support the development of OIG telehealth compliance guidance to health-care organizations to help prevent and mitigate unintentional mistakes related to Medicare telehealth billing.
  - Strengthen the Public-Private Partnership for Health Care Waste, Fraud and Abuse Detection created by the Consolidated Appropriations Act of 2021 (Section 1128C(a) of the Social Security Act (42 U.S.C. 1320a–7c(a))). This public-private partnership must be empowered with experts with experience in virtual care delivery and payment.
    - After—(6)(E)(i)(II) add "(III) The executive board shall include no less than 3 individuals with significant expertise delivering and managing the delivery of virtual care, including practitioners, medical directors and individuals with oversight of telehealth programs, and virtual care experts with experience in corporate fraud prevention.
- *Work with CMS to develop restrictions on the solicitation of Medicare Fee-For-Service telehealth services.* It is our understanding that one of the primary ways in which fraudulent actors exploit virtual services is by calling Medicare beneficiaries to solicit their interested in high-value DME products. We believe a restriction on marketing, as currently exists for DME, would significantly hinder situations in which DME fraud actors exploit telehealth services to drive DME sales. As long as there was a significant allowance for legitimate marketing practices, we do not believe this restriction would hinder legitimate telehealth providers.
- *Work with CMS to strengthen the Medicare provider enrollment process.* The provider enrollment process is the best tool to prevent fraudulent actors from billing the Medicare program. Rather strengthened to identify and screen higher risk entrants.
- *Encourage CMS to advantage of the enhanced data capabilities present in most telehealth platforms.* Technology platforms that provide telehealth are often capable of automatically recording times, dates, patient information, prescribing, and other details which can be used to enhance compliance. These technologies should allow for the greater use of audits and other forms of retroactive monitoring approaches on providers. As long as data capture requirements are very clear, and that compliance with any requirements do not impose a significant

[9] *https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp?utm_source=oig-home&utm_medium=oig-hero&utm_campaign=oig-grimm-letter-02262021.*

regulatory burden they could be a compliance tool. (Please note that very small-providers should likely be exempted from these burdens.)

- *Work with CMS to develop targeted restrictions on high-value, high-risk DME prescribing through telehealth.* While we continue to believe that there are some appropriate circumstances for this prescribing, a step like this could significantly lower risk to the Medicare program.

Thank you for your consideration of these recommendations. Some combination of these recommendations could protect the Medicare program while aligning with the recommendations of the Task Force on Telehealth Policy,[10] which stated "we should not hold telehealth to higher standards than other care sites, and we should trust clinicians providing telehealth services to triage patients needing a higher level or care or in-patient care, as we do in other care settings. As is done in other care settings, patients' preference for obtaining care in-person or via telehealth should be respected."

Thank you for your consideration—we look forward to working with you on this important effort. Please contact Chris Adamec at cadamec@connecwithcare.org with any questions.

Sincerely,

Krista Drobac
Executive Director

AMERICA'S HEALTH INSURANCE PLANS
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Everyone deserves access to affordable, high-quality care and coverage. This is a core principle for health insurance providers and our industry. America's Health Insurance Plans (AHIP) greatly appreciates the Committee holding this hearing on COVID–19 health-care flexibilities.[1]

Through temporary flexibilities enacted during the national emergency period, health insurance providers have expanded access to virtual care via telehealth so that Americans can get the care they need when and where they need it. Health insurance providers have also innovated the way care can be delivered, especially for individuals who are homebound to ensure the safety and well-being of their members during the COVID–19 pandemic.

AHIP looks forward to working with the Committee to ensure that many of the flexibilities enacted during the pandemic will endure beyond COVID–19 in order to continue to provide Americans with affordable, convenient, high quality care.

Telehealth Growth During COVID–19

The COVID–19 crisis led to an exponential increase in telehealth use as a safe and convenient way for people to access needed care. Telehealth claims increased over 8,000 percent in April 2020 compared to April 2019.[2] Several health insurance providers have seen 50 times the number of telehealth claims as in years past, with telehealth claims in some cases comprising roughly 25 percent of all claims in 2020.[3] Among those experiencing significant growth are Blue Cross of Idaho, which processed more than 90,500 telehealth claims between March and June of 2020, with telehealth representing more than one-quarter of all claims.[4]

Patients and providers understand and experience the value of telehealth. They accept—and often prefer—digital technologies as an essential part of health-care delivery. Telehealth delivers convenient access to affordable, high-quality care.

---

[10] *https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-findings-and-recommendations-overarching-issues/*.

[1] America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

[2] *https://www.fairhealth.org/states-by-the-numbers/telehealth.*

[3] *https://www.ahip.org/telehealth-growth-during-covid-19/*.

[4] *https://www.ahip.org/telehealth-growth-during-covid-19/*.

Patients have taken advantage of telehealth from wherever they are, making it a vital tool to bridge health-care gaps nationwide. For patients in rural communities or underserved areas with a shortage of practicing clinicians, telehealth programs and remote patient monitoring can make care more accessible, efficient, and sustainable than it otherwise would be. Patients can connect with a doctor within seconds rather than driving long distances for an office visit. Patients who can access care remotely can also avoid challenges associated with taking time off work or finding childcare. Those accessing behavioral health services can do so from the privacy of their own homes and free from stigma. Telehealth is a tool that can connect patients with care in the most convenient, comfortable settings—without the challenges of finding in-person care.

Additionally, telehealth costs less. Even before the pandemic, 93 percent of consumers who used telehealth said that it has lowered their health-care costs.[5] Furthermore, studies have shown that a virtual visit can save up to $100 compared to a visit in other care settings (*e.g.,* urgent care, primary care, emergency room) when accounting for cost of services, cost of travel to a physical care setting, and lost earnings associated with travel and wait times.[6]

By connecting patients with convenient care, providers are also reporting lower no-show rates with telehealth.[7] Telehealth can lead to better management of chronic diseases, reduced travel times, reduced emergency department visits, and fewer or shorter hospital stays.[8] Patients are healthier and have better peace of mind by getting the right care at the right time and in the right setting.

Faster expansion of telehealth has been made possible through flexibilities implemented during the COVID–19 crisis. For instance, the Coronavirus Preparedness and Response Supplemental Appropriations Act (CARES Act) temporarily authorized the Secretary of Health and Human Services (HHS) to waive originating site requirements for telehealth services under Medicare, as well as allowing reimbursement of more video-enabled telehealth and audio-only telehealth services for the duration of the COVID–19 public health emergency (PHE). HHS also expanded the number and types of providers who are eligible and licensed to deliver care via telehealth and allowed providers to waive telehealth visit cost-sharing for Federal health-care programs.[9] Medicare Advantage (MA) plans were also allowed to waive or reduce enrollee cost-sharing for telehealth benefits and expand coverage of telehealth services beyond those approved in the plan's benefit package.[10] These measures allowed for greater flexibility in telehealth use for both patients and providers, leading to exponential growth in use.

The Centers for Medicare and Medicaid Services (CMS) issued guidance allowing health insurance providers in the individual and group market to amend plan benefits during the 2020 plan year to expand coverage for telehealth services.[11] Many health insurance providers have since reduced or eliminated cost-sharing for telehealth during the PHE, and broadened coverage of telehealth benefits by expanding coverage options and increasing telehealth provider networks. CMS issued guidance on remote supervision of nurse practitioners and physician assistants, expanding the capacity to treat patients without requiring every element of care to be in-person. These policies helped many patients remain safe from possible and unnecessary exposure to COVID–19 in waiting rooms or other in-person care settings while still ensuring that patients received high-quality care.

Many states provided similar flexibilities in state Medicaid and CHIP programs and facilitated the delivery of telehealth by modifying provider licensure restrictions that have long served as a barrier to the effective delivery of telehealth.[12] However, most of the actions on both the state and federal levels are limited in scope and temporary for the public health emergency. Long-term telehealth policy changes are

---

[5] *https://www.prnewswire.com/news-releases/39-of-tech-savvy-consumers-have-not-heard-of-telemedicine-healthmine-survey-300241737.html.*

[6] *https://news.regence.com/releases/regence-data-measures-real-world-savings-for-telehealth-users.*

[7] *https://www.healthcareitnews.com/news/telehealth-linked-ehr-drastically-reduces-no-show-rate-garfield-health-center#:~:text=Data%20for%20October%202020%20shows,the%20office%20for%20an%20appointment.*

[8] *https://www.ahip.org/wp-content/uploads/FactSheet_Telehealth-030719.pdf.*

[9] 45 CFR §§ 160, 164 (2020). *See www.govinfo.gov/content/pkg/FR-2020-04-21/pdf/2020-08416.pdf* (accessed February 23, 2021).

[10] *https://www.cms.gov/files/document/updated-guidance-ma-and-part-d-plan-sponsors-42120.pdf.*

[11] *www.cms.gov/files/document/faqs-telehealth-covid-19.pdf.*

[12] *Spring2021_SummaryChartFINAL.pdf (digitaloceanspaces.com).*

necessary to drive innovation, promote investment, and address patient needs during periods of stability and crisis.

Homebound Care During COVID–19

As the COVID–19 crisis disrupted lives and livelihoods, it also worsened health disparities and access to care for vulnerable populations, including homebound populations and seniors. Additionally, many home health and home and community-based services (HCBS) providers lacked sufficient supplies of personal protective equipment (PPE), creating significant risk for providers and patients, and exacerbating the challenges in reaching patients who were afraid to receive care out of concern over potential exposure to COVID–19.

Nationally, between 2 million and 4.4 million older adults are homebound with the vast majority receiving services from Medicare, Medicaid, or both.[13] More than 600,000 people receive Medicaid funded home health services, 1.2 million people receive Medicaid funded personal care services, and total enrollment in Medicaid HCBS waivers exceed 2.5 million people. According to a 2019 MedPAC report, about 3.4 million Medicare beneficiaries received home health care in 2017.[14]

Medicare requires that individuals be homebound to receive home health care. Given limits on the use of Medicare's home health benefit, there are significant numbers of Medicare beneficiaries who are in fact homebound but not receiving home health services. In 2011, the prevalence of homebound Medicare beneficiaries was estimated to be 5.6 percent, or about 2 million people.[15] Applying the same percentage to today's Medicare population, an estimated 3.5 million Medicare beneficiaries are homebound. During the public health emergency (PHE), CMS expanded the Medicare definition of homebound to allow patients to be considered such if it is medically contraindicated for the patient to leave the home. This includes patients with a confirmed or suspected COVID–19 diagnosis or patients with conditions making them more susceptible to contract COVID–19.

The Biden Administration proposed to increase funding for HCBS by $400 billion in the American Jobs Plans and recently outlined $1.4 billion in funding from the American Rescue Plan for Older Americans Act programs, including programs to support vaccine outreach and coordination, address social isolation, provide family caregiver support, and offer nutrition support.[16] As part of the American Rescue Plan Act, states can also receive a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid HCBS from April 1, 2021, through March 31, 2022.

Health insurance providers know that many Americans are homebound or rely on caregivers and family members to manage their health even under normal conditions. Plans are playing a leadership role in meeting the medical and social needs of their members and helping to provide emotional support to members, their families, and caregivers, and making sure individuals and caregivers have access to peer coaches and support specialists with information on social services.

Health Insurance Providers Are Committed to Delivering Affordable and Convenient Care Through Telehealth and Homebound Care

During the COVID–19 crisis, health insurance providers have expanded and innovated in the way care is delivered. Many of AHIP's member companies significantly expanded telehealth accessibility and benefits, effectively encouraging people to continue to receive care they need despite the public health crisis.

Those who are older, live in rural areas, are a racial or ethnic minority, have a lower socioeconomic status, or represent other vulnerable populations may have less access to broadband and other technologies and resources necessary to fully leverage the promise of telehealth.[17] These same populations often face disparities in access to in-person services.

---

[13] *https://www.washingtonpost.com/health/vaccinating-homebound-seniors/2021/03/26/a06c71f8-7620-11eb-9537-496158cc5fd9_story.html.*

[14] *http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec.pdf?sfvrsn=0#:~:text=In%202017%2C%20about%203.4%20million%20Medicare%20beneficiaries%20received%20home%20care,billion%20on%20home%20health%20services.*

[15] *https://www.researchgate.net/publication/277251465_Epidemiology_of_the_Homebound_Population_in_the_United_States.*

[16] *https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/03/fact-sheet-biden-harris-administration-delivers-funds-to-support-the-health-of-older-americans/.*

[17] *https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/; https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/.*

America's health insurance providers embrace digital solutions that help increase access to care and want to ensure that the people they serve, regardless of where they live or their economic situation, can access safe and convenient care. For instance:

- **Centene** has worked with Samsung Electronics America to supply providers with 13,000 Samsung Galaxy A10e smartphones to disseminate to patients who would not otherwise be able to receive their health care virtually.
- **CareOregon** is working with providers to supply flip phones and basic smartphones along with data plans for their members.
- **Blue Shield Promise** (the Medicaid Managed Care Organization of Blue Shield of California) and **LA Care** partnered to establish resource centers for local communities to provide members with wellness programs and to connect them with local resources to address socioeconomic needs. As their services and programs moved online due to COVID–19, Blue Shield Promise and LA Care offered technology and Wi-Fi to help their members access virtual programs, services, and telehealth.

Health insurance providers are encouraging their vulnerable members, particularly older people and others who may have delayed care, to get their preventive screenings, routine care, and chronic condition management despite the COVID–19 pandemic.

- **Bright Health** makes non-emergency transportation available for all members, and ride limits are being waived for non-emergency visits to and from their doctor.
- **Priority Health** has partnered with technology company Papa to connect college students with Medicare members with specific chronic conditions who need assistance with transportation, house chores, technology lessons, companionship, and other senior services.
- **Humana** mailed more than 1 million in-home preventive screening kits to members in 2020, helping increase access to routine screenings that many members have put off during the COVID–19 crisis.

Health insurance providers have also taken proactive actions to provide COVID vaccines for vulnerable seniors, individuals who are homebound, and other vulnerable populations.

Given the vast majority of Medicare beneficiaries are enrolled in Medicare Advantage or Medicare Part D (50.8 million)[18] and 40 [19] states leverage Medicaid Managed Care as their delivery system (including 25 [20] who use health plans to deliver managed long-term services and supports), health insurance providers are uniquely situated to help get the homebound population vaccinated quickly, effectively, and equitably.

On March 3, 2021, the White House, America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association announced the Vaccine Community Connectors (VCC) pilot initiative. As vaccine supplies expand and appointments become more available, health insurance providers have committed to use their combined expertise, data, and insights to:

- Identify seniors who are vulnerable to COVID–19 and who live in areas where vaccination rates are most inequitable;
- Work with partners in the community to educate seniors on the safety, efficacy, and value of COVID–19 vaccines;
- Contact those seniors who are eligible to get a vaccine through multiple channels to facilitate vaccine appointment scheduling;
- Coordinate services to help overcome barriers that may stand between them and getting vaccinated; and
- Track and report progress to ensure those who need vaccinations most are receiving them.

---

[18] *https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/contract-summary-2021-05.*

[19] *https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/#:~:text=As%20of%20July%202019%2C%2040,Medicaid%20beneficiaries%20(Figure%201).*

[20] *https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/.*

The VCC has since expanded to include the Medicaid population, many of whom are members of the at-risk and underserved communities this program aims to reach.[21]

As part of these broader vaccination efforts, health insurance providers are helping vulnerable, homebound individuals to receive the COVID–19 vaccine. Examples of health plans partnering to address the needs of homebound individuals are growing across the country include:

- **Commonwealth Care Alliance (CCA)** has partnered with the Commonwealth of Massachusetts to lead the state's effort to vaccinate homebound individuals. In this partnership, CCA serves as the vaccine coordinator for the Massachusetts homebound population. CCA manages a technological, logistical, and provider infrastructure to receive referrals of state-screened homebound residents for outreach and appointment scheduling, vaccine distribution, delivery of vaccines to people's homes, and reporting on their performance. CCA has expanded the program to all homebound individuals in Massachusetts, regardless of health plan.[22]
- **SCAN Health Plan** provides in-home COVID–19 vaccinations to homebound plan members and their families in Los Angeles County. The vaccination program is made possible through a unique partnership between SCAN and MedArrive, a logistics platform that enables health-care payers and providers to seamlessly extend care services into the home, unlocking access to highly qualified, trusted EMTs and Paramedics. The vaccines are being administered by trained EMTs at no cost to the members. Caregivers and other eligible household members are also receiving the vaccine at no cost.[23]
- **HealthPartners** has collaborated with 10 health systems across Minnesota to coordinate efforts to distribute and administer vaccines, leveraging HealthPartners' home health subsidiary to offer vaccines in people's homes.
- **Blue Cross Blue Shield of Tennessee** is bringing vaccines to their homebound members by working with local health departments, provider partners, and local emergency services to identify, educate, and deliver vaccines to those with mobility issues.

Policy Recommendations to Strengthen Health Care Flexibilities, Telehealth and Homebound Care

AHIP is ready to work with Congress and the Administration to strengthen telehealth and homebound care and establish policies that ensure the programs' long-term sustainability. Policymakers can further advance this work by embracing comprehensive, multi-stakeholder approaches:

(1) Make permanent the flexibilities in benefit design implemented during the PHE. The Coronavirus Preparedness and Response Supplemental Appropriations Act allowed the HHS Secretary to waive certain Medicare telehealth payment requirements and the CARES Act enacted flexibility for commercial health insurance providers to cover telemedicine. Congress should pass legislation to make these provisions permanent and redefine how Medicare and commercial (*e.g.,* employer-sponsored coverage) and individual market enrollees can access telehealth. To solidify several regulations implemented by CMS and HHS during the COVID–19 crisis, Congress should revise section 1834(m) of the Social Security Act to allow for flexibility in benefit design for originating sites, eligible geographies, eligible services, and eligible providers. In reviewing this law, we encourage Congress is to leave room for flexibility and innovation—the speed at which telehealth and virtual care evolved during the COVID–19 crisis alone shows how quickly the care delivery landscape can change. We recommend against lawmakers attempting to strictly define the future of virtual care and instead allowing health insurance providers and other innovators the opportunities to connect patients with the most convenient, affordable, and high-quality care available.

Additionally, while telehealth may be no more subject to fraud and abuse than other modalities, it will be essential to monitor the impact of telehealth on health outcomes, including quality and costs.

(2) Pass S. 150, the Ensuring Parity in MA for Audio-Only Telehealth Act of 2021. This bipartisan bill would reduce health disparities that result from unequal access to health technology, broadband service, and video telehealth plat-

---

[21] *https://www.communityplans.net/acap-joins-ahip-bcbsa-in-advancing-vaccine-accessibility-and-equity-initiative/.*

[22] *https://www.commonwealthcarealliance.org/news/2021/march/commonwealth-care-alliance-to-lead-massachusetts-h.*

[23] *https://www.businesswire.com/news/home/20210426005231/en/.*

forms. It would also ensure that the more than 26.5 million seniors and people with disabilities who receive their Medicare benefits through Medicare Advantage (MA) and PACE continue to receive the high-quality care on which they rely.

Rural patients may have trouble accessing technology or broadband services necessary to support video-enabled telehealth. Additionally, seniors or frail populations may have physical limitations that prevent them from using video-enabled telehealth platforms. An audio-only telehealth visit may be the only option for these patients to safely and conveniently access needed care. MA plans have taken decisive steps to support these patients by expanding telehealth services, including providing coverage for telephonic (also known as "audio-only") telehealth at the onset of the COVID–19 pandemic despite CMS's decision to exclude diagnoses identified during the delivery of this care in determining the severity of those patients' health conditions.

In addition, allowing diagnoses from audio-only telehealth services to count for MA and PACE risk adjustment will help ensure patient health costs are adequately accounted for and reimbursed. Without the accurate documentation of diagnoses for MA and PACE risk adjustment, the programs will effectively experience cuts, leaving MA and PACE organizations and providers with fewer resources necessary to care for patients. This could lead to unequal access, fewer choices, higher premiums, or reduced benefits for beneficiaries in the long run. Given that MA and PACE plan rates are benchmarked at the county level, this impact could be particularly acute in areas where accessing video-enabled telehealth posed more significant challenges for many enrollees, enhancing disparities between communities on either side of the digital divide.

That is why AHIP strongly supports S. 150, the Ensuring Parity in MA for Audio-Only Telehealth Act of 2021, introduced by Senators Catherine Cortez Masto and Tim Scott. This bipartisan legislation would reduce health disparities due to unequal access to health technology while supporting the more than 26.5 million Americans enrolled in MA and PACE and the providers who have cared for them throughout the COVID–19 crisis.

AHIP recently joined with 17 other health-care organizations in support of the bill.[24] We appreciate the Committee's focus on the importance of telehealth and the recognition that for many Medicare beneficiaries, a phone call is their best or only option for immediately accessing health care. We look forward to working with the lead sponsors of S. 150 and the Senate Finance Committee to support the MA and PACE programs, their provider partners, and the 43 percent of Medicare beneficiaries choosing these programs for their care.

(3) Improve Workforce Opportunity and Support for Caregivers and Home Health Care Providers. Lack of training, lack of opportunity, and low wages lead to low job satisfaction, high rates of caregiver burnout, and high rates of turnover. Many in the workforce cite lack of professional development and growth as a reason for exiting the direct care workforce. Studies have shown a decrease in departures among workers who are offered training and a career ladder.[25] Policymakers and health insurance providers must champion efforts to create training opportunities and develop pathways to promotion.

(4) Sustain Funding for HCBS. We support enacting measures that incentivize adoption and expansion of HCBS as an alternative to institutional care in state Medicaid programs. Policies such as sustained enhanced federal financial participation and flexibilities for states in developing HCBS infrastructure are key elements in making home-based care available to everyone who needs it.

(5) Extend Telehealth Safe Harbor for High Deductible Health Plans. The CARES Act created a temporary safe harbor for High Deductible Health Plans (HDHPs) that may be paired with tax-advantaged Health Savings Accounts (HSAs) to allow health insurance providers offering those plans to pay for telehealth services without applying a deductible. This safe harbor has allowed plans to offer benefits that better serve the needs of the more than 32 million Americans enrolled in these plans, particularly during the pandemic. This flexibility is both cost-effective and, as with access to virtual care in other plan types, highly responsive to patient needs. The safe harbor applies only to commercial health plans that begin prior to

---

[24] *https://www.ahip.org/wp-content/uploads/04.28.21-Stakeholder-LoS-HR-2166-and-S-150.pdf.*

[25] *https://www.leadingage.org/sites/default/files/Direct%20Care%20Workers%20Report%20%20FINAL%20%282%29.pdf.*

December 31, 2021, and many health insurance providers and their employer clients would like to see this safe harbor extended. There continues to be strong bipartisan support for extending the safe harbor and promoting greater utilization of telehealth among commercial plans while helping working families access care when it is convenient to them without imposing undue costs. We urge Congress to take bipartisan action to extend this highly popular change to HDHPs.

Conclusion

Everyone deserves access to affordable, high-quality care, whether delivered directly to a person in their home or virtually. Together with the Administration, Congress, and our provider partners, health insurance providers are working to ensure that patients continue to have access to health care when they need it so that no community is left behind. AHIP thanks the Committee for focusing on this important issue, and we look forward to working together on more initiatives to improve health care in every community.

AMERICAN ASSOCIATION OF NURSE PRACTITIONERS

On behalf of the more than 118,000 individual members of the American Association of Nurse Practitioners (AANP), and the over 325,000 nurse practitioners (NPs) across the nation, we appreciate the opportunity to provide the following statement for the record to the United States Senate Committee on Finance (the Committee). We commend Chairman Wyden, Ranking Member Crapo and the members of the Committee for holding this hearing on the experiences and lessons learned regarding COVID–19 flexibilities. NPs have been on the front lines providing care to patients since the onset of this pandemic, and many of these flexibilities, specifically those related to telehealth and workforce expansion, have been integral in their ability to provide high-quality and timely care to patients. Making these waivers permanent will increase patient access to health care, particularly in rural and underserved communities, and help alleviate the health-care disparities that were exacerbated by this pandemic.

As you are aware, NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health-care setting including clinics, hospitals, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs), nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia and complete more than one billion patient visits annually.

NPs have a particularly large impact on primary care as approximately 70% of all NP graduates deliver primary care.[1] NPs comprise approximately one quarter of the primary care workforce, with that percentage growing annually.[2] They provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status. As such, they understand the barriers to care that face vulnerable populations on a daily basis.[3, 4, 5] NPs are the second largest provider group in

---

[1] *https://www.aanp.org/about/all-about-nps/np-fact-sheet.*

[2] "Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners," Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsolf, *Health Affairs* 2018 37:6, 908–914.

[3] Davis, M.A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J.P.W., and Shipman, S.A. (2018). "Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status." *Journal of General Internal Medicine,* 4–6. *https://doi.org/10.1007/s11606-017-4287-4.*

[4] Xue, Y., Smith, J.A., and Spetz, J. (2019). "Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010–2016." *Journal of the American Medical Association,* 321(1), 102–105.

[5] Andrilla, C.H.A., Patterson, D.G., Moore, T.E., Coulthard, C., and Larson, E.H. (2018). "Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas." *Medical Care Research and Review,* Epub ahead. *https://doi.org/10.1177/1077558718793070.*

the National Health Services Corps[6] and the number of NPs practicing in community health centers has grown significantly over the past decade.[7]

As noted in the testimony before the Committee provided by Jessica Farb, Director of Health Care for the Government Accountability Office, the Medicare waivers issued by the Centers for Medicare and Medicaid Services (CMS) for the COVID–19 public health emergency (PHE) can broadly be broken into three categories: expansion of hospital services, workforce expansion and telehealth services. Our comments will focus on workforce expansion and telehealth services. First, we would like to highlight the impact that some of these flexibilities have had for our members, their patients and communities. For instance, AANP members have reported that the waiver authorizing NPs to perform the initial assessment and all other mandatory assessments in skilled nursing facilities has provided flexibility to meet the needs of skilled nursing facility (SNF) patients while also meeting the other demands that COVID–19 has placed on their communities. Additionally, increased coverage of telehealth and remote technologies, particularly coverage and increased reimbursement for audio-only services, has been an essential lifeline for meeting the needs of their patients. Many of our members have patients who lack access to audio-video technology, and they would have had to make the difficult choice between delaying care or risking exposure to COVID–19 if this authorization had not been made.

Workforce Expansion

During the PHE, CMS waived multiple barriers to practice within the Medicare program that have previously prevented nurse practitioners from practicing to the full extent of their education, clinical training and State scope of practice. Below are waivers that should be made permanent before the end of the PHE. These recommendations are consistent with the National Academies of Science, Engineering and Medicine report *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity* which recommends that "[b]y 2022, all changes in policies and state and federal laws adopted in response to COVID–19 should be made permanent, including those that expanded scope of practice, telehealth eligibility, insurance coverage, and payment parity for services nurses provide."[8] The World Health Organization's *State of the World's Nursing 2020* report also recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, and noted the positive impact this would have on addressing health-care disparities and improving health-care access within vulnerable communities.[9]

Removing barriers to care for NPs and their patients has also garnered widespread bipartisan support. In addition to bipartisan support in Congress, reports issued by the American Enterprise Institute,[10] the Brookings Institution,[11] the Federal Trade Commission[12] and the U.S. Department of Health and Human Services under the past two administrations[13, 14, 15] have all highlighted the positive impact of removing barriers on NPs and their patients.

State experience has also shown that removing state restrictions on NP practice improve access to care for patients in rural areas, reduce unnecessary complications, lower costs and improve quality of life. Currently, twenty-three states and DC are considered Full Practice Authority (FPA) states because their licensure laws allow full and direct access to NPs. No state has ever moved away from FPA once it has been enacted.

States that restrict the legal authorization of NPs to practice their profession limit patient choice and decrease access to care, with particularly acute effects in rural

---

[6] *https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf.*
[7] *https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf.*
[8] *https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf.*
[9] *https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf.*
[10] *https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.*
[11] *https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.*
[12] *https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.*
[13] *https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.*
[14] *https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.*
[15] *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.*

areas.[16] Recent studies have found that restrictive practice environments are associated with a lower percentage of NPs obtaining medication-assisted treatment (MAT) waivers.[17] States that adopt FPA have found overall positive rural health-care workforce trends. Arizona adopted FPA in 2001 and found that "the number of Arizona licensed NPs in the state increased 52% from 2002 to 2007", with the largest increase occurring in rural areas.[18] Other states that have reported similar workforce trends include Nevada,[19] Nebraska[20] and North Dakota.[21] South Dakota also reported reduced administrative costs after adopting FPA.[22] These results highlight the importance of removing barriers to practice on NPs to increase access to care for patients.

Authorizing NPs to perform all mandatory visits in SNFs.

As noted above, authorizing NPs to perform all mandatory visits in SNFs has enabled practices and SNFs to maximize their workforce. This waiver improves continuity of care and infection control by reducing unnecessary contacts among patients and multiple providers. This is also consistent with the permanent policy for Medicaid nursing facilities,[23] creating further alignment between these two programs and improving care for dual-eligibles. Patients and health-care providers in SNFs have been hardest hit by COVID–19. Making this waiver permanent will provide them with the necessary flexibility to provide the care that patients require for the duration of the PHE and beyond.

Authorizing NPs in rural health clinics (RHCs) and federally qualified health centers (FQHCs) to practice to the top of their license.

Waiving the requirement for physician supervision of NPs in RHCs and FQHCs has provided much needed workforce flexibility in rural and underserved communities where provider shortages are being exacerbated by COVID–19. Our members reported that this waiver has helped the entire health-care workforce because they are able to increase the focus on patient care instead of unnecessary paperwork and more expeditiously provide necessary treatments to their patients.

Authorizing NPs in critical access hospitals (CAHs) to practice to the top of their license.

We support making the waiver of the CAH physician physical presence requirement permanent. This will enable NPs in CAHs to practice to the full extent of their education and clinical training. NPs who stated that this waiver was implemented in their facilities have reported positive impacts including: reduced regulatory burden for the clinical workforce, allowing more time to be spent on direct patient care, improved continuity of care, and more timely initiation of necessary treatments. Making this waiver permanent would improve the ability of CAHs to appropriately utilize their entire health-care workforce to meet the needs of their patients following the PHE.

Authorizing Medicare hospital patients to be under the care of an NP.

Waiving the requirement that every admitted hospital patient be placed under the care of a physician enables NPs in hospitals to practice to the top of their license and authorizes hospitals to optimize their workforce strategies. Similar to the CAH waiver, NPs who stated that this waiver was implemented in their facilities reported that this waiver has streamlined the health care delivery process and improved continuity of care. Facilities also increased the utilization of NPs in leadership positions and participation in administrative planning for emergency policies. While some of the changes that were reported were allowed prior to the PHE, the removal of this barrier was noted to have positive ancillary impacts on many additional hospital policies and bylaws.

Telehealth Services

As mentioned previously, increased flexibility to provide telehealth to patients has been an essential component of providing care during COVID–19 and will continue

---

[16] *https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.*

[17] *https://jamanetwork.com/journals/jama/fullarticle/2730102?widget=personalizedcontent&previousarticle=2737024.*

[18] *http://azahec.uahs.arizona.edu/sites/default/files/u9/azworkforcetrendanalysis02-06.pdf.*

[19] *https://www.healthaffairs.org/do/10.1377/hblog20181211.872778/full/.*

[20] Holmes, L.R., Assistant, F.C., and Waltman, N. (2019). Increased access to nurse practitioner care in rural Nebraska after removal of required integrated practice agreement, 31(5).

[21] *https://cnpd.und.edu/research/_files/docs/cnpd-ndnpwfreport.pdf.*

[22] *http://sdlegislature.gov/docs/legsession/2017/FiscalNotes/fn61A.pdf.*

[23] 42 CFR 483.30(f).

to be integral to clinicians after the PHE. Specific telehealth provisions that we support making permanent are removing the geographic limitations, removing originating site restrictions so that patients can receive telehealth in their homes and increased coverage and reimbursement for audio-only telehealth services. We also support the expansion of telehealth to previously uncovered services and visits when the clinician determines that it is clinically appropriate. These flexibilities have enabled NPs and other clinicians to reach patients who otherwise may have been unable to receive medically necessary health care, particularly in rural and underserved communities.

Conclusion

AANP appreciates the Committee's examination of these flexibilities granted under the PHE. These flexibilities are essential to building back a robust health-care system after the pandemic and ensuring that all providers are practicing to the full extent of their education and clinical training. We look forward to working together to improve our health-care system in the wake of the COVID–19 pandemic.

AMERICAN HOSPITAL ASSOCIATION
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001–4956
(202) 638–1100

On behalf of our nearly 5,000 member hospitals, health systems and other health-care organizations, our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health-care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record. Since the first COVID–19 cases were diagnosed and the pandemic changed the ways in which patients were able to access traditional health-care settings, providers were required to navigate significant challenges to ensure their services were still able to reach millions of patients. In response, Congress and the Administration granted various flexibilities intended to improve access and facilitate the delivery of safe, quality care.

As health-care providers reflect on lessons learned and plan a post-pandemic course for the future, it is evident that several of the flexibilities have enhanced the patient experience and led to better outcomes. The AHA believes that, if extended, these flexibilities can continue to drive significant improvements in patient care long after the public health emergency (PHE) ends. Given the beneficial impact of those specific flexibilities, the AHA urges Congress and the Administration to make them permanent. In addition, a second group of flexibilities will remain critically important for some time following the PHE and will require a carefully crafted phase-out plan to ensure enough time is provided for a necessary transition. Without action from Congress and the Administration prior to the termination of the PHE, we are concerned that much of the progress made because of the implementation of many of these flexibilities may be unnecessarily halted or even lost. America's hospitals, health systems and post-acute care providers have taken significant steps to improve the way care can be delivered due to the pandemic, and failing to seize the opportunity presented by the progress made would be a step back for the nation's health-care infrastructure. Following are the AHA's recommendations for each category of flexibilities.

Flexibilities That Should Be Made Permanent

Telehealth Provisions. The increased use of telehealth since the start of the PHE is producing high-quality outcomes for patients, enhancing patient experience, and protecting access for individuals susceptible to infection. With the appropriate statutory and regulatory framework, this beneficial shift in care delivery could continue to improve patient experiences and outcomes and deliver health system efficiencies beyond the pandemic. The AHA urges Congress and the Administration to consider making these flexibilities permanent.

Telehealth policies should work together to maintain access for patients by connecting them to vital health-care services and their personal providers through videoconferencing, remote monitoring, electronic consults and wireless communications. We support the following: elimination of the 1834(m) geographic and originating site restriction; coverage and reimbursement for audio-only services; an expanded list of providers and facilities eligible to deliver and bill for telehealth services, including rural health clinics and federally qualified health centers; a national

approach to licensure so that providers can safely provide virtual care across state lines; and, adequate reimbursement for the substantial costs of establishing and maintaining a telehealth infrastructure, among others.

Payment Flexibility. In addition to the payment flexibilities needed to continue effectively offering telehealth services beyond the PHE, further payment flexibility is necessary to ensure access to care for patients. Specifically, Congress and the Administration should consider permanently increasing flexibility for site-neutral payment exceptions for providers seeking to relocate hospital outpatient departments and other off-campus provider-based departments. These steps would permit hospitals and health systems to better and more effectively serve their communities.

Hospital-at-Home Programs. The pandemic forced providers to rethink ways to deliver care safely to all patients, while simultaneously responding to surges in COVID–19 cases. To help providers make necessary adaptations, the Centers for Medicare & Medicaid Services (CMS) created new opportunities for providers to implement hospital-at-home programs.

These flexibilities permit approved providers to offer safe hospital care to eligible patients in their homes, and the results have proved pivotal in caring for COVID–19 and non-COVID–19 patients during the pandemic. While the initial aim of this flexibility was to increase health-care capacity while keeping patients safe at home during the PHE, promising outcomes are demonstrating the need for hospital-at-home to be made permanent.

Hospitals and health systems are increasingly interested in standing up hospital-at-home programs, yet many hesitate to do so without assurances that their programs, which are very popular among patients and their families, could continue to exist beyond the PHE. Extending the hospital-at-home flexibilities permanently can engage providers who may be hesitant to implement these programs now and will help transform the way more providers deliver care, while enhancing the patient experience. Given the benefits provided by this program, AHA anticipates considerable additional provider interest and growth of hospital-at-home programs should the flexibilities be made permanent.

Workforce Assistance. The COVID–19 pandemic has exacerbated the strain on an already overworked and understaffed health-care workforce. To help mitigate that strain, we support allowing health-care professionals to practice at the top of their licenses and permanently permitting out-of-state providers to perform certain services when they are licensed in another state. We also support extensions of the five-year cap-building period for new Graduate Medical Education (GME) programs to account for COVID–19-related challenges and support long-term sustainability of physician training. Permanently extending these workforce flexibilities would help alleviate workforce shortages as the PHE ends.

Review of Certain Conditions of Participation. The PHE has shed light on several shortcomings and outdated practices across the national health-care infrastructure; however, it also creates the unique opportunity to reevaluate and improve upon processes based on the lessons we have learned thus far. Conditions of participation (CoPs) are a logical starting point for review and reevaluation, as they serve as the foundation for ensuring high quality care and safety for patients and set the baseline for hospital participation in the Medicare and Medicaid programs. Compliance with the CoPs and the potential for termination from the Medicare and Medicaid programs for non-compliance serve as valuable tools ensuring hospitals are meeting critical safety and quality requirements. However, the past year's experiences demonstrated the need to modernize certain CoPs. For example, reexamining and updating infection control and life safety code requirements would allow hospitals and health systems to continue to employ innovative approaches, such as allowing for separate facility entrances for potentially infectious patients and minimizing personal protective equipment (PPE) use and infection risk by placing IV tubes outside patient rooms. The AHA has urged CMS to collaborate with providers to determine how specific CoPs can be revamped to improve quality and safety.

Rural Capacity. CMS should continue to support increased bed capacity in rural areas when an emergency requires such action. Rural hospitals should be held harmless for increasing bed capacity during any future emergency, and those providers should be permitted to maintain pre-emergency bed counts for applicable payment programs, designations and other operational flexibilities.

Flexibilities Requiring a Transition Period

Emergency Use Authorization (EUA) Transition. The COVID–19 pandemic placed significant strain on an already fragile medical supply chain and highlighted

several substantial flaws in the acquisition process. Many of those impacts still exist today to varying degrees. In response to supply chain disruptions, the Food and Drug Administration (FDA) issued an unprecedented number of EUAs to help mitigate constant disruption and continuous impact. The EUAs covered a broad range of devices, from respirators and COVID–19 tests to ventilators and decontamination systems. These EUAs saved lives by opening up new supply lines to ensure providers have the items they need to safely and effectively care for patients throughout the pandemic. However, the EUAs are not a silver bullet, and additional disruptions will occur post-pandemic. Congress should reassess how the supply chain operates and consider modifications to mitigate further disruptions. To ensure supply chain stability, the FDA should offer full approval to those devices deemed necessary, and provide sufficient transition periods to move away from devices that do not receive full approval.

Personal Protective Equipment. The COVID–19 pandemic illuminated several supply chain shortcomings, not least of which was adequate access to PPE necessary to keep both front-line health-care workers and patients safe. In response to the massive PPE shortages, the FDA issued EUAs for a number of items, such as respirators and facemasks. To address the short- and long-term challenges associated with PPE, the FDA should take steps to ensure a reasonable wind-down of PPE EUA flexibilities to allow the supply chain to recalibrate and providers to use supply on-hand. In addition, the FDA should examine the long-term fragility of the PPE supply chain and consider offering certain non-traditional medical PPE manufacturers the opportunity to receive full medical supply authorization from the FDA. Finally, as this wind-down occurs, the FDA and other federal agencies, including the Occupational Safety and Health Administration (OSHA), the National Institute for Occupational Safety and Health (NIOSH) and the Centers for Disease Control and Prevention (CDC) should work together to ensure a coordinated approach to the transition.

Health Information and Data Sharing. Robust health information and data exchange capabilities among providers and with patients and government agencies are foundational to improving care delivery, supporting better health outcomes and facilitating emergency response. Data exchange capabilities support decision-making at the point of care and the data generated can provide insights into health disparities and inequities at the patient and population health levels. Yet, to realize these benefits, robust, secure infrastructure must be in place for all entities, utilizing a common set of data definitions and standards. Requirements around data collection and sharing also must be well defined and well understood by health-care providers and have a clear value proposition. Building this information technology infrastructure requires significant resources, both capital and workforce, and extensive efforts to redesign procedures and workflows and train clinicians and staff across the organization. Until all of these core building blocks are in place across the health information exchange continuum, implementation of new requirements on health-care providers, such as the Office of National Coordination for Health Information Technology's information blocking rules and CMS' admit, discharge and transfer notification CoP, should be delayed.

Quality Measurement Reporting. During the pandemic, CMS provided hospitals relief from quality reporting requirements, including making quality reporting optional in Q1 and Q2 of 2020, and allowing hospitals to apply for reporting waivers using the pandemic as justification. We note, however, that hospital performance on the measurement programs, like readmissions, hospital-acquired conditions and value-based purchasing, will be affected over multiple fiscal years to come, and it is vital that performance be assessed reliably and fairly. For that reason, CMS should use its statutory flexibilities to not apply payment adjustments in program years where it determines that, as a result of measure reporting exceptions, it has insufficient data to calculate national performance in a reliable manner.

Federal Medical Assistance Percentages (FMAP) Increase. The temporary FMAP increase in the COVID–19 relief laws has provided critical financial support for states to ensure their Medicaid programs can provide coverage for millions of their citizens during the COVID–19 pandemic. The temporary FMAP increase of 6.2 percentage points is set to expire at the end of the quarter in which the PHE ends. To benefit from the temporary FMAP increase, states must meet certain maintenance of effort requirements, including continuous enrollment for those enrolled in the program as of March 18, 2020. State governments, advocates and stakeholders recommend that additional federal funding will be needed for up to a year after the PHE ends. Extending FMAP will provide a smooth process to reevaluate Medicaid COVID–19-related coverage extensions.

Congress addressed a similar situation during the Great Recession of 2008–2009. Then, the FMAP was increased by 6.2 percentage points for 27 months (through the end of 2010) and then extended and tapered down from 6.2 % to 3.2% and finally to 1.2% for another six months ending in June 2011. Congress should consider a comparable approach for states at the end of the PHE. Congress also should consider an enhanced FMAP for states with high unemployment rates. During the Great Recession, states with increases in unemployment rates of 3.5% received an enhanced FMAP above the 6.2%.

Medicaid Coverage, Enrollment and Outreach. The PHE enabled states to leverage Medicaid's emergency authorities to make temporary changes to their programs that increased access to coverage and care. Most policies adopted by states helped individuals qualify for and enroll in Medicaid coverage. The two major pathways for states to change Medicaid eligibility, coverage and enrollment during the PHE were: Medicaid disaster relief state plan amendments that allow states to modify their state Medicaid plans quickly to change eligibility, benefits, cost sharing and payments; and disaster relief verification plan addenda that allowed state agencies to verify eligibility and use electronic data sources without prior approval from CMS.

The coverage needs facing states—and the policy changes needed to respond adequately—will continue to exist beyond the PHE. To provide continued flexibility, CMS should relax hospital-based presumptive eligibility standards, maximize flexibility for income verification and the use of self-attestation, and continue allowing qualified entities like hospitals to make presumptive eligibility determinations for all Medicaid eligibility groups.

Post-acute Care. Post-acute care (PAC) providers continue to play a key role in the national COVID–19 response. In communities that faced or are facing surges of the virus, they have treated many of the sickest COVID–19 patients following hospital discharge, as well as provided important relief to hospitals and other settings overwhelmed by patients with and recovering from the virus. Concurrently, the prospective payment systems (PPS) of three of the four PAC settings—the long-term care hospital, inpatient rehabilitation hospital, and skilled nursing facility PPSs—have been in the midst of major payment transformations during the PHE. The collective magnitude of the PHE and these PPS redesigns is extensive, and time is needed for policyholders and stakeholders to disentangle and understand the longer-term ramifications of each. Thus far, their combined impact includes, as examples, material reductions in case volume and overall payments, the rise of average levels of patient acuity, facility closures, personnel shifts and revised clinical pathways. For example, AHA analysis shows that, in comparison to prior patterns, case volume for these settings dropped by 6% to 30% while the average case-mix index rose from between 2.5% and 6.9% over the prior year.[i] In recognition of this complex dynamic, the recent FY 2022 PAC proposed rule calls upon stakeholders to provide guidance on how to account for both of these overlapping and powerful drivers of change. At this time, it remains unclear which of these and other operational impacts will persist after the PHE, but given their scope and duration, it seems possible that the PAC field will not return to its pre-PHE profile. Given this level of change and uncertainty, key PAC flexibilities should remain in effect during a transition period that follows the official end of the PHE. In particular, such extended flexibilities should include PHE-levels of payment and coverage for highest acuity COVID–19 patients who remain in the PAC setting following the PHE, including those "long-haul COVID–19 patients" for whom the virus has concluded but related symptoms remain.

The AHA is gratified that the Committee is examining the many flexibilities granted during the COVID–19 pandemic. We stand ready to work with the Committee as you consider learnings from these flexibilities and how to ensure that the nation's health-care system can continue to evolve for the benefit of patients and the health of their communities.

---

[i] These data compare a 12-month period during the PHE, January 27, 2020 through January 26, 2021, to a pre-PHE 12-month period, January 26, 2019 through January 26, 2020. Data source: Medicare fee-for-service claims, Centers for Medicare and Medicaid Services, Chronic Conditions Data Warehouse, *https://www2.ccwdata.org/web/guest/home.*

AMERICAN MEDICAL ASSOCIATION
25 Massachusetts Avenue, NW, Suite 600
Washington, DC 20001
Division of Legislative Counsel
(202) 789–7426

The American Medical Association (AMA) appreciates the opportunity to provide a statement for the record to the Senate Finance Committee as part of the hearing on "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." We welcome the opportunity to support congressional efforts to ensure patients and physicians continue to have access to valuable services that flexibilities during the COVID–19 Public Health Emergency (PHE) enabled. In particular, the AMA strongly supports congressional efforts to ensure that Medicare beneficiaries have access to telehealth services and to make permanent valuable flexibilities provided for the treatment of substance abuse services, hospital at home services, and the Medicare Diabetes Prevention Model.

Telehealth Flexibilities Should Remain in Place

Telehealth is a critical part of the future of effective, efficient, and equitable delivery of health care in the United States. Efforts must continue to build capacity and support access to care centered on where the patient is located (to the greatest extent it is clinically efficacious), and to ensure physicians and other health-care professionals have the tools to optimize care delivery. The AMA has been a leader in advocating for expanded access to telehealth services for Americans because it has the capacity to improve access to care for many underserved populations and improve outcomes for at-risk patients, particularly those with chronic diseases and/or functional impairments.

In response to the COVID–19 PHE, Congress passed the CARES Act, which, among other things, provided the Centers for Medicare and Medicaid Services (CMS) the authority to waive the geographic and originating site requirements for the duration of the COVID–19 PHE, which CMS subsequently did.[1] Following these policy actions, telehealth usage among Medicare beneficiaries has expanded greatly as patients could, for the first time, access telehealth services from wherever they are located, including their home, regardless of where they reside in the country. The AMA remains deeply grateful for these flexibilities, which have allowed Medicare patients across the country to receive care from their homes. With many physician offices closed, elective procedures postponed, personal protective equipment difficult to obtain, and an ongoing infectious disease pandemic that has forced patients to stay home for their safety, the ability to provide services directly to patients regardless of where they are located via telehealth has allowed many vital health-care services to continue. In addition to facilitating continuity of care for patients being treated for acute and chronic conditions, telehealth has also facilitated initial assessment of patients experiencing potential COVID–19 symptoms and those who have been in close contact with people diagnosed with COVID–19 to determine if referrals for testing or treatment are indicated while minimizing risks to patients, practice staff, and others. With this expansion of services has come a recognition from patients, physicians, and other providers that telehealth services offer effective and convenient health care in many circumstances. Congress must act now to ensure that Medicare patients can continue to access telehealth services from wherever they are located after the pandemic ends by modernizing the Social Security Act to keep pace with our digital future.

However, without further legislative action from Congress, Medicare beneficiaries who have come to rely on telehealth services during the PHE will abruptly lose access to these services completely. Under section 1834(m) of the Social Security Act (SSA), Medicare is prohibited from covering and paying for telehealth services delivered via two-way audio-visual technology unless care is provided at an eligible site in a rural area.[2] This means that, in order to access telehealth services, patients must live in an eligible rural location, and must also travel to an eligible "originating site"—a qualified health-care facility—to receive telehealth services, except in the few cases where Congress has authorized provision of telehealth services in

[1] Coronavirus, Relief, and Economic Security (CARES) Act, Pub L. No. 116–136, 134 Stat. 281 (2020), *https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf.*

[2] Special Payment Rules for Particular Items and Services, 42 U.S.C. § 1395m(m), *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.*

the home of an individual.[3] As a result, the 1834(m) restrictions bar the majority of Medicare beneficiaries from using widely available two-way audio-visual technologies to access covered telehealth services unless they live in a rural area, and with a few exceptions, even those in rural areas must travel to an eligible health-care site.

Congress must act now to remove the origination and geographic restrictions on telehealth coverage for Medicare patients. Continued access to telehealth services beyond the PHE is critical for patient populations that have come to rely on its availability. That is why the AMA supports S. 368/H.R. 1332, the "Telehealth Modernization Act of 2021," which would eliminate the 1834(m) statutory restrictions on originating site and geographic location, thereby ensuring Medicare coverage of telehealth services regardless of where the patient is located. It is critically important that Medicare beneficiaries continue to be able to access telehealth services from their physicians without arbitrary restrictions throughout the COVID–19 public health emergency and beyond.

The PHE Has Demonstrated the Value of Telehealth

The success of telehealth technology adoption during the COVID–19 public health emergency has made it abundantly clear that geographic and origination restrictions on accessing telehealth services are outdated and arbitrary given today's technology that allows for access to digital tools from anywhere. Physicians and patients have seen the value of telehealth services and should not be forced to stop using these tools when the public health emergency ends. Some have argued that statutory changes cannot be made without additional data on how telehealth services are used, however, this has the problem backwards. More data is not necessary to determine that the underlying policy needs to be permanent, but instead can help CMS determine which services need to continue to be covered or can be safely removed from the Medicare telehealth list. In the meantime, the certainty that appropriate telehealth services will be covered would provide physicians confidence in investing in new technology and give patients peace of mind that they can continue to access services in a way that works best for them.

The rapid and widespread adoption of telehealth by physicians in 2020 was one of the most significant improvements in health-care delivery in decades. The new telehealth coverage and payment policies enabled physicians to deliver valuable services they previously could not afford to provide but that their patients needed. With legislative provisions such as the establishment of the CMS Innovation Center and Medicare's Quality Payment Program, Congress has sought for many years to support physician adoption of innovations in the delivery of care. The successful adoption of telehealth throughout the country has demonstrated that, if the financial barriers are removed, physicians will adopt important innovations in the delivery of care that are necessary to improve their patients' health.

Telehealth technologies allow physicians to increase continuity of care, extend access beyond normal clinic hours, and help overcome clinician shortages, especially in rural and other underserved populations. This ultimately helps health systems and physician practices focus more on chronic disease management, enhance patient wellness, improve efficiency, provide higher quality of care, and increase patient satisfaction. Telehealth has helped increase provider/patient communication, increase provider/patient trust, and access to real-time information related to a patient's social determinants of health (*i.e.,* a patient's physical living environment, economic stability, or food insecurity), which can lead to better health outcomes and reduced care costs. The ability to gain greater access to chronic disease management services and better assess the impact of a patient's social determinants of health will undoubtedly contribute to improved treatment and health outcomes for historically marginalized and minoritized populations as well.

Telehealth services can help patients avoid delaying care that can lead to expensive emergency department visits and hospitalizations. They also cut down on trips to the office that may be difficult or risky for patients with functional or mobility impairments, frail elderly who need a caregiver to accompany them, those who need to stay home to care for other family members, and patients who are immunocompromised or vulnerable to infection. Providing access to telehealth services creates greater safety and efficiencies for both patients and physicians, delivering value to the Medicare program.

---

[3] For example, substance abuse disorder treatment delivered via telehealth is explicitly exempted from the geographic and origination restrictions.

Physician practices are ready to invest in the technology required to provide these services; however, it will be very difficult to provide the sustained financial commitment needed to incorporate delivery of telehealth services into their workflows if the coverage is only temporary. The removal of coverage and financial barriers has allowed the explosive growth in telehealth and certainty about future coverage is necessary for it to continue. It has allowed CMS to make more informed decisions about which services to cover, and, in fact, CMS has expanded coverage of telehealth services greatly during the PHE.[4] While more data behind current telehealth usage trends may be valuable to gather evidence about which particular Current Procedural Terminology® (CPT®) codes need to stay on the Medicare telehealth list, that is a much different concern than whether nationwide coverage and ability to deliver care to patients wherever they are located should be available; these determinations are already appropriately made by CMS.

While CMS has expanded coverage of telehealth services during the PHE, only Congress can assure all Medicare beneficiaries can receive equal access to those services moving forward. Delaying action, such as extending the current 1834(m) waiver authority, will only make it more expensive to change the policy permanently in the future.

CMS Already Makes Coverage Determinations on Telehealth Services

CMS currently has all the tools necessary at its disposal to make determinations about which telehealth services it should cover and at what payment level. For the duration of the COVID–19 PHE, CMS has added many services to the list of those that Medicare pays for when they are provided via telehealth. The newly covered services include emergency department visits, observation care, hospital and nursing facility admission and discharge services, critical care, and home care, as well as services like ventilator management that have been especially necessary for COVID–19 patients. The newly added services have greatly assisted physicians during the PHE when both patients and health professionals needed to maintain physical distance from others as much as possible. Through telehealth communications, for example, an emergency physician, potentially assisted by members of the patient's household, can diagnose, and treat emergency conditions without sick patients having to endure difficult travel and expose themselves and others to SARS–CoV–2 and other dangers. In all, CMS added interim Medicare coverage for more than 150 services for the duration of the COVID–19 PHE at payment parity with in- person services. Equivalent payment for telehealth services during the PHE was crucial to ensure physicians could cover the cost associated with offering virtual care. In future rulemaking, CMS has indicated it may extend the interim coverage for a longer period of time to help gather more evidence of how the services are used when provided via telehealth outside the context of a pandemic.

The only thing holding CMS back from expanding access to appropriate telehealth services to its beneficiaries are the outdated restrictions currently in the statute. Since telehealth is simply a modality for delivering health care, AMA continues to urge Congress and CMS to provide payment parity for two-way audio-visual services upon conclusion of the COVID–19 pandemic.

Telehealth Helps Provide Access to Health Care to Underserved Communities

Access to telehealth services can help reduce inequalities in care for underserved communities by providing access to services for patients regardless of where they are located. Patients in rural areas or underserved urban communities often have to travel long distances to access care, especially specialty services including emergency and critical care. Telehealth can also help eliminate commutes to physician offices for those with mobility or transportation difficulties.

In conjunction with expanded access to telehealth services, the AMA supports Congressional efforts to expand high-speed broadband Internet access to underserved communities and increase digital literacy education efforts. Patients cannot take advantage of telehealth services if they do not have the requisite Internet connection to access them or the appropriate skills to use digital technologies. Providing digital literacy skills is particularly important for non-English speaking patients and is another crucial aspect of ensuring health equity. Solving this problem requires enhanced funding for broadband Internet infrastructure in rural areas and support for underserved urban communities and households to gain access to affordable Internet access, as well as support for patient education on how to use digital tools.

---

[4] Medicare Physician Fee Schedule 2021, 85 Fed. Reg. 84472 (December 28, 2020), *https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf.*

Concerns About Fraud and Abuse and Overutilization Are Misplaced

Some have raised concerns that expanded coverage of telehealth services could lead to greater fraud and abuse or duplication of medical services. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication are of particular concern for telehealth services. Therefore, Congress should not create artificial barriers to telehealth by defining an established doctor-patient relationship inconsistently with the standard of care or otherwise creating unique and burdensome fraud and abuse requirements that would stifle access to telehealth services. The AMA supports removing restrictions on access to Medicare tele-mental health services that were included in H.R. 133, the Consolidated Appropriations Act, 2021. Specifically, the new requirement that Medicare beneficiaries must be seen in person at least once by the physician or non-physician practitioner during the six-month period prior to the first telehealth services should be repealed. Such restrictions were not imposed on tele-mental health services covered by Medicare prior to the passage of the COVID–19 telehealth waiver, or on tele-mental health services covered by Medicare under the waiver during the PHE. Moreover, they are not supported by the data we have seen regarding the benefits of increased access and improved patient adherence to treatment in tele-mental health services and they directly conflict with the standard of care.

CMS and the Office of Inspector General (OIG) at HHS already have all of the Medicare coverage and payment and fraud and abuse authorities to monitor telehealth service compliance just as they do any other Medicare covered service. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare and Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority, or other technologies such as phone, text, or remote patient monitoring.

In recent remarks regarding the potential for telehealth fraud, Principal Deputy Inspector Grimm of OIG never mentioned any concerns with OIG's authority or ability to address concerns of fraud and abuse.[5] Instead, he described OIG's concerns with "telefraud" schemes which he distinguished from telehealth fraud, in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the televisit but instead used the sham televisit to induce a patient to agree to receive unneeded items and gather their info. In other words, whether or not the telehealth service itself is covered has no impact on these kinds of fraudulent schemes.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via the Modifier 95. The Modifier 95 describes "synchronous telemedicine services rendered via a real time Interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. The Modifier 95, along with listing the Place of Service (POS) equal to what it would have been for the in-person service, is also applicable for telemedicine services rendered during the COVID–19 PHE. The requirement to code with the Modifier 95 enables CMS to properly decipher and track telemedicine services, thus improving the chances of identifying and rooting out fraud, waste, and abuse.

Data analyzed by CMS since the start of the PHE shows that fears of overutilization are overblown. Data from Medicare claims from Q1 and Q2 show that less than 4% of telehealth spending was for new patient audiovisual office visits. Moreover, nothing in the data or anecdotal evidence suggests that telehealth services have been duplicative of in person services rather than used as an alternative or in addition to in person care. The AMA will continue to monitor and analyze the data as it becomes available, but this suggests that there is no reason to think better access to telehealth will lead to an explosion in unnecessary services.

---

[5] Principal Deputy Inspector Grimm on Telehealth (February 26, 2021), *https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp.*

As a result, Congress should refrain from imposing new and discriminatory restrictions on the use of audio-visual communications technologies, such as restrictions on how a physician-patient relationship can be established. AMA policy, established in 2014, states that a valid physician-patient relationship may be established virtually face-to-face via real-time audio and video technology, if appropriate for the service being furnished.[6] It also allows for the relationship to be established in a variety of other ways such as meeting standards of care set by a major specialty society. All 50 states and the territories allow a physician-patient relationship to be established virtually or through other means. The exact parameters vary by state; however, many state laws are based on an AMA model law. Congress should not impose a one-size-fits-all requirement on services furnished via telehealth technology that are in direct conflict with standards of care and that do not exist for other technologies.

Gains made in access to telehealth will be greatly hampered if unique and arbitrary barriers are erected around the use of telehealth services. Such barriers will have a dramatic and negative impact on patients seeking care, particularly during the current COVID–19 pandemic, and in any future pandemic where patients need access to care without the concerns surrounding a visit to a crowded health-care facility.

Audio-only Services Should Remain Covered

The AMA also strongly supports coverage for audio-only services and has called on CMS to continue this coverage after the PHE ends. There are numerous patients and entire communities that have no access to the Internet connectivity necessary to utilize audio-visual telehealth services in their homes. There are also medical practices that do not have sufficient connectivity to provide audio-visual telehealth services. Patients who cannot utilize audio-visual telehealth services include those in communities lacking broadband access, those where the technological capabilities are present, but the patient cannot afford it, and others who have access to the technology and the connectivity but do not know how to use it. Inability to use audio-visual telehealth services is also a matter of health equity. Too often it is the same communities that face other barriers to good health outcomes who also face these technology barriers, such as Native Americans living on reservations and those in the rural South's Black Belt. But patients who cannot participate in audio-visual telehealth services are no less sick than those who can, and it is important to their health care to retain access to these services.

Pursuant to authority granted under the CARES Act, CMS waived the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR §410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology for certain services. This has allowed the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services. Expanded use of audio-visual telehealth services during the pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients, and those in rural and other areas with limited Internet access. It would be inappropriate to prevent these patients from accessing such services. In addition, we have heard from many physicians about the need to have access to audio-only services because a number of their patients, even those who own the technology needed for two-way real-time audio-visual communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner.

Audio-only services are an important part of a fully integrated care plan and physicians should be able to permanently deliver E/M (evaluation and management) services by telephone to patients who need a telecommunications-based service in the home but who do not have access to a video connection or cannot successfully use one. Without access to an audio-only option, limitations in Internet and/or technology access as well as lack of experience with its use will increase inequities in access to medical care and widen disparities in health outcomes.

Flexibilities for the Treatment of Substance Abuse Disorder Should Be Continued

Early on in the COVID–19 Public Health Emergency, the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration

[6] American Medical Association, H–480.496: Coverage of and Payment for Telemedicine, *https://policysearch.ama-assn.org/policyfinder/detail/telemedicine?uri=%2FAMADoc%2FHOD.xml-0-4347.xml* (last modified, 2019).

(SAMHSA) put several important flexibilities in place to help DEA-registered physicians manage care for their patients with opioid use disorder (OUD). During this PHE, physicians who have a waiver allowing them to prescribe buprenorphine for the treatment of OUD can initiate and continue this treatment based on telehealth visits and audio-only visits with patients. Opioid Treatment Programs can also initiate new patients and treat existing patients being managed with buprenorphine based on telehealth and phone visits. Patients cannot be initiated with methadone treatment based on telehealth visits, but existing patients on methadone can be managed via telehealth or phone. Opioid Treatment Programs can also provide patients who are stable with take-home medication.

Based on a survey led by the American Academy of Addiction Psychiatry and conducted last summer of more than 1,000 physicians and other health professionals who treat OUD, these new flexibilities were extremely important in allowing them to continue to manage their patients' care. A major finding of the survey is that more than 80% of X-waivered survey respondents want the telehealth options to continue after the COVID–19 PHE. The AMA has written to the DEA urging that these flexibilities remain in place at least until the end of the opioid PHE and believes Congress should support these continued flexibilities.

Hospital at Home Services Flexibilities Should Remain

A number of other countries pay for delivering services equivalent to hospital inpatient care to patients in their own homes. These "hospital at home" services have been successful in allowing patients with specific types of conditions that qualify for inpatient care to receive services in the home and avoid the risks associated with an inpatient admission. The services are more intensive than can be supported through traditional home health-care payments. Although some hospitals in the U.S. were delivering hospital at home care and some Medicare Advantage plans were paying for it before the PHE, the service was difficult to sustain or expand without payment support from Medicare because a minimum number of patients need to participate in order for the service to be cost-effective. During the pandemic, one of the key flexibilities that CMS now has allowed is for hospitals to deliver services to patients in their homes. It would be desirable to continue this flexibility after the national emergency ends for the subset of patients who meet the criteria used in hospital at home programs in the U.S. and other countries.

Medicare Diabetes Prevention Expanded Model Flexibilities Should be Made Permanent

Through the rulemaking process for the 2021 Medicare physician payment schedule, CMS adopted important flexibilities that are effective for the duration of the COVID–19 PHE and in future 1135 waiver emergencies that could cause a disruption to in-person MDPP services. These MDPP policies will only apply in emergency situations, however, and not on an ongoing basis. MDPP services are being significantly underutilized. If the MDPP flexibilities that have been adopted for COVID–19 and future emergencies were instead continued as regular, ongoing MDPP policies, it would significantly strengthen the effectiveness of diabetes prevention services for Medicare patients with prediabetes. The AMA strongly urges Congress to pass H.R. 2807, the PREVENT Diabetes Act.

To furnish virtual services during an emergency period, MDPP suppliers must already have preliminary or full CDC Diabetes Prevention Program recognition for in-person services. CMS continues to bar virtual-only suppliers that have achieved CDC recognition from furnishing MDPP services, even during the PHE. Under its current regulations, CMS will require MDPP providers to resume in-person services at the conclusion of the COVID–19 PHE. Against AMA urging, CMS has declined to allow virtual providers to participate in MDPP to the fullest extent either during or after the PHE. CMS regulations also prohibit patients from participating in their MDPP sessions virtually when offered by suppliers who provide both in-person and virtual services except during an emergency period. Many patients with prediabetes are unable to effectively participate in in-person MDPP sessions, often because they live far from any supplier location or because the sessions are not offered at times that are convenient for them. The MDPP should be modified to allow patients to obtain their session virtually at any time.

CMS regulations also impose a once-per-lifetime limit on patients obtaining MDPP services. During an emergency period, patients who continue their MDPP participation through virtual services will still be subject to the once-per-lifetime limit, but patients whose MDPP participation is interrupted by an emergency period will be able to restart MDPP services with the first core session after the emergency period ends. Other Medicare behavior modification programs such as tobacco cessation and

obesity counseling do not have lifetime limits and there is no justification for a once-per-lifetime limit on MDPP services. This limit should be lifted for all patients, not just those who discontinue MDPP during a declared emergency.

Conclusion

The AMA thanks the Committee for this hearing and for the careful consideration of the flexibilities that have been put in place for the COVID–19 PHE. We look forward to working with the Committee and Congress to seek solutions that will ensure patients can continue to benefit from these flexibilities after the end of the PHE.

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION
529 14th Street, NW, Suite 1280
Washington, DC 20045
Phone: 202–591–2469
Fax: 202–591–2445

The American Medical Rehabilitation Providers Association (AMRPA) commends the Senate Committee on Finance for its efforts to closely assess the nation's response to the COVID–19 public health emergency (PHE) and determine whether and what type of permanent policy changes should be considered in the PHE aftermath. In particular, AMRPA was pleased to hear Chairman Wyden remark that there "is bipartisan interest in building on the changes that worked well for both seniors and providers" during the PHE, as we believe that getting patient and provider feedback is critical in the assessment of COVID–19 waivers. As providers who were able to furnish critical care to acute COVID- 19 survivors due to the numerous statutory and regulatory flexibilities granted to our field, we appreciate the opportunity to offer recommendations from the inpatient rehabilitation hospital perspective.

AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (referred to collectively by regulators as inpatient rehabilitation facilities, or IRFs). As you may be aware, IRFs have and continue to play a vital role in their communities' PHE response effort, due in large part to their hospital-level care, clinical competence, personnel, quality, equipment, and emergency response/preparedness capabilities that distinguish IRFs from other post-acute care (PAC) settings. Patients' access to IRFs during the pandemic has been particularly critical in light of the unprecedented surge demands faced by acute-care hospitals and the infection control and safety issues that restricted patients' access to other PAC options. Through the utilization of waivers granted during the PHE, AMRPA members have continually reported the long-term, positive impact that medical rehabilitation has had for both COVID–19 survivors and other complex patients who required medical rehabilitation care during the PHE. As the Medicare program now faces a confluence of an aging population, the new clinical and care delivery challenges presented by "long-hauler" COVID–19 survivors, and Trust Fund insolvency projections, protecting patient access to inpatient rehabilitation has never been more important. It is therefore vital that Congress takes steps to ensure IRFs have the appropriate regulatory environment and resources for the duration of the PHE and beyond.

As background, AMRPA engaged extensively with both Congressional offices and the Centers for Medicare and Medicaid Services (CMS) since the beginning of the pandemic regarding the flexibilities that would be needed to address the surges of both COVID–19 and non-COVID–19 patients requiring hospital-level care during the PHE. Given that IRFs are arguably the most closely-regulated post-acute care entity within the Medicare program, wide-ranging flexibilities were needed with respect to admission criteria, documentation, and reporting requirements, among others. CMS leaders conveyed to AMRPA that the comprehensive flexibilities granted to IRFs during this time were intended to facilitate timely and effective patient access to IRFs and ensure that IRF providers were able to dedicate time and resources to patient care rather than regulatory burdens. As the Finance Committee contemplates a legislative response that builds off the "lessons learned" from the COVID–19 pandemic and protects patient access to care in an evolving health-care environment, we appreciate your consideration of our legislative recommendations informed by the PHE. While our recommendations may evolve in future stages of the PHE and its aftermath, our primary asks currently include:

- Consider commonsense reforms to key IRF coverage requirements to better reflect the value of rehabilitation services for patients;

- Prohibit the use of prior authorization by Medicare Advantage plans in all future PHEs and throughout their duration, and implement significant reforms to current prior authorization practices that harmfully impeded care over the past year (AMRPA has supported the recently-introduced H.R. 3173, the *Improving Seniors Access to Timely Care Act,* as a key first step in this regard);
- Permanently implement some of the critical telehealth-related waivers and flexibilities granted during the PHE (*e.g.,* the recognition of physical therapists, occupational therapists, respiratory therapists and speech-language pathologists as telehealth providers);
- Ensure providers can practice across state lines, or at minimum, authorize interstate licensing immediately upon any future PHE declaration; and
- Reset the implementation of the IMPACT Act timeline to account for the ongoing burdens on each PAC sector and the need to account for the COVID–19 PHE in any future payment reform effort.

We believe many of these asks complement the 117th Congress' broader focus on burden reduction and regulatory modernization efforts, and AMRPA stands ready to work with your offices as specific legislation is considered.

Our more detailed recommendations follow:

Using PHE Flexibilities to Modernize IRF Coverage Rules

At the beginning of the pandemic, two key IRF coverage waivers were granted to maximize patient access to IRFs—the 60% rule and the 3-hour rule. Even before the PHE, AMRPA urged policymakers to reexamine these rules and modernize them in light of the significant policy and operational changes that have occurred since their implementation. With both rules currently suspended due to the PHE, AMRPA believes it is an optimal time to reassess and refine these rules.

As background, the current "60% rule" broadly requires that 60% of the IRF's patients must have a qualifying condition in order to be paid as an IRF under the Medicare program. There are currently 13 such conditions, including, stroke, spinal cord or brain injury, and hip fracture, among others. There have been no major categories added for decades—despite medical and technological advancements that have led broader patient populations to gain significant clinical benefits from IRF care. The waiver of the 60% rule during the PHE has improved access for patients that had conditions other than those categorized as a compliant condition—such as oncology and cardiac-related conditions, and COVID–19—and led to improved outcomes and functional recoveries for such patients. *AMRPA therefore urges Congress to direct CMS to revisit and potentially broaden the 60% rule's "compliant" conditions before putting the rule back into effect. This would be an important step to both protect patient access and ensure that Medicare regulations reflect the current state of medicine.*

Similarly, AMRPA asks Congress to modernize the 3-hour rule, which requires an IRF patient to participate in, and benefit from, at least three hours of rehabilitation therapy per day, five days per week (or 15 hours per week if documented appropriately). Due to a 2010 regulatory change, only physical therapy, occupational therapy, speech therapy, and/or orthotics and prosthetics are countable therapies toward the 3-hour threshold. AMRPA recognizes that the volume of therapy received by IRF patients is among the characteristics that distinguish IRF care from other PAC settings. At the same time, AMRPA has advocated for the inclusion of other therapy modalities that rehabilitation physicians often determine are necessary for patients' full functional recovery, such as psychological services, neuropsychological services, and respiratory therapy. AMRPA members already provide these therapies when needed (despite their exclusion from the 3-hour rule calculation) given the clear benefit that they provide for a range of complex patients in IRFs. Their utilization and the benefit provided to patients clearly demonstrates that these therapies should be recognized as part of the "intensive rehabilitation therapy program" for which the 3-hour rule is attributed.

The rationale for counting these modalities toward the 3-hour threshold is all the more compelling in light of the impact of the PHE waiver. The aforementioned therapies were particularly beneficial as patients with acute respiratory disease were treated by IRFs during the pandemic, and AMRPA members expressed appreciation for the flexibility provided through the waiver in this regard. As such, AMRPA believes that they should permanently be allowed to count toward the threshold in the PHE aftermath. We have already worked with Congressional offices to discuss a bill that would deliver these much-needed modernizations, and *we look forward to working with the Finance Committee to facilitate its introduction and advancement in the 117th Congress.*

On a related issue, AMRPA requests that the full 3-hour rule waiver be included within the scope of flexibilities that can be granted by CMS (via Section 1135 waivers) in future PHEs. This would negate the need for Congressional action and ensure that this rule be waived promptly by regulators in emergency circumstances.

Significant Reforms to Prior Authorization Practices

In the first quarter of 2020, many Medicare Advantage (MA) plans voluntarily waived their prior authorization/pre-authorization policies to ensure that patients were able to access IRF beds in the safest and most timely way possible. These voluntary waivers enabled patients that were ready for clinical intervention to receive such care expeditiously, rather than incur the 3–5 business day delays that these policies frequently impart. Unfortunately, after the first few months of the pandemic, most MA plans reinstated prior authorization requirements. This severely impeded movement of patients from acute-care hospitals into PAC settings, exacerbating an already critical hospital bed shortage. Data that AMRPA has examined from the time period before, during and after the suspension of prior authorization made clear that the removal this requirement provided access to complex patients that otherwise may have been delayed or denied receiving care. The positive impact of these waivers makes it clear that prior authorization policies must be fully and immediately suspended in all future public health emergencies for the emergency's full duration, and we urge you to include this protection statutorily in future pandemic- focused legislation.

In addition, AMRPA believes there are a number of reforms that must be made to prior authorization policies outside of the context of a PHE. Under current practices, an MA representative who has never seen or examined the patient, and often lacks training or expertise in rehabilitation medicine, second- guesses the judgement of the treating physicians that have deemed an admission to an IRF to be medically necessary and appropriate. In turn, these prior authorization policies often cause lengthy delays or inappropriate denials for patients needing IRF care, which adversely affects outcomes and functional recovery. With prior authorization practices now generally back in effect across the nation, AMRPA members report that these policies are once again compromising timely patient access to timely IRF care.

AMRPA therefore asks Congress to advance H.R. 3173—the Improving Seniors' Access to Care Act—as an initial and commonsense step towards prior authorization reform. Importantly, the legislation would direct HHS to establish that prior authorization decisions to be made in "real time" to address the aforementioned delays and inappropriate referrals tied to current practices. AMRPA believes that 6 hours is an appropriate "real time" measure for an inpatient rehabilitation admission authorization decision, and we look forward to working with both Congress and ultimately HHS in this regard. Furthermore, AMRPA asks the Committee to consider other legislative actions to improve prior authorization practices, such as:

- Strengthen beneficiary protections for all MA enrollees by ensuring prior authorization requests are reviewed by physicians with appropriate training and experience in inpatient rehabilitation.
- Limit or eliminate the use of proprietary guidelines/decision tools to ensure enrollees' statutory right to Medicare fee-for-service benefits are fulfilled and that admission decisions take into account patient-specific characteristics and conditions.

Telehealth Expansion

Some of the most important waivers granted during the COVID–19 PHE relate to telehealth expansion, particularly for medical rehabilitation patients. In particular, AMRPA strongly supported policymakers' decision to (1) expand the list of telehealth services that can be provided in the Medicare program via telehealth to include therapy services, (2) recognize therapists—including physical therapists, occupational therapists, and speech-language pathologists—as eligible telehealth providers, (3) relax distant site guidelines, and (4) permit a broader range of telemedicine in the context of inpatient care—such as remote consultations and virtual team meetings. Many of our hospital members report that these waivers allow patients to continue the outpatient therapy component of their intensive rehabilitation program without undertaking the risk of entering the hospital or outpatient care setting. *We therefore urge Congress to enact legislation to make these flexibilities permanent in the PHE aftermath.*

Even before the COVID–19 pandemic, AMRPA is on record expressing support of efforts—such as the *CONNECT for Health Act* (which was again recently reintroduced in the 117th Congress)—to modernize telehealth rules in the Medicare pro-

gram to better reflect the state of medicine and technology. Consistent with this position, AMRPA believes that these outpatient therapy-focused waivers will prove beneficial outside of a PHE, such as when patients face other obstacles (*e.g.,* weather, protests, or mobility restrictions) that prevent them from traveling to an IRF or outpatient therapy site. At the same time, clearer billing rules—particularly for hospital outpatient departments—may be required to ensure sufficient uptake. Further, Congress should consider flexibility within the definition of telehealth, such as allowing audio-only services for those patients unable to use or without access to video technology or Internet connectivity. *AMRPA therefore believes that permanent implementation of these telehealth waivers and requisite guidance to the industry is a commonsense way to improve patient access to care without compromising quality or safety.*

Implementing Interstate Licensing Flexibilities

During the PHE, numerous AMRPA members were able to provide critical capacity to acute-care hospitals across state lines and provide both surge and COVID–19 patients with the acute beds they required. The interstate licensing flexibilities offered by CMS were utilized broadly by IRF providers and helped ensure that patients received the timely care they required for survival and recovery, without jeopardizing the quality of the care they received. *AMRPA therefore requests that these flexibilities be made permanent to alleviate patient access issues and address arbitrary restrictions on care options when patients live near state lines.* At minimum, AMRPA urges Congress to ensure that interstate licensing flexibilities are automatically triggered whenever a PHE is declared to ensure that partner hospitals in different states can immediately assist each other in furnishing the capacity and provider access required for their patients. Additionally, and consistent with our telehealth-related recommendations, AMRPA also recommends that providers be allowed to practice across state lines via telehealth in the same way they would be permitted to do so in-person.

Delaying the Implementation Timeline and Considering Other Potential Changes to the *IMPACT Act*

As Congress assesses policy changes informed by COVID–19 waivers and flexibilities, AMRPA urges Members to also be mindful of the lessons learned by and about post-acute care providers in the context of other legislative efforts. Specifically, AMRPA believes the PHE requires policymakers to reconsider the timing and underlying goals of the unified post-acute care (UPAC) prototype required under the *IMPACT Act.* With respect to timing, AMRPA has long been concerned about the data being used to develop a UPAC prototype given the significant changes in each of the post-acute care setting payment systems since the implementation of the *IMPACT Act.* The current PHE now raises new and serious concerns about the use of claims and cost data for any year that the PHE is/was in effect and the years immediately following. Therefore, as policymakers consider how the COVID–19 PHE should impact future work related to post-acute care reform, the development of a UPAC prototype should at the very least be delayed for several years until useable data is available.

This delay would also allow policymakers to consider the seismic impact of the COVID–19 PHE on the post-acute care continuum and the permanent changes in care delivery that will stem from the exact policy changes being considered through the Committee in this line of work (for example, the impact of future telehealth expansions). Therefore, AMRPA urges the Committee to support *The Resetting the IMPACT Act* (H.R. 2455), which would make these commonsense reforms and reset the timeframe in a way that could improve the accuracy of a prototype (and ensure more meaningful stakeholder engagement). We also look forward to working with the Committee to ensure that any future payment and coverage changes are informed by the lessons the Committee seeks to glean from the PHE.

In closing, AMRPA applauds the leadership of the Committee and greatly appreciates the opportunity to provide comments on how COVID–19 waivers should inform future policy changes. Should you wish to discuss our comments further, please contact Kate Beller (kbeller@amrpa.org; 973–224–4501) or Kristen O'Brien (klobrien@mcdermottplus.com).

Sincerely,

Anthony Cuzzola
Chairman, AMRPA Board of Directors
Vice President/Administrator

JFK Johnson Rehabilitation Institute
Hackensack Meridian Health

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
6116 Executive Boulevard, Suite 200
North Bethesda, MD 20852–4929
fad@aota.org
301–652–6611
https://www.aota.org/

Pandemic Experience Demonstrates Need to Continue OT Telehealth Options for Medicare Beneficiaries After the Public Health Emergency

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 230,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities. In so doing, growth, development, and overall functional abilities are enhanced, and the effects associated with illness, injuries, and disability are minimized.

Telehealth and Occupational Therapy Before the Pandemic

As noted in AOTA's Telehealth in Occupational Therapy backgrounder (attached), some occupational therapy professionals were providing occupational therapy (OT) services via telehealth before the COVID–19 pandemic struck, with significant innovation occurring at the Veterans Administration. The number of OT telehealth encounters increased dramatically, however, as Congress and CMS reacted quickly to enable Medicare beneficiaries to receive OT and other therapy services via telehealth during the declared Public Health Emergency (PHE) to minimize infection risk.

Congressional action was essential to waive statutory restrictions on CMS that prevented occupational therapy practitioners and other therapy providers' ability to provide services to Medicare beneficiaries via telehealth. CMS responded to Congressional waivers included in the CARES Act by issuing an emergency rule that added a series of therapy CPT® codes to the telehealth services list, and then subsequently issued another rule that included occupational therapy practitioners as eligible Medicare telehealth providers. This effectively enabled OTs to provide services via telehealth to Part B Medicare beneficiaries during the COVID–19 emergency; however, these waivers are not permanent.

The delivery of OT services via telehealth expanded exponentially after the CMS waivers were issued, and in response to actions by state Medicaid plans and private insurance to also allow patients to receive OT services via telehealth to reduce infection risk. This enabled occupational therapy professionals to continue to provide essential OT services, while gaining the necessary experience to fully appreciate potential benefits to patients that are unrelated to minimizing in-person contact during a pandemic.

Congressional action is now essential to enable OT services to continue to be provided to Medicare beneficiaries via telehealth when appropriate, as CMS has indicated that it does not have the authority to do so under existing statute. The Expanded Telehealth Access Act (H.R. 2168) was introduced in the House by Reps. Mikie Sherrill (D–NJ) and David McKinley (R–WV) to enable OT professionals as well as physical therapists (PTs), speech-language pathologists (SLPs), and audiologists to provide services via telehealth under Section 1834(m) of the Social Security Act. Unless Congress acts, Medicare beneficiaries will face a telehealth "cliff" when the PHE ends, whereby beneficiaries who are now accustomed to receiving some OT services via telehealth, suddenly lose access to such services.

Experience During PHE Demonstrates Effectiveness of OT Services via Telehealth

The rapid expansion of telehealth as a delivery mechanism for OT services during the PHE has enabled occupational therapists and occupational therapy assistants to demonstrate the clear value of these services provided alone or in conjunction with in-person services. Telehealth has been especially beneficial for people in rural and other underserved areas and to those for whom travel to receive services was already a barrier to access, including people with disabilities.

OT practitioners report that telehealth has enhanced the effectiveness of OT services for Medicare beneficiaries in many ways. It has enabled more patients to start care on the day ordered and to minimize cancellations, postponements, and schedule changes that are commonly connected to transportation, mobility, caregiver availability, weather, and other issues related to treatment in a clinical setting. This in turn has enabled some patients to complete treatment sooner and with fewer visits, which can reduce the cost of care.

Telehealth has also made it much easier to connect with beneficiary caregivers who are often unable to take the time required to travel with the patient to in-person visits. This is especially important for some patients in the Medicare population who rely more heavily on a caregiver for assistance during appointments and for follow-up in the home. In addition, telehealth visits have enabled OT professionals to better identify home safety issues, which are often minimized or not referenced at all by patients during an office visit. This can be crucial in preventing falls, addressing functional decline, and avoiding costly emergency room visits and hospital admissions which, in turn, can reduce the cost of care.

Research Demonstrates Efficacy of OT Delivered via Telehealth

A study (infographic attached) by Focus on Health Outcomes (FOTO), one of the major health data registries used by therapists, reported on five data-driven benefits of therapy when provided via teleheatlh utilizing differing proportions of in-person and telehealth visits per patient. The study indicated that therapy provided via telehealth can promote patient confidence, drive better attendance numbers, and sustain the continuity of care for existing patients. It also indicated that therapy services provided via telehealth and non-telehealth were equally effective in relation to improving the functional status of patients, with differing mixes of teleheatlh and in-person visits utilized as needed/desired by the patient. In addition, the study demonstrated a reduced number of visits per episode of care when telehealth was involved, and equal patient satisfaction.[1]

The AOTA Telehealth Position Paper[2] summarizes how occupational therapy practitioners use telehealth technologies as a method for service delivery for evaluation, intervention, consultation, monitoring, and supervision of students and other personnel. Further, it references the results of research on the use of telehealth in rehabilitation or habilitation, which includes occupational therapy.

There is a growing base of evidence demonstrating the efficacy of technologically mediated occupational therapy.[3] Ongoing research at University of Southern California Mrs. T. H. Chan Division of Occupational Science and Occupational Therapy Faculty Practice has shown that increased use of telehealth for pain-management patients decreased cancellations, increased access, and improved treatment effectiveness. Patient satisfaction with telehealth is also high. A more detailed list of their findings follows:

- Ability to access more people with chronic pain by eliminating the geographic barrier of having to drive to an in-person session. A recent evaluation of a telehealth group intervention for pain management, specifically for patients living in rural or remote areas, revealed that participants benefited from telehealth specialty pain management services.[4]
- Decreased cancellation rates due to pain flare ups or symptom exacerbations because patients do not have to commute to in-person sessions, but can participate from the comfort of their own home where they can access many of their pain management tools (*i.e.,* medication, heat/ice, self-massage units, lying down as needed, more control over ambient temperature).

---

[1] Data-Driven Benefits of Telehealth for Rehab Therapists (2020). *Net Health, https://www.nethealth.com/5-data-driven-benefits-of-telehealth-for-rehab-therapists/.*

[2] American Occupational Therapy Association (2013). Telehealth. *American Journal of Occupational Therapy,* 67(6 Suppl.), S69–S90, *http://dx.doi.org/10.5014/ajot.2013.67S69.*

[3] Cason J (2009). A Pilot Telerehabilitation Program: Delivering Early Intervention Services to Rural Families. *International Journal of Telerehabilitation,* 2009;1(1):29–37. Hoffmann T, Russell T, Thompson L, Vincent A, Nelson M. (2008). Using the Internet to assess activities of daily living and hand function in people with Parkinson's disease. *NeuroRehabilitation,* 23, 253–261. Ng EM, Polatajko HJ, Marziali E, Hunt A, Dawson DR (2013). Telerehabilitation for addressing executive dysfunction after traumatic brain injury. *Brain Inj.* 2013;27(5):548–64.

[4] Scriven, H., Doherty, D.P., and Ward, E.C. (2019). Evaluation of a multisite telehealth group model for persistent pain management for rural/remote participants. *Rural and Remote Health,* 19(1).

- Improved treatment effectiveness due to improved ability to assess and evaluate a person's home environment and contextual factors, rather than through verbal discussion or photos. This allows for more effective problem solving and identification of environmental barriers. This is especially clear in OT interventions for pain regarding body mechanics, ergonomics, physical activity routines, sleep positioning, falls prevention and recovery, and placement of durable medical equipment for optimal safety.
- Improved continuity of care because patients who would travel long distances to come to the clinic may only be seen for treatment 1x/month, but with telehealth services, they can be seen weekly for improved accountability and to support long-term, sustainable behavior change.
- Improved patient satisfaction—patients are reporting improved participation and effectiveness of treatment because commuting to the clinic and driving can often be a trigger of pain or stress. By eliminating this factor, patients avoid starting treatment sessions in pain or fatigue and are able to participate more effectively during session.
- Reduced social isolation and occupational deprivation—due to compounding factors of managing a chronic condition and the long-term effects of pandemic-related restrictions, patients are reporting feelings of isolation and reduced functional participation in daily routines and meaningful activities. Experiencing occupational deprivation can have detrimental effects on health and wellness, self-efficacy, and identity.[5] With OT telehealth, patients can collaborate with their OT to identify strategies and opportunities to engage in occupations and social activities to combat isolation, occupational deprivation, and associated adverse health consequences.

Additional research has shown strong strength of evidence that motivational interviewing, fatigue management, and medication adherence performed via telehealth lead to positive outcomes.

Based on this research, both Medicare beneficiaries and the Medicare Program would see great benefits in quality care, reduced costs, and reduced hospitalizations if occupational therapy is utilized fully. AOTA asserts that the same ethical and professional standards that apply to the traditional delivery of occupational therapy services also apply to the delivery of services received via telehealth. Occupational therapy interventions delivered via telehealth can assist patients to regain, develop, and build functional independence in everyday life activities to significantly enhance a Medicare beneficiary's quality of life. Telehealth may also address provider shortages and access problems, making necessary occupational therapy services available to underserved beneficiaries in remote, inaccessible, or rural settings and to beneficiaries with limited mobility outside their home. Further, occupational therapy is the chief profession with expertise in activities of daily living and community environments, which may be better observed and evaluated through telehealth services when the beneficiary is in their home environment.

Occupational Therapists Describe Benefits of OT via Telehealth During PHE

AOTA commends the Government Accounting Office for conducting a study on the use of telehealth during the PHE, and we look forward to seeing the results of their work. In addition, examples of the use of telehealth to provide OT services during the PHE follow, as described by OT professionals:

- Telehealth has been crucial for service to our CMS patients in our Post-ICU multidisciplinary clinic during the pandemic and would continue to be a vital resource for these patients. Many of these patients will not be able to access the services for a variety of reasons if we cannot continue with telehealth.
- Telemedicine has been a very helpful but unexpected resource for service delivery. One of the primary barriers to clients participating in the 55+ Program in the past has been transportation. Many clients are fearful of driving, unable to drive due to other health conditions, or do not have access to a vehicle and alternative transportation is too expensive. Telemedicine has allowed these clients access to treatment now.
- Initially many of my older adult clients struggled and were fearful of technology and did not think they would be able to participate in online treatment. With coaching and assistance, many clients have overcome these barriers and now

[5] Whiteford, Gail. (2000). Occupational deprivation: global challenge in the new millennium. *British Journal of Occupational Therapy,* 63(5).

are using technology more to connect with family, friends, and other community resources. It has helped to decrease isolation for many both for treatment and in the community.

- I am an occupational therapist in an outpatient neurological clinic. The majority of my patient caseload includes adults and older adults with comorbidities and/or [who] are immuno-compromised. During the global pandemic, taking months off of therapy could have resulted in significant decrease in function for some of the patients I serve. Our clinic was on the edge of our seats while waiting to hear the CMS changes to allow occupational therapy providers to provide telehealth services. Once the change had been made, it opened up a new world of opportunity for us to serve these patients who so needed skilled therapy, but were unable to physically come into the clinic. As occupational therapists, we adapt. I am able to provide individualized, client-centered care through a new medium that was aligned with the patient's plan of care to reach their functional goals. Without the ability to provide the skilled services via telehealth, our clients would not have received the care they needed. Patients have been surprised with the effectiveness of telehealth therapy services. If CMS allows these changes to be permanent, we would be able to better serve those patients in effective ways through the use of this technology.
- Clients who have difficulty with transportation to the clinic or consistent transportation have been able to receive services and those that have anxiety with new providers or leaving home have benefitted in that this is a great bridge to start with to start to expose to social skills and situations and still provide them with the therapy that they need to succeed.
- One particular patient was a woman with Parkinson's. She and her husband were sleeping on an air mattress in their den because she had a hip fracture and was not steady enough to climb the stairs to her bedroom. After her OT eval, she refused further in-person visits. I trialed telehealth visits with great success. I was able to have the husband aim the camera so that I was able to provide placement of recommended grab bars in the bathrooms, both upper and lower levels, as well as get a tour of the second level, something I had not been able to assess at the eval. I was able to help with technique and positioning for upper extremity exercises, and eventually, I was able to teach the husband how to assist the patient up/down the stairs, safely, as well as teach bed mobility so that the patient was able to sleep in her own bed upstairs versus an air mattress on the floor on the main level. She and her husband looked forward to my weekly visits and always updated me on the progress she had made. They were so grateful for the therapy I was able to provide remotely.

Global Telehealth Issues of Specific Concern to AOTA

While Congressional action is urgently needed now to allow occupational therapy professionals to provide services via telehealth after the PHE, AOTA also notes that for telehealth to move forward in any way, several other issues must also be addressed. **In order to maximize the benefit of telehealth services, the originating site for a telehealth visit must be the patient's home, especially for OT services as described above.** In addition, there is no justification for a payment differential for telehealth services, as practice expenses are unlikely to go down since practitioners need to maintain an office to perform both telehealth and in-person visits. Additionally, practice expense may increase as practitioners invest in HIPAA-compliant software and other technology to assist in telehealth visits. AOTA appreciates the relaxation of HIPAA requirements during the PHE for telehealth software; however, these restrictions should be reinstated after the PHE ends to protect the security of Personal Health Information. Finally, Congress must allow some limited services to be provided via audio only, especially in the area of mental health and substance abuse, with self-care as an example of a code used by OT professionals.

Summary—Congressional Action Essential to Avoid Therapy Telehealth Cliff

In summary, OT interventions delivered via telehealth have enabled patients to develop, regain, and build functional independence in everyday life. Telehealth has also demonstrated advantages over in-person visits in some situations, especially for people in rural and underserved areas, and for the large number of seniors in all communities who face transportation and mobility issues, especially those with disabilities. Telehealth is also an ideal platform for conducting home safety evaluations as it provides a window into the person's home and often great access to their caregiver.

As noted, Congressional action is essential to enable Medicare beneficiaries to continue to receive OT services via telehealth when appropriate. Passage of the Expanded Telehealth Access Act (H.R. 2168) would enable OT professionals as well as PTs, SLPs, and audiologists to **provide services via telehealth under Section 1834(m) of the Social Security Act.** Unless Congress acts, Medicare beneficiaries will face a telehealth "cliff" when the PHE ends, whereby beneficiaries who are now accustomed to receiving some OT services via telehealth suddenly lose access to such services. We urge Congress to prevent this outcome.

AMERICAN PHARMACISTS ASSOCIATION
2215 Constitution Avenue, NW
Washington, DC 20037

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record for the U.S. Senate Finance Committee Hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned."

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA thanks the Committee for holding this important hearing examining COVID–19 health-care flexibilities. During the COVID–19 public health emergency (PHE), pharmacists have demonstrated the ability to significantly expand access to care and equity in care,[1] and they will continue to do so if certain regulatory barriers are permanently removed. The pandemic has demonstrated how essential and accessible pharmacists are in the United States. Pharmacists and pharmacies' lights stayed on from the start of the pandemic and are essential components of public health infrastructure.

As you know, the fight against COVID–19 has demanded the federal government take action to allow pharmacists and other health-care professionals to do more of what they are trained to do. By being more flexible about certain requirements and expanding scope of practice through new authorities, the federal government made it easier for pharmacists to provide care to patients during the COVID–19 PHE. The problem is many of these flexibilities and authorities are not considered permanent and further action is needed to expand access to pharmacist-provided services. If action is not taken, patients will not be able to receive needed care at pharmacies across the country once the PHE ends.

Accordingly, APhA urges Congress to expeditiously use its authority to pass legislation to make permanent:

- Pharmacists' ability to order, authorize, test, treat, and administer immunizations and therapeutics against infectious diseases;
- Removal of operational barriers that address workforce and workflow issues which previously prevented pharmacists from engaging in patient care;
- Including pharmacists under existing and future telehealth flexibilities; and
- Maintaining compounding flexibilities to address current and future drug shortages.

Securing Ability of Pharmacists to Order, Authorize, Test, Treat, Immunize, and Provide Other Services

Many of these new authorities and flexibilities, including pharmacists' ability to order and administer COVID–19 and childhood vaccines and COVID–19, influenza, and RSV tests, as well as pharmacy interns and technicians to administer COVID–19 tests and vaccinations to persons aged 3 years or older as well as childhood vaccines to individuals ages 3 to 18 years old should continue as they have significantly increased patient access and care.

---

[1] National Pharmacy Organizations Unite to Take a Stand Against Racial Injustice. June 5, 2020, available at: *https://www.accp.com/docs/news/Pharmacy_Statement_On_Racial_Injustice.pdf.*

Removal of Operational Barriers for Pharmacists

The COVID–19 pandemic has stressed and strained our health-care system and revealed generations of health inequities in communities of color, medically underserved, and rural areas. In order to protect public health, detect and respond to future epidemics, and improve the equitable delivery of health care, every pharmacist needs to be able to support health-care teams.

In January 2021, the Department of Health and Human Services (HHS), under the Public Readiness and Emergency Preparedness Act (PREP Act), authorized any health-care provider, including pharmacists, who are licensed or certified in a state to prescribe, dispense, and/or administer COVID–19 vaccines across state lines, during the public health emergency.[2] Congress needs to make this authority permanent to maintain the ability of pharmacists to fill gaps in primary care and surge to meet public health crises.

Additionally, the Centers for Medicare and Medicaid Services (CMS) has encouraged insurance plans to practice flexibility regarding prior authorization protocols, refills, deliveries, and pharmacy audits. These practices have reduced the administrative burden on clinicians and allowed for more efficient patient care, testing and vaccine delivery. Given the benefits to patients and the system, we recommend that Congress pass legislation to require all Medicare Advantage (MA) and Part D plans to continue offering these flexibilities to prevent decreased medication adherence in vulnerable populations, especially older adults and people of color. CMS has also issued policies relaxing Medicare Part D audit requirements for signature logs. Accordingly, we recommend Congress make the following policies permanent for MA, Part D plans and contracted pharmacy benefit managers (PBMs):

- Relaxing to the greatest extent possible prior authorization requirements, where appropriate;
- Suspending plan-coordinated pharmacy audits during any PHE; and
- Waiving medication delivery documentation and signature log requirements to limit unnecessary contact with sick and potentially infectious patients.

Including Pharmacists under Existing and Future Telehealth Flexibilities

The rapid shift to telehealth services during the COVID–19 PHE has illustrated the value of telehealth long-term, particularly for patients with mobility issues and those in rural and/or medically underserved areas. Prior to the PHE, pharmacists were already actively involved in virtual care delivery for Medicare beneficiaries through provision of Part B services such as Chronic Care Management (CCM), Transitional Care Management (TCM), Continuous Glucose Monitoring (CGM), Remote Patient Monitoring (RPM), and Behavioral Health Integration (BHI), as well as Medication Therapy Management Services in the Part D program. The onset of the COVID–19 pandemic has brought about additional opportunities to leverage pharmacists in telehealth services, including medication management services, chronic disease management, education on healthy lifestyle interventions, patient counseling on point of care diagnostic tests, and more.

APhA recommends Congress take the following steps to enhance patient access to telehealth services:

- Make permanent the authority allowing direct supervision to be provided using real-time interactive audio and video technology under incident to physician services arrangements;
- Make permanent the authority allowing Medicare-enrolled pharmacies offering accredited diabetes self-management training (DSMT) programs to offer DSMT services via telehealth;
- Designate pharmacists as practitioners (providers) for the Medicare Telehealth Benefit, and add patient care services provided by pharmacists using telehealth to the Medicare Telehealth List;
- Ensure Medicare payment for pharmacist-provided telehealth and in-person services is commensurate with the time and complexity of the services provided;
- Allow for telephonic or video prescription counseling of patients to facilitate contactless care; and
- Make permanent Medicare coverage and payment of audio-only telephone calls for opioid treatment program therapy, counseling, and periodic assessments.

---

[2] *https://www.phe.gov/Preparedness/legal/prepact/Pages/COVID-Amendment5.aspx.*

Maintaining Compounding Flexibilities to Address Current and Future Drug Shortages

Drug shortages are another factor that can negatively affect patients in terms of medication cost and the availability of their treatments. APhA urges the Committee to consider mechanisms to both better control the price of medications in shortage and improve tracking and prediction systems used to identify drugs in shortage. For example, FDA issued temporary guidance granting flexibility for pharmacists to compound certain necessary medications under 503A and 503B for hospitalized patients without patient-specific prescriptions to address COVID–19. Many of our members have told us FDA's compounding flexibility is the only reason hospitals were able to keep up with patient demand. Accordingly, the recent flexibility to compound medications under both sections 503A and 503B are likely to be necessary for the foreseeable future, and we strongly urge the Committee to pass legislation to codify this flexibility to address drug shortages. We believe maintaining stability within the supply chain during the global COVID–19 pandemic is crucial. We strongly urge the Committee to focus on solutions that harness existing relationships with international trading partners to promote supply chain resiliency and diversity while avoiding measures that could undermine our ability to work with the international community.

S. 1362/H.R. 2759, the Pharmacy and Medically Underserved Areas Enhancement Act

The COVID–19 pandemic has further illustrated how difficult it is for some patients living in medically underserved communities to access care and achieve optimal medication therapy outcomes. A strong body of evidence has shown that including pharmacists on interprofessional patient care teams with physicians, nurses, and other health-care providers produces better health outcomes and cost savings. Pharmacists are one of the most accessible health-care providers in the nation, with nearly 90% of Americans living within five miles of one of the nation's 88,000 pharmacies.[3]

Despite the fact that many states and Medicaid programs are turning to pharmacists to increase access to health care, Medicare Part B does not cover many of the impactful and valuable patient care services pharmacists can provide. As proven during the COVID–19 pandemic, pharmacists are an underutilized and accessible health-care resource who can positively affect beneficiaries' care and the entire Medicare program.

Accordingly, APhA strongly urges the Committee to include S. 1362, the Pharmacy and Medically Underserved Areas Enhancement Act, recently introduced by Committee members Charles Grassley (R–IA), Robert Casey (D–PA), and Sherrod Brown (D–OH), in the Committee's legislative package to allow pharmacists to deliver vital patient care services in medically underserved areas to help break down the barriers to achieving health-care equity in this country, improve patient care, health outcomes, the impact of medications,[4] and consequently, lower health-care costs and extend the viability of the Medicare program.

By recognizing pharmacists as providers under Medicare Part B, S. 1362 would enable Medicare patients in medically underserved communities to better access health care through state-licensed pharmacists practicing according to their own state's scope of practice. In medically underserved communities, pharmacists are often the closest health-care professional and the most accessible outside normal business hours. S. 1362 recognizes that pharmacists can play an integral role in addressing these longstanding disparities to help meet health equity goals[5] and ensure that our most vulnerable patients have access to the care they need where they live. Helping patients receive the care they need, when they need it, is a common sense and bipartisan solution that will improve outcomes and reduce overall costs.

---

[3] NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

[4] *See,* Avalere Health. Exploring Pharmacists' Role in a Changing Healthcare Environment. May 2014, available at: *http://avalere.com/expertise/life-sciences/insights/exploring-pharmacists-role-in-a-changing-healthcare-environment. Also, see,* Avalere Health. Developing Trends in Delivery and Reimbursement of Pharmacist Services. October 2015, available at: *http://avalere.com/expertise/managed-care/insights/new-analysis-identifies-factors-that-can-facilitate-broader-reimbursement-o.*

[5] The White House. Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. January 20, 2021, available at: *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

Conclusion

APhA would like to thank the Committee for holding this important hearing and for continuing to work with us by making key COVID–19 health-care flexibilities permanent and including S. 1362 in your legislative package to increase access to pharmacist-provided patient care services for medically underserved communities to promote health-care equity. Please contact Alicia Kerry J. Mica, Senior Lobbyist, at AMica@aphanet.org or by phone at (202) 429–7507 as a resource as you consider this legislation. Thank you again for the opportunity to provide comments on this important issue.

AMERICAN PHYSICAL THERAPY ASSOCIATION
3030 Potomac Ave., Suite 100
Alexandria, VA 22305–3085
703–684–2782
https://www.apta.org/

May 18, 2021

Senator Ron Wyden
Chairman
U.S. Senate
Committee on Finance

Senator Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to provide a statement for the record on the committee's hearing "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span—helping individuals improve overall health and prevent the need for avoidable health-care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

Value of Physical Therapy Through Telehealth

The ongoing coronavirus pandemic has highlighted the need for patients, health systems, payers, and providers to rapidly adopt or expand models and modes of care delivery that minimize disruptions in care and the risks associated with those disruptions. The expansion of telehealth payment and practice policies under the section 1135 waivers during this Public Health Emergency, including permitting physical therapy services to be furnished via telehealth by physical therapists and physical therapy assistants across settings has demonstrated that many needs can be safely and effectively met via the use of technology and that patients can have improved access to skilled care by leveraging these resources.

Physical therapy is well-suited for telehealth—primarily as an enhancement of in-person services, although a telehealth visit also may replace an in-person visit when needed or indicated. Physical therapists and physical therapist assistants can use telehealth as a supplement to in-person services to evaluate and treat a variety of conditions prevalent in the Medicare population, including but not limited to Alzheimer's disease, arthritis, cognitive/neurological/vestibular disorders, multiple sclerosis, musculoskeletal conditions, Parkinson disease, pelvic floor dysfunction, frailty, and sarcopenia.

Physical therapists make determinations, in consultation with patients and caregivers, regarding the appropriate mix of in-person and telehealth services to meet the goals in the plan of care. The evaluation and treatment of a patient via the use of telehealth allows the physical therapist to interact with the patient within the real-life context of their home environment, which is not easily replicable in the clinic. Patient and caregiver self-efficacy are inherent goals of care, and telehealth not only allows a physical therapist to maintain the continuity of care anticipated in the plan of care but also allows for immediate and effective engagement when a specific challenge arises. A patient's and/or caregiver's ability to interact in their own environment with a physical therapist when they are facing a challenge, rather than

waiting for the next appointment, can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, and promote engagement.

Skilled physical therapy interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Further, physical therapists already are experienced in modifying exercises for the patient to perform them safely at home, as a home exercise program is a common element of a treatment plan for patients who are treated in person. Education and home exercise programs—including those focused on falls prevention—function particularly well with telehealth because the physical therapist can evaluate and treat the patient within the real-life context of their home environment. This is not easily replicated in the office setting.

Physical therapy progresses patients toward total independence of their program in their own homes. Telehealth facilitates this objective,[1] as the physical therapist can progress the patient in their native environment rather than in a "simulated" one in the clinic. Moreover, a patient's and/or caregiver's ability to interact in their own environment with a physical therapist can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, and promote engagement. Telehealth expands the clinical impact of physical therapy by providing patients on-demand access to their physical therapist to promote increased adherence, access to booster sessions to ensure sustainability of therapeutic gains and functional performance, and access to supplemental care in-between in-person visits to reduce the length of the episode of care and to lower costs.

Moreover, physical therapy is not synonymous with exercise. Although much of skilled physical therapy is high-touch, a significant component is transition of skills—promoting self-efficacy, environmental assessment and modification, training and education, and, most important, ongoing assessment, analysis, and clinical decision-making. A critical component of physical therapy is the prescription of carryover techniques, tasks, and activities—not just exercise—by a patient in their own environment. Physical therapy services performed via telehealth enhance this component of care.

Examples of physical therapy providers using telecommunications technology to provide real-time, interactive audio and video care include the following:

- Physical therapy practitioners use telehealth technologies to conduct evaluations or reevaluations[2] or provide quicker screening, assessment, and referrals that improve care coordination.
- Physical therapy practitioners provide interventions use telehealth by interacting with the patient in real time to provide instruction in exercise and activity performance, observing return demonstration and instruction in modifications or progressions of a program, providing caregiver support, and promoting self-efficacy.
- Physical therapy practitioners provide verbal and visual instructions and cues to modify how patients perform various activities. They also may suggest that the patient or caregiver modify the environment for safety reasons, or to potentially produce even more optimal outcomes.
- Physical therapy practitioners use telehealth technologies to provide prehabilitation and conduct home safety evaluations.
- Physical therapy practitioners use telehealth technologies to observe how patients interact with their environment and/or other caregivers, and to provide caregiver education.
- Physical therapy practitioners can assess the carryover of the activity modification strategies and activities to determine effectiveness immediately rather than waiting for the next in-person visit.
- Physical therapists use telehealth to reduce the number of "in-clinic" visits and still maintain important follow-up care. This might reduce travel time and/or burden for a patient—which, for some conditions, might result in faster healing. This also prevents any delays in modifying a program when it needs to be upgraded or downgraded.
- Physical therapists can use technology to satisfy supervision requirements.
- A physical therapist can co-treat with another clinician who is treating via real-time audio and visual technology.

---

[1] *https://clinicaltrials.gov/ct2/show/NCT02914210.*
[2] *https://pubmed.ncbi.nlm.nih.gov/26658151/.*

- A treating physical therapist can consult directly with another physical therapist or physical therapist assistant for collaboration and/or to obtain specialty recommendations to incorporate into an existing plan of care.
- Physical therapists use telehealth for quick check-ins with established patients.

Telehealth services furnished by physical therapists and physical therapist assistants offer cost savings, allow for coordination of care, and may improve adherence and patient satisfaction. Many studies[3] have illustrated the clinical benefit of telerehabilitation for a variety of conditions, including pelvic floor dysfunction[4] and multiple sclerosis.[5]

A 2019 study[6] examined the efficacy of home-based telerehabilitation versus in-clinic therapy for adults after stroke, finding that poststroke activity-based training resulted in substantial gains in patients' arm motor function whether provided via telerehabilitation or in person. Other studies[7] show that home-based telerehabilitation significantly improved veterans' functional independence, cognition, and patient satisfaction. See Appendix A for additional studies. Physical therapists also have been collecting a variety of data related to health outcomes and ease of use of technology. To promote data collection, APTA developed a patient satisfaction survey[8] for providers to share with their patients, which is available in both English and Spanish.

When considering the value of telehealth furnished by physical therapists and physical therapist assistants, Congress should consider the effects of telehealth on downstream spending. Hospital admissions and readmissions, emergency department visits, and urgent care visits, among other expenses, potentially will decrease if patients have access to both in-person and telehealth services.

Patient Access

Telehealth helps to overcome access barriers caused by distance, lack of availability of specialists and/or subspecialists, impaired mobility, and the burden associated with commuting/arranging transportation to a physical therapy appointment. Using virtual engagement tools can prevent unnecessary exposure during a pandemic, epidemic, or even the annual flu season—a feature especially important for frail and immunocompromised persons. Furthermore, access to telehealth services is critical for beneficiaries who live in areas with inclement weather, which is a deterrent to traveling outside of the home.

For patients who have difficulty leaving their homes without assistance, lack transportation, or need to travel long distances, the ability to supplement or replace in-person sessions with those furnished via telehealth greatly increases access to care and ensures uninterrupted courses of therapy. Telehealth is a tool to overcome access barriers caused by distance, unavailability of specialists and/or subspecialists, inclement weather, and impaired mobility. For example, a Colorado physical therapist practice that offers treatments for neurological conditions provides a significant portion of the care via telehealth, for several reasons: (1) the area's sometimes severe inclement weather; (2) the patient's vestibular condition that renders them unable to drive, forcing them to rely on friends or family to drive them; and (3) a lack of physical therapy providers within a reasonable driving distance—particularly providers that address dizziness and balance issues.

Access to health-care services is critical to good health and functional performance, yet Medicare beneficiaries, particularly those who reside in rural areas, face a variety of access barriers. Individuals across the lifespan want the ability to appropriately access telehealth, and telehealth is key to helping individuals age in place. If we as a nation truly wish to help individuals age in their homes, telehealth is a key to making this a reality. As demand for care to help individuals with chronic conditions continues to grow, Congress should recommend telehealth payment and coverage policies that will improve beneficiary access and increase collaboration and efficiency of care across the care continuum.

Further, access to physical therapy in rural, medically underserved, and health professional shortage areas often depends on the availability of physical therapist as-

---

[3] *https://pubmed.ncbi.nlm.nih.gov/26940798/.*
[4] *https://www.researchgate.net/publication/330736628_Telerehabilitation_for_Treating_Pelvic_Floor_Dysfunction_A_Case_Series_of_3_Patients%27_Experiences.*
[5] *https://pubmed.ncbi.nlm.nih.gov/31042118/.*
[6] *https://pubmed.ncbi.nlm.nih.gov/31233135/.*
[7] *https://pubmed.ncbi.nlm.nih.gov/26658151/.*
[8] *https://www.aptahpa.org/page/COVID19.*

sistants to provide care under the supervision of physical therapists. Unfortunately, the 15% Medicare Physician Fee Schedule payment reduction for services furnished in whole or in part by physical therapist assistants beginning in 2022 will have a detrimental impact on the ability of physical therapy providers, particularly in rural areas, to continue to deliver care. The payment reduction will unfairly penalize providers in rural, medically underserved, and health professional shortage areas. Access to medical care already is dwindling in rural localities. Physical therapists and physical therapist assistants play a crucial role in bridging these gaps in access to care.

Quality

APTA developed a patient satisfaction survey[9] about the use of telehealth for providers to share with their patients in English and Spanish based on AHRQ's guidance. Copied below are the results from a physical therapist vestibular practice in Colorado that asked some of the questions from this survey:

- The experience was an effective way to get my physical therapy: 70% of respondents strongly agreed; 30% agreed.
- Feelings of comfortability being evaluated and treated via telehealth: 67% of respondents strongly agreed; 20% agreed; 10% were neutral.
- Feelings of physical safety receiving physical therapy treatment via telehealth: 83% of respondents strongly agreed; 17% of respondents agreed.
- Overall satisfied with the experience: 93% strongly agreed; 7% agreed.
- In response to the question: If a telehealth visit was not available to you from this PT clinic, how would you plan to receive PT in future? 10% of respondents said they would seek telehealth from another clinic, 10% said they would not seek care, 60% said they would seek in-person care with the clinic, and 17% provided other answers, including:
  - "I don't know what I would do."
  - "I might not seek care. This is the safest way for me to receive care."

In addition, the following are stories shared by Medicare beneficiaries during the COVID–19 pandemic:

Medicare Beneficiary #1:

- The beneficiary was experiencing severe back pain, had significant physical limitations, and used pain medications daily. She was "high risk" for COVID–19, so she engaged in physical therapy via telehealth. After an initial evaluation in the clinic and several telehealth sessions at her home, she is now walking pain-free, can engage in more physical activity, and has reduced her pain medications. These telehealth visits have allowed her to care for her husband, who is in hospice.

Medicare Beneficiary #2:

- I am writing to express my gratitude for the telehealth services that were provided during the COVID–19 pandemic. I was happy to start in the clinic and then transition to a home-based program so that I could carry the work into my daily routine, while staying safe at home. After every meeting, I felt better and felt that I had gotten a good workout. I would recommend telehealth services to a friend or family member. Even out of quarantine, I feel as though the telehealth services may be beneficial to those who cannot go to an appointment in person. I advocate that Medicare continues to allow telehealth services to be furnished by physical therapists in the future.

Medicare Beneficiary #3:

- I was being treated for thoracic outlet syndrome and referred to physical therapy. I found my experience most successful. Due to COVID–19, I was able to do telehealth therapy from home. Once the clinic was able to reopen, I was able to resume office visits and have continued to make good progress. I have had a very positive experience.

Medicare Beneficiary #4:

- I am writing to express my appreciation for the telehealth services that were provided during this COVID–19 pandemic. About 7 or 8 weeks ago I had to have physical therapy for a pinched nerve. I contacted you since my husband was already participating in your telehealth program. I have been working with the DPT and have had wonderful results. I have used my 1- and 2-pound weights as well as my wall to do push-ups. I also use my banister to do rowing exercises. I would recommend telehealth services to a friend or family member or anyone who should ask and I'm hoping that these telehealth services con-

[9] *https://www.aptahpa.org/page/COVID19.*

tinue in the future. This is a great way to remain safe at home, which is critical during this pandemic

Recommendations

Current statutes limit Medicare beneficiaries from receiving telehealth services, including a geography limitation, site limitation, and provider limitation. Congress must pass legislation that permanently affords providers and patients the ability to furnish and receive telehealth, just as they have done during the COVID–19 PHE.

Congress should:

(1) Enact the Expanded Telehealth Access Act of 2021 (H.R. 2168). This legislation would permanently allow rehabilitation providers to use telehealth under Medicare after the PHE is declared over. Specifically, the bill adds physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, audiologists, and speech language pathologists and facilities that furnish outpatient therapy, as authorized providers of telehealth under Medicare.
(2) Enact changes to Section 1834(m)(4)(C)(i) of the Social Security Act so that telehealth services, including therapy services, will no longer be restricted by geographic location of the beneficiary or the originating site. All Medicare beneficiaries should be eligible to receive telehealth services from their home, whether that home is in the community or part of an institutional setting.

Federal policies also should advance a definition of parity that includes equal coverage, reimbursement, and cost-sharing (copayments, coinsurance, and deductibles) for audio-only telehealth, audio and visual telehealth, and in-person visits, particularly given the fact that telehealth is merely a modality to enable physical therapists and physical therapist assistants, for example, to provide care within their scope of practice. In addition, such policies should promote outreach to patients with limited technology and connectivity and offer flexibility in platforms that can be used for audio and visual (live video) interactions, audio-only options, online patient portals, etc.

Conclusion

We appreciate the opportunity to provide the committee with our perspective on the role of telehealth in physical therapy and the need to continue to provide Medicare beneficiaries this option beyond the PHE. Should you have any questions, please do not hesitate to contact David Scala, APTA congressional affairs senior specialist, at davidscala@apta.org. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, Ph.D.
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

AMERICAN TELEMEDICINE ASSOCIATION
901 North Glebe Road, Suite 850
Arlington, VA 22203
T: 703–373–9600

May 19, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC 20515

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20515

RE: ATA Testimony for Senate Finance Committee Hearing on "COVID–19 Health Care Flexibilities: Perspective, Experience, and Lessons Learned"

On behalf of the American Telemedicine Association (ATA), thank you for thoughtfully considering the future of telehealth during the upcoming Finance Committee hearing entitled, "COVID–19 Health Care Flexibilities: Perspective, Experiences, and Lessons Learned" on Wednesday, May 19. Federal flexibilities over the past year have allowed patients to continue to access much-needed care even as the health-care system was shuddered by the pandemic. This hearing is an essential step toward determining and enacting commonsense policies that will ensure Medicare seniors are not pushed off the telehealth cliff at the end of the current COVID–

19 Public Health Emergency (PHE). Please accept this letter as testimony by the ATA and continue to consider the ATA as a resource as we work together on this important bipartisan issue.

As the only organization exclusively devoted to expanding access to care through telehealth, the ATA appreciates the opportunity to share our federal policy priorities for 2021. During the COVID–19 PHE, telehealth has finally become a reality for millions of Americans out of necessity. This has been possible because of swift, decisive actions by Congress and the Department of Health and Human Services (HHS). However, unless Congress acts again before the end of the PHE, telehealth access will vanish for millions of Medicare beneficiaries overnight. As you consider how to address this looming telehealth cliff, we request that you review ATA's Permanent Policy Recommendations [1] as well as ATA's Federal Legislative Priorities.[2]

We encourage you to ensure policies reflect beneficiaries' and providers' growing interest in having telehealth as a choice when accessing care. Data continues to show that Medicare beneficiaries like telehealth and want to keep it. The nonpartisan Medicare Payment Advisory Commission's [3] annual beneficiary survey this year found that 90% of Medicare respondents were satisfied with telehealth. The ATA has worked with partners to identify similar trends,[4] including nearly two thirds of patients expecting telehealth to continue post-pandemic. To ensure these patients have the choice to access telehealth in the future, the ATA has prioritized the following policies for consideration in the 117th Congress and would greatly appreciate the Committee's taking these priorities into consideration when drafting potential telehealth legislation.

- Remove provisions in law that mandate, for telehealth delivery of care or reimbursement, a prior in-person relationship between practitioner and patient.
- Allow state licensing boards and practitioners to determine the appropriate standards of care for patients. This includes removing the in-person requirement for telemental health services in the recently signed Consolidated Appropriations Act.
- Permanently remove the geographic and originating site barriers in statute.
- The originating site should be wherever the patient is located, including but not limited to a patient's home.
- Enhance HHS authority to determine appropriate telehealth services and providers.
- Ensure Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can furnish telehealth and receive equitable reimbursement.
- Make permanent HHS's temporary waiver authority for future emergencies.
- Support existing fraud, waste, and abuse resources within HHS, including the Health Care Fraud and Abuse Control Program.

The ATA is proud that telehealth is a strong bipartisan issue in Congress. The above listed priorities have been reflected in several bipartisan bills already under consideration this Congress, including the Telehealth Modernization Act (S. 368, H.R. 1332), the Protecting Access to Post-COVID–19 Telehealth Act (H.R. 366), and the soon-to-be-reintroduced CONNECT for Health Act. The ATA would greatly appreciate your support of each of these important pieces of legislation.

At minimum, the ATA urges Congress to remove existing statutory barriers that limit access to care and not simply replace existing statutory access restrictions with new ones. For far too long, 1834(m) of the Social Security Act has categorically excluded too many patients from even having the option to access care via telehealth because of the law's antiquated and arbitrary barriers whose only purpose is to limit access to health care. Providers and patients are best suited to determine clinical appropriateness of medical services, not federal law. The 1834(m) restrictions are nearing 20 years old, and by allowing them to persist, Congress will only punish Medicare beneficiaries by banning their access to technology already available to non-Medicare patients. As such, the ATA urges the Committee to take great care in considering the consequences of having restrictions specifically codified in statute as opposed to allowing these issues to be decided at the regulatory level. By explicitly and arbitrarily limiting care in statute through so-called "guardrails," legislators

---

[1] *https://www.americantelemed.org/policies/ata-recommendations-for-permanent-telehealth-policy/*.

[2] *https://www.americantelemed.org/policies/atas-federal-telehealth-legislative-tracker/*.

[3] *http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf*.

[4] *https://www.americantelemed.org/in-the-news/covid-19-healthcare-coalition-surveys-patients-on-telehealth-impact-during-covid-19/*.

will unnecessarily stifle innovation and tie the hands of regulators, providers, and patients. Should the Committee have concerns with cost, utilization, or telefraud, the ATA stands ready to work with you on our shared goal of ensuring program integrity. As such, please consider ATA's recently released Program Integrity Overview [5] as a resource.

While the ATA appreciates Congress's recent actions to expand access to care, specific restrictions on patients, providers, services, or the modality of care in statute only add to complexities in the health-care system. One of the ATA's main federal policy priorities is removing the in-person requirement for telemental health services which was included in the Consolidated Appropriations Act, 2021, Pub. L. 116–260 (*e.g.,* Section 123 establishes coverage and reimbursement of a telemental health service *only if* the practitioner has conducted an in-person examination of the patient in the prior six months and subsequently continues to conduct in-person exams at such a frequency to be determined by HHS). The ATA strongly opposes statutory in-person requirements as they create arbitrary and clinically unsupported barriers to accessing affordable, quality health care.

Today, not a single state in the U.S. requires a prior in-person relationship. At the national level, the association of state regulators who oversee standards of medical care, the Federation of State Medical Boards, stated that ". . . the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health-care practitioner) and patient."

We cannot ignore the importance of providing all Americans, regardless of whether they have a medical provider with whom they have an established relationship, the opportunity to access health care. Requiring a physician and patient to meet in person before receiving certain telehealth services would be a huge step backward, and we hope to work with you to find an alternative to in-person requirements.

Thank you again for holding this important hearing and for your thoughtful deliberation on how your committee can enable access to quality health-care services for Medicare beneficiaries. The ATA's policy development and ultimate recommendations are guided by a specific set of policy principles [6] which all support the goal of promoting a health-care system where people have access to safe, effective, and appropriate care when and where they need it. Please know the ATA is honored to continue to be a resource for you, the Committee, and your dedicated staff. If you have any questions or would like to further discuss the ATA's perspective, please contact kzebley@americantelemed.org.

Kind regards,

Kyle Zebley
Public Policy Director

ASSOCIATION FOR CLINICAL ONCOLOGY
2318 Mill Road, Suite 800
Alexandria, VA 22314
T: 571–483–1300
F: 571–366–9530
https://beta.asco.org/

May 19, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

The Association for Clinical Oncology (ASCO) commends the Committee for holding the May 19, 2021, hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." We are pleased to provide the attached comments

[5] *https://www.americantelemed.org/wp-content/uploads/2021/03/ATA-Program-Integrity-One-Pager-3-1-21.pdf.*
[6] *https://www.americantelemed.org/policy/.*

on regulatory flexibilities during the pandemic that have made a difference in cancer care.

ASCO is the world's leading professional society representing physicians who care for people with cancer. With nearly 45,000 members, our core mission is to ensure that patients with cancer have meaningful access to high quality, equitable cancer care.

In addition to the attached comments on regulatory policies, ASCO urges Congress to address the 4% PAYGO cuts before they are scheduled to take effect in Medicare and extend the Medicare sequestration moratorium. We appreciate Congress' extension of the Medicare sequestration moratorium through the end of 2021 but are seriously concerned about the impact a 6% Medicare cut will have on cancer care if PAYGO and sequestration are not addressed before the end of this year.

Thank you for examining these important issues. If you have questions on our comments or any other issues related to the treatment of patients with cancer, please do not hesitate to contact Jennifer Brunelle at Jennifer.brunelle@asco.org.

Sincerely,

Monica Bertagnolli, M.D., FACS, FASCO
Chair of the Board

December 23, 2020

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar,

The nature of the COVID–19 pandemic and resulting public health emergency required unprecedented response and flexibility across the health-care sector to avoid disruption in care delivery, continuity of research activities and to ensure the protection and safety of patients and health-care workers. Additionally, in the face of economic pressures created by the pandemic, practices, health-care facilities and institutions—functioning as employers and businesses—required similar response and flexibility from state and federal policymakers. The Association for Clinical Oncology (ASCO) appreciates the opportunity to provide feedback on The Agency's Request for Information on Regulatory Relief Efforts to support Economic Recovery.

ASCO is a national organization representing more than 45,000 oncology professionals who care for people living with cancer. Through research, education, and promotion of the highest-quality patient care, our members are committed to ensuring that evidence-based practice for the prevention, diagnosis, and treatment of cancer are available to all Americans. ASCO supports major quality initiatives that enhance performance measurement and improvement, clinical practice guidelines, big data analytics, and the value of cancer care.

Cancer patients and survivors are one of the most vulnerable patient populations, and face increased risk related to COVID–19. Prior to the public health emergency, certain longstanding policies, care delivery practices and research procedures posed barriers to the efficient delivery of care and effective clinical research. During the pandemic, temporary regulatory relief offered by the Agency on some of those same policies, coupled with the nimbleness of the health-care sector, proved beneficial to patients and enabled the nation's health-care system to continue to operate safely during the time of crisis. ASCO commends the Administration and the Department of Health and Human Services (HHS) for recognizing the need to modify existing policies that would have significantly affected care for cancer patients. Like many organizations, ASCO has taken the opportunity to evaluate whether the changes in care delivery and research prompted by the pandemic could inform new approaches to delivery of high quality, high value care and research moving forward.

ASCO recently published the *Road to Recovery Report: Learning from the COVID–19 Experience to Improve Clinical Research and Cancer Care,* which outlines recommendations based on lessons learned during the pandemic. Proposed actions and policies aim to make cancer care delivery and research opportunities more accessible and equitable for patients in every community. With these recommendations, ASCO intends to address long-standing cancer care disparities that have been highlighted

by the pandemic. To achieve these goals, certain regulatory flexibilities driven by the pandemic may need to be permanent—or at least extended for a minimum of 24 months following expiration of the PHE. This would enable cancer patients to continue access to life-saving treatments for their disease, for providers to continue delivery of high-quality cancer care, and all in the cancer community to benefit from protections against personal and economic the impacts COVID–19.

Part I: Cancer care delivery—Policies and regulatory action must build on strategies that have helped to meet patients' most urgent needs in the worst of the pandemic. Specifically:

Increased access to and equity of care—by making expanded coverage for telemedicine permanent; preventing Medicaid cuts; ensuring accessible, affordable and comprehensive insurance plans, and preventing other threats to patients' health coverage; enhancing grants and other support for oncology practices in underserved communities; and sustaining federal safety net programs.

Protecting patient safety—for example, by creating new chemotherapy infection control standards that account for viral threats like the novel coronavirus; ensuring reliable access to personal protective equipment (PPE) and future COVID vaccines; and limiting home infusion of potentially risky chemotherapy to exceptional circumstances.

Supporting patient and provider well-being—by expanding access to behavioral health care and psychosocial support for patients; and enhancing training and support for care teams, which have been disrupted by staffing changes and burnout in the face of the pandemic.

Additional recommendations related to Cancer Care Delivery can be found in the *Road to Recovery Report.*[1]

Below, ASCO outlines recommendations for regulatory policies implemented temporarily during the PHE to be permanently implemented.

A. Telemedicine—Generally, ASCO supports the flexibility CMS has implemented to ensure telemedicine is available to more practitioners and patients during the COVID–19 PHE, and we urge CMS to extend those expanded telemedicine policies after the expiration of the PHE. In addition to Medicare beneficiaries, we support the permanent implementation of these policies for Medicare Advantage as well as Medicaid enrollees.

4—Notification of Enforcement Discretion for Telehealth Remote Communications

ASCO supports the use of HIPAA compliant audio/visual technology after the expiration of the PHE.

Privacy and data security issues and concerns related to health care information technology (HIT) have been key barriers to adoption of telemedicine and impact the confidence of patients and practitioners using these tools. As the use of telemedicine continues to increase, it will necessarily generate large quantities of personal health information and data, highlighting the need for data protection. Clear direction on the application of HIPAA requirements and necessary liability protections for providers is needed.[2]

111—Communication Technology Based Services (CTBS); and

112—Direct Supervision by Interactive Telecommunications Technology

ASCO supports the permanent implementation of policies allowing the provision and reimbursement of CTBS for new and established patients. Additionally, ASCO supports permanent implementation of provisions allowing direct supervision through interactive telecommunications technology. However, ASCO does not support direct supervision through interactive telecommunications technology in the context of home infusion for anti-cancer therapies outside of the PHE.

Mitigating the need for an in-person visit is critical for cancer patients, who are at an increased risk during the PHE, but may also experience similar risks because of compromised immune systems during cancer treatment. Allowing both new and established patients use of CTBS to access necessary care during brief communica-

---

[1] *https://ascopubs.org/doi/full/10.1200/JCO.20.02953.*

[2] *https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020-ASCO-Interim-Position-Statement-Telemedicine-FINAL.pdf.*

tion mitigates the need for an in-person visit that could represent an exposure risk. Granting physicians flexibility to provide clinically appropriate and high-quality care to these beneficiaries via telemedicine can help keep these vulnerable patients in their homes, reducing unnecessary exposure to all illnesses, not just COVID–19.

Regarding direct supervision for home infusion of anti-cancer therapies, ASCO believes that guardrails need to be in place as this temporary policy introduces the potential for risk.[3] There is a paucity of evidence directly comparing the safety of chemotherapy infusions in the home with treatments delivered in outpatient settings. Most of the literature examines home infusion in general, which is of limited utility given the toxicity and hazardous materials specific to chemotherapy. However, multiple criteria in ASCO's existing safety standards may be difficult to satisfy in the home infusion context. For example, safety principles emphasize using more than one practitioner to verify and document patient name, drug name, dosage, infusion volume, route/rate of administration, etc., to minimize errors and prevent patient harm. Within a health-care setting additional trained staff are available for such verification. In the home infusion setting, these verifications need to be performed virtually and with multiple forms of identification, as sending multiple health workers to supervise home infusions may not be practical or feasible. Most importantly, certain adverse events that may quickly escalate and become life-threatening emergencies may not be able to be safely resolved in the patient's home.[4]

In addition to safety concerns outlined above, there are workforce and reimbursement issues that present challenges with home infusion of anticancer therapy. An oncology nurse in a clinical setting can safely supervise infusion of multiple patients at once, compared to single-patient oversight in the home setting. There may therefore be insufficient oncology nursing expertise to widely adopt home infusion and substituting generalist infusion nurses does not provide the same level of patient safety.[5]

113—Telephone Evaluation and Management (E/M) Services Codes

ASCO supports the implementation of permanent policies to allow Telephone Evaluation and Management Services. ASCO encourages Policymakers and payers at the national and state levels to ensure robust, adequate reimbursement and coverage of telemedicine for care delivery via audio and/or audio and visual formats regardless of site of service.[6]

State and federal policymakers should make permanent coverage and reimbursement for audio- visual and when appropriate, audio-only services and continue to expand coverage for all modes of delivery of telemedicine. The lack of broadband and/or access to technology for both patients and physicians will not be limited to the time during the PHE; therefore, we urge that all respective agencies extend these regulatory changes beyond the PHE. Patient populations who lack computer skills or broadband access could potentially benefit especially from audio-only services.[7]

ASCO is committed to supporting efforts that ensure oncologists have the resources they need to provide high-quality cancer care regardless of where that care is delivered; therefore, we believe CMS should cover and reimburse audio-only services. Analysis of data from ASCO practices shows that of all services provided through technology-based communications from mid-March through mid-June, audio-only visits make up 35%–50% of these technology-based visits; virtual check-ins made up less than 1%.[8] Cancer patients are relying heavily on audio-only E/M services and need CMS to ensure they have access to the care they need.

ASCO's Policy Statement on Cancer Disparities and Health Equity commits ASCO to "support and promote policies, systems, environments, and practices to address persistent barriers to equitable receipt of high-quality cancer care across the care

---

[3] *https://www.asco.org/sites/new-www.asco.org/files/content-files/2020-COVID19-IFC1-Comment-Letter.pdf.*

[4] *https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020_Home-Infusion-Position-Statement.pdf.*

[5] *https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020_Home-Infusion-Position-Statement.pdf.*

[6] *https://ascopubs.org/doi/pdf/10.1200/jco.2008.21.1680.*

[7] *https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020-ASCO-Interim-Position-Statement-Telemedicine-FINAL.pdf.*

[8] *https://www.asco.org/sites/new-www.asco.org/files/content-files/practice-and-guidelines/documents/2020-PracticeNET-COVID19-Insights.pdf.*

continuum."[9] CMS should work to promote health equity through encouraging the use of telemedicine in all care settings, including but not limited to rural and safety net providers. CMS should cover and reimburse audio-only services in order to prevent the unintentional exacerbation of health inequities.

While we agree with the agency that telehealth platforms incorporating both audio/visual two-way communication—when available—is preferred, there are instances when this is not possible. This lack of access to technology, often impacting patients vulnerable to other disparities in care, will not be limited to the time during the PHE; therefore, we urge the agency to permanently cover and reimburse audio-only services beyond the PHE.[10]

115—Use of Telecommunications Technology Under the Medicare Home Health Benefit

ASCO supports CMS' proposal to permit patient services and/or monitoring performed through telecommunication technology on a permanent basis when such services are included as part of the home health plan of care.

ASCO supports CMS' proposal to make this temporary flexibility provided during the COVID–19 PHE a permanent part of the Medicare home health program. This proposal will ensure patient access to the latest technology and give home health agencies the confidence that that they can continue to use telecommunications technology as part of patient care beyond the PHE. Cancer patients, because they are often immuno-compromised, are an especially vulnerable subset of the Medicare population. Granting HHAs the flexibility to provide clinically appropriate and high-quality care to these beneficiaries through technology can help keep these vulnerable patients in their homes, reducing unnecessary exposure to all illnesses, not just COVID–19.[11]

122—Physician Supervision Flexibility for Outpatient Hospitals—Outpatient Hospital Therapeutic Services Assigned to the Non-surgical Extended Duration Therapeutic Services (NSEDTS) Level of Supervision

We believe this flexibility to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and critical access hospitals (CAHs) may have many positive effects on physician workload. Permanent implementation could allow physicians to devote more time to clinical work and allow more flexibility on the part of cancer clinics to provide more timely care.

ASCO remains committed to ensuring that cancer patients have access to high quality and safe care. While we support CMS's proposal, we urge CMS to carefully monitor its implementation to ensure that it does not unintentionally place some patients at elevated risk for medical errors.

125—Payment for Medicare Telehealth Services Under Section 1834(m) of the Act; and 149—Updating the Medicare Telehealth List on a Sub-regulatory Basis

ASCO supports the permanent coverage and inclusion of additional services on the Medicare telehealth list, and we encourage CMS to continue soliciting stakeholder comments and feedback regarding potential future additions.

In our interim position statement,[12] ASCO urges CMS to extend the expanded telemedicine policies after the expiration of the PHE. We support the permanent and temporary addition of services to the telehealth list, as this has the potential to increase access to services for cancer patients.

Additionally, ASCO urges CMS to evaluate the safety, quality of care, and outcomes resulting from telehealth visits and to consider such evidence and specialty input when considering additions in future rulemaking.[13] Since CMS has the authority to add services to the list of covered Medicare telehealth services, we support updates

---

[9] *https://ascopubs.org/doi/pdf/10.1200/jco.2008.21.1680.*

[10] *https://www.asco.org/sites/new-www.asco.org/files/content-files/ASCO-MPFS-QPP-2021-Comments.pdf.*

[11] *https://www.asco.org/sites/new-www.asco.org/files/content-files/2020-2021-Home-Health-Comment-Letter.pdf.*

[12] *https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020-ASCO-Interim-Position-Statement-Telemedicine-FINAL.pdf.*

[13] *https://www.asco.org/sites/new-www.asco.org/files/content-files/ASCO-MPFS-QPP-2021-Comments.pdf.*

to the Medicare Telehealth list on a sub-regulatory basis where there is demonstrated clinical benefit to the patient and other requirements are met.

B. Testing/PPE—ASCO supports long-term and widespread distribution of any COVID–19 testing, treatment, or vaccine, to ensure accessibility to health-care providers and disadvantaged populations. ASCO urges the Agency to consider prioritizing resources in a transparent and ethical way.

74—Policy for Coronavirus Disease 2019 Tests During the Public Health Emergency (Revised)

ASCO believes there is a need for FDA premarket regulatory review for high risk tests in addition to CMS CLIA oversight. Physicians rely on high quality and accurate tests to appropriately diagnose and treat patients. There is also a need for flexibility in the review and approval of these tests particularly to inform cancer treatment planning. This flexibility is particularly important in oncology, as new information develops rapidly and is disseminated widely, leading to demand by both physicians and patients for new tests that impact medical decision-making.

C. Access—As the leading organization for physicians and oncology professionals caring for people with cancer, ASCO is committed to promoting access to high quality, high value cancer care.

29—Notifying FDA of a Permanent Discontinuance or Interruption in Manufacturing Under Section 506C of the FD&C Act Guidance for Industry;

30—Exemption and Exclusion from Certain Requirements of the Drug Supply Chain Security Act During the COVID—19 Public Health Emergency; and

61—Notifying CDRH of a Permanent Discontinuance or Interruption in Manufacturing of a Device Under Section 506J of the FD&C Act During the COVID–19 Public Health Emergency

ASCO supports the continuation of policies to enhance transparency in the drug supply chain, assess and strengthen the Food and Drug Administration's (FDA) efforts to prevent shortages, and empower the FDA to have drug makers identify and address vulnerabilities in the supply chains to ensure access to critical medications.

The spread of novel viruses such as COVID–19, and natural disasters such as hurricanes, have highlighted vulnerabilities in the drug supply chain that can lead to significant shortages of critical medications throughout the world. United States drug manufacturers currently rely on China for a majority of their active pharmaceutical ingredients, and this issue is being highlighted by the current COVID–19 epidemic. A disruption in the supply chain, whether caused by manufacturing or quality issues, will likely leave many patients without the critical medications they need.

ASCO urges CMS to make permanent policies that would ensure information about shortages is publicly available. Providing the FDA with the necessary authority to ensure that drug makers increase transparency in their supply chains and identify and address potential manufacturing and quality issues, is critical to guaranteeing patient access to needed medications.

221—Part D "Refill-Too-Soon" Edits and Maximum Day Supply;

226—Prior Authorization;

227—Home or Mail Delivery of Part D Drugs;

285—Prior Authorization [Medicare Advantage]; and

288—Prior Authorization for Part D Drugs.

ASCO urges HHS to implement long-term policies to eliminate longstanding barriers to access associated with utilization management policies within the Medicare program, including Medicare Advantage and Medicare Part D, as well as Medicaid.

ASCO has always advocated for adherence to high quality clinical pathways as a mechanism to drive appropriate use of medications, rather than arbitrary utilization management policies that largely focus on cost rather than clinical evidence. Temporary policies during the pandemic have relaxed certain utilization management strategies during the pandemic. ASCO appreciates the relaxation

of policies like "refill-too-soon" edits, giving patients the ability to obtain the maximum extended day supply available under their plan to allow an uninterrupted supply of critical medications. This is critical support at a time when disruptions to routine care may be expected.[14] However, despite the attempt to relax utilization policies, ASCO members report they still experienced significant delays in care resulting from prior authorization requirements, particularly related to imaging. The pandemic has highlighted the need for permanent solutions to utilization barriers. ASCO continues to work with the AMA and others to achieve reforms related to utilization management. We call on the Agency to put renewed emphasis on addressing this longstanding and increasing burden on patients and their providers.

Restrictive networks and requirements for patients to use designated specialty pharmacies for Part D drugs can impair patient care and access. Patients with cancer should be allowed to seek the services of their preferred pharmacy, including dispensing physicians. For cancer patients, this is important as some studies have suggested that practices with medically integrated services may improve patient adherence to treatment regimens.

D. Quality Payment Program—ASCO encourages the Agency to continue flexibilities in quality reporting across all programs for two years, allowing these flexibilities to remain in effect through performance year 2022. This offers critical time for physician practices to adjust and begin to recover from the repercussions of the COVID–19 pandemic.

106—Merit-based Incentive Payment System (MIPS) Updates

ASCO supports the flexibilities provided to MIPS eligible clinicians to receive hardship exemptions for performance years 2020 and 2021. We encourage the Agency to enable these flexibilities through performance year 2022 to allow practices to recover from the impact of the PHE.

ASCO thanks CMS for recognizing that during this public health crisis it may be challenging or impossible for physicians, groups, and virtual groups to meet the data submission deadline due to circumstances beyond their control. We support flexibilities provided to MIPS eligible clinicians and group practices to choose to submit data or to apply for—and in some circumstances, receive automatically—a hardship exemption. Allowing these flexibilities to remain in effect through performance year 2022 will be important to recovery from the repercussions of COVID–19 and to preserving access to care in communities across the U.S.[15]

ASCO supports submission of patient data to a COVID–19 clinical data registry for participation in Improvement Activity IA—ERP—3 and for extending this through the 2021 performance period.

ASCO supports CMS' designation of data entry to clinical registries as a qualified Improvement Activity for clinicians who are caring for COVID-positive patients. ASCO established a COVID–19 registry to help the entire cancer community learn about the pattern of symptoms and severity of COVID–19 among patients with cancer. The ASCO Registry is designed to collect both baseline and follow-up data on how the disease impacts cancer care and cancer patient outcomes during the COVID–19 pandemic—up to 12 months after a patient's COVID–19 diagnosis. Cancer patients with a COVID diagnosis are a special subgroup of individuals whose clinical condition need to be understood to ensure effective treatment protocols and positive health outcomes. ASCO thanks CMS for confirming that ASCO's Survey on COVID–19 in Oncology Registry is an acceptable registry for the attestation of this highly weighted practice improvement activity.

ASCO supports the extension of this IA into 2021. It is likely that this improvement activity will remain relevant throughout the next year and possibly beyond, given the unknowns around how long the virus will persist in the community and possible long-term effects stemming from infection. Given the impact the coronavirus has on caring for cancer patients, it is imperative that oncologists

[14] *https://www.asco.org/sites/new-www.asco.org/files/content-files/2020-COVID19-IFC1-Comment-Letter.pdf.*
[15] *https://www.asco.org/sites/new-www.asco.org/files/content-files/2020-COVID19-IFC1-Comment-Letter.pdf.*

submit meaningful improvement activity data that reflect real-world events and that are of value to patients and clinicians.[16]

With the following recommendations, we aim to make cancer research opportunities more accessible and equitable for patients in every community.

Part II: Clinical cancer research—Implementation of policies to ensure the clinical trials system is more resilient and flexible, and more accessible to patients must be a priority. Specifically:

Increase patient access and equity—by continuing remote and virtual approaches to consent, and other trial procedures; and by better integrating trials into routine cancer care.

Increase trial efficiency—by streamlining and standardizing regulatory and training requirements; and using central Institutional Review Boards and innovative trial designs, including adaptive trials, master protocols, and common control groups.

Increase flexibility so research will be more resilient in future crises—for example, by "cross training" research teams so that key functions can be led by various team members; and by sustaining flexibility, adopted during the pandemic, for site selection, initiation, and data collection.

ASCO also encourages the Agency to support enhanced data collection efforts to understand the impact of COVID–19 on patients with cancer, including its effect on social determinants of health.

Additional recommendations related to Cancer Care Delivery can be found in the Road to Recovery Report.

ASCO recommends the following policy be permanently implemented after the PHE.

33—Institutional Review Board (IRB) Review of Individual Patient Expanded Access Requests for Investigational Drugs and Biological Products During the COVID–19 Public Health Emergency.

ASCO continues to support the use of central IRBs as one way to promote efficiency, oversight, and review of clinical trial conduct, reduce costs and eliminate duplicative reviews by multiple institutions. During COVID–19, central IRBs were important in expediting research on testing and treatment. ASCO supports expanded access to address unmet needs for many patients and the approval to access investigational therapies should continue to be done so with establish standards of safety and efficacy.

Many of the flexibilities implemented during the PHE have indeed provided relief in managing the unprecedented crisis presented by the COVID–19 pandemic. We encourage the agency to make determinations regarding the future implication of policies and practices based emerging data, and lessons learned, and the experiences of patients, physicians, care teams and health systems, researchers, and research programs during the COVID–19 pandemic. We thank you for the opportunity to provide feedback. Should you have any questions, please contact Gina Baxter at gina.baxter@asco.org or Karen Hagerty at karen.hagerty@asco.org.

Sincerely,
Monica M. Bertagnolli, M.D., FACS, FASCO
Chair of the Board

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
655 K Street, NW, Suite 100
Washington, DC 20001–2399
T 202–828–0400
https://www.aamc.org/

The AAMC (Association of American Medical Colleges) thanks the Senate Finance Committee for convening the May 19 hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned," and for the opportunity to provide written comments for inclusion in the public record.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its

[16] *https://www.asco.org/sites/new-www.asco.org/files/content-files/ASCO-COVID-19-IFC3.Comment-Letter.pdf.*

members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC appreciates the work that this Committee, the Congress, and the Centers for Medicare and Medicaid Services (CMS) have done to provide important flexibilities to ensure that providers can continue to deliver quality health care for patients during the public health emergency (PHE). Many of these flexibilities have proven to expand access to care and should continue to be integrated into the health-care system beyond the end of the PHE. Specifically, the AAMC urges Congress to:

- Remove patient location and rural site requirements to allow patients access to telehealth visits in any location.
- Reimburse providers the same amount for telehealth services as in-person visits.
- Allow Medicare payment for audio-only services.
- Allow patients to access telehealth services across state lines as appropriate.
- Allow for virtual supervision of residents by teaching physicians.
- Allow "authorized practitioners" to prescribe buprenorphine via telehealth.
- Improve access to broadband technology.
- Eliminate the skilled nursing facility (SNF) three-day prior hospitalization requirement.
- Expand the delivery of inpatient care in patients' homes.
- Consolidate all health-related waivers under the authority of the Health and Human Services (HHS) Secretary.

Telehealth Flexibilities

Teaching hospitals, faculty physicians, and other providers have responded to the PHE and the waivers and flexibilities provided by Congress by rapidly implementing telehealth in their settings and practices in order to provide continued access to medical care for their patients.Telehealth provides both patients and providers with a variety of benefits and expands access to care, especially to those in rural and other underserved areas.

- **Increased Access for Patients Improves Care:** Data from the Clinical Practice Solutions Center (CPSC),[1] which contains claims data from 90 physician faculty practices, shows that in March and April 2020, faculty practices on average were providing approximately 50% of their ambulatory visits via telehealth, a dramatic increase from the use of telehealth prior to the pandemic. This is consistent with reports from CMS regarding telehealth services provided to Medicare beneficiaries during that time frame.[2] The use of telehealth expands care for the frail or elderly, for whom travel to a provider or facility is risky or difficult even when there is no pandemic. Telehealth also protects patients from exposure to infectious diseases, including COVID–19 and the seasonal flu. Physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital admissions.
- **Increased Access to Specialist Care:** The use of telehealth enables specialists, such as pediatric specialists, cancer specialists, and critical care physicians, to bring their skills to rural areas and other areas that may not have subspecialty care in their communities. Immediate availability of a pediatric infectious disease specialist or a stroke critical care physician via telehealth can be life saving for those in remote, rural, or small size communities. In addition, telehealth can be used effectively to provide asynchronous consultation for front line providers. Patients can benefit from more timely access to the specialist's guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist.

---

[1] The Clinical Practice Solutions Center (CPSC), owned by the Association of American Medical Colleges and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.

[2] *Health Affairs,* Early Impact of CMS Expansion of Medicare Telehealth During COVID–19. July 15, 2020. *https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/*.

- **High Patient Satisfaction:** Analyses of surveys of more than 30,000 patients conducted by Press Ganey for services in March and April 2020 show that patients feel overwhelmingly positive about their virtual interactions with health-care providers.[3] According to a recent Health Affairs article, 79% of patient respondents reported satisfaction with their telehealth visit and 78% felt that their health concern could be addressed via telehealth.[4]

Due to statutory limitations, most of the current flexibilities are only in place until the end of the PHE. The AAMC believes telehealth is an important method to deliver health care in many circumstances and urges Congress to make legislative changes that would preserve these new practices and the gains we've made in telehealth to date, and to ensure that reimbursement remains at a level that supports the infrastructure needed to provide this level of telehealth services.

The AAMC recommends the following:

Congress Should Remove Patient Location Restrictions and Rural Site Requirements

The AAMC strongly supports changes made by Congress that waived patient location restrictions that applied to telehealth service during the PHE. These changes have enabled CMS to pay for telehealth services furnished by physicians and other health-care providers to patients located in any geographic location and at any site, including the patient's home, during the PHE. We also thank Congress for including changes in the Consolidated Appropriations Act, 2021 that permanently allow patients to receive mental health services via telehealth regardless of the geographic location requirements ordinately applicable to Medicare telehealth services.

These changes have allowed patients to remain in their home, reducing their exposure to COVID–19 and reducing the risk of exposing another patient or their physician to COVID–19. Maintaining such a change even after the threat of the pandemic is contained would allow patients who find travel to an in-person appointment challenging to receive vital care, especially for patients with chronic conditions or disabilities who need regular monitoring. The AAMC encourages Congress to remove the rural site requirements and allow the home to be an originating site.

Providers Should be Paid the Same Amount for Telehealth Services as Services Delivered In-Person

The AAMC strongly recommends that providers be paid the same for furnishing telehealth services as services delivered in person. The quality and cost of care delivered is not different if the patient is seen via telehealth. We recommend Congress provide a facility fee under the outpatient prospective payment system for telehealth services provided by physicians that would have been provided in the provider-based entity.

Teaching hospitals and faculty practice plans have highlighted significant infrastructure costs to fully integrate their electronic health record systems with HIPAA-compliant telehealth programs. Physicians and hospitals employ medical assistants, nurses, and other staff to engage patients during telehealth visits and to coordinate care, regardless of whether the services are furnished in person or via telehealth. Before the virtual visit occurs, the physicians and other health-care professionals must be provided the technology they need and acquire a platform to use for the visits. Other staff will contact patients to complete registration, obtain consent for a telehealth visit, and ensure that the patient receives the email with a link to participate in the virtual visit. In addition, staff will educate the patients on the use of technology as needed to ensure they are able to participate in the visit.

On the day of the visit, clinical staff reach out to the patient to provide intake services (*e.g.,* ask for chief complaint, symptoms, weight, temperature and help the patient identify a review of current medications and therapies) prior to the patient visit with the physician or health-care professional. The patient then participates in the visit with the physician, and at the conclusion of the visit, the physician must arrange any follow-up plan for the patient related to their care. Staff will follow-up as needed to schedule any additional visits for the treating physician or subspecialty referral, tests, or laboratory studies.

---

[3] Press Ganey, *The Rapid Transition to Telemedicine: Insights and Early Trends.* May 19, 2020. *https://www.pressganey.com/resources/white-papers/the-rapid-transition-to-telemedicine-insights-and-early-trends?s=White_Paper-PR.*

[4] "Congress: Act Now To Ensure Telehealth Access for Medicare Beneficiaries," Health Affairs Blog, May 10, 2021. *https://www.healthaffairs.org/do/10.1377/hblog20210505.751442/full/.*

Without sufficient reimbursement, providers may no longer be able to continue to provide the current level of telehealth services to their patients.

Congress Should Allow Payment for Audio-Only Services

CMS established a separate Medicare payment for specific audio-only services to provide reimbursement at the same rates as in-person visits. However, the final 2021 physician fee schedule rule stated that this separate payment will no longer exist after the PHE ends, since CMS does not have the statutory authority to allow coverage and payment for telephone evaluation and management services.

Audio-only calls improve access to virtual care for patients who do not have access to the devices or broadband for audiovisual calls, are not comfortable with digital technology, or do not have someone available to assist them. During the PHE, coverage and payment for audio-only calls has been critical to ensure access to care for many patients. Physicians have been able to provide a wide array of services efficiently, effectively, and safely to patients using the telephone.

Data from the CPSC shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient. CMS data show that nearly one-third of Medicare beneficiaries received telehealth by audio-only telephone technology from March through June 2020,[5] which is consistent with CPSC data.

Many factors contribute to the high use of audio-only services. Patients in rural areas or those with lower socioeconomic status are more likely to have limited broadband access and may not have access to the technology needed for two-way audio-visual communication. The Pew Research Center found that about a third of adults with household incomes below $30,000 per year do not own a smartphone and about 44% do not have home broadband services.[6]

Some providers report that even when their patients have access to technology that would allow for audio-visual communication, they may be unable to use the technology without assistance, thus limiting them to telephone use. For these patients, the only option to receive services remotely is through a phone. Without coverage and payment for these audio-only services, there will be inequities in access to services for these specific populations. We urge Congress to permanently make changes to allow coverage and payment for audio-only services.

Congress Should Allow Patients to Access Telehealth Services Delivered Across State Lines

As part of the COVID–19 response, Congress and CMS have allowed providers to be reimbursed by Medicare for telehealth services across state lines. This waiver creates an opportunity to improve patient access to services and to help improve continuity of care for patients who have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment under federal programs, states need to act to allow practice across state lines to occur.

The AAMC urges Congress to pass the Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168, H.R. 708). This bipartisan, bicameral legislation would expand care for patients by creating a temporary uniform licensing standard for all practitioners and professionals that hold a valid license in good standing in any state to be permitted to practice in every state—including in-person and telehealth visits—during the COVID–19 public health emergency.

Congress Should Allow for Virtual Supervision of Resident Physicians

During the PHE, CMS has allowed resident physicians to furnish telehealth services that are virtually supervised by the teaching physician. In the physician fee schedule final rule, CMS states that this policy regarding telehealth will be allowed on a permanent basis only in rural sites.

Resident education is a crucial step of professional development before autonomous clinical practice and requires varying levels of faculty supervision depending on

---

[5] ASPE issue brief: Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID–19 Pandemic (7/18/2020); Health Affairs Blog; Early Impact of CMS Expansion of Medicare Telehealth During COVID–19. July 15, 2020. *https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/abs.*

[6] Pew Research Center, Digital divide persists even as lower-income Americans makes gains in tech adoption. May 7, 2019. *https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/.*

where the resident is in training and developing competency. As part of this development, it is essential for residents to have the experience with telehealth visits while supervised as they will be providing them in the future to their patients when they practice autonomously.

The AAMC recommends that CMS allow residents to provide telehealth services permanently while a teaching physician is present via real-time audio-visual communications technology after the PHE ends in all regions of the country. This change to CMS policy will improve patient access to care while also enhancing the resident's skills.

Congress Should Allow "Authorized Practitioners" to Prescribe Buprenorphine via Telehealth

The AAMC supports the Substance Abuse and Mental Health Services Administration's and Drug Enforcement Agency's temporary change to allow "authorized practitioners" to prescribe buprenorphine to new and existing opioid use disorder patients for maintenance or detoxification treatment via telehealth examination without the need for a prior in-person visit. We urge Congress to make this change permanent to ensure this important expansion is not limited solely to the current PHE.

Congress Should Takes Steps to Improve Access to Broadband Technology

In many parts of the country, providers and their patients have limited access to broadband connectivity, which has been a major barrier to use of telehealth. This is particularly true for rural areas and underserved communities. The Federal Communications Commission has reported that 30% of rural residents lack broadband services.[7] Also, racial and ethnic minorities, older adults, and those with lower levels of socioeconomic status are less likely to have broadband access. In order to expand access to telehealth and other important online services, we recommend that Congress take steps to increase funding for broadband access and infrastructure development.

Other Targeted Health Care Flexibilities

Eliminate the SNF three-day prior hospitalization requirement.

CMS has waived the requirement for a three-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay for those people who experience dislocations or are otherwise affected by COVID–19. The AAMC supports this waiver and recommends that the SNF three-day prior hospitalization requirement be eliminated permanently to better coordinate and improve care for patients. Eliminating the three-day stay would rely on physicians' judgment to ensure that their patients receive the most appropriate care in the most appropriate settings without creating the possibility of an unforeseen financial burden on the patient.

Expand the Delivery of Inpatient Care in Patients' Homes

CMS launched the Hospital Without Walls program in March 2020 to allow hospitals to provide services beyond their existing walls to help address the need to expand care capacity and to develop sites dedicated to COVID–19 treatment. The Acute Hospital Care At Home program is an expansion of this initiative that allows eligible hospitals to have regulatory flexibility to treat certain patients, who would otherwise be admitted to the hospital, in their homes and receive Medicare payment under the Inpatient Prospective Payment System.

The Acute Hospital Care At Home program launched with six health-care systems that have experience with providing acute hospital care at home. To date, 129 hospitals within 56 systems located in 30 states—including many academic medical centers—have received waivers from CMS to participate in the program.[8] The increase in hospital participation underscores the need for flexibility to meet the health-care needs of certain patients without having to admit them into the inpatient setting.

The AAMC supports the flexibility and benefits this program provides for patients and urges Congress to maintain these flexibilities after the end of the PHE.

---

[7] Federal Communications Commission, 2018 Broadband Deployment Report, February 2, 2018. *https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report.*

[8] Updated as May 14, 2021. Updated list available at: *https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.*

Consolidate All Health-Related Waivers Under the Authority of the HHS Secretary

The AAMC is appreciative of the temporary health care-related regulatory flexibilities and emergency authorities granted by the federal government in response to the coronavirus. These flexibilities have been granted by the White House, HHS, and CMS, among others. To better coordinate these flexibilities, the AAMC recommends that all health-related waivers be consolidated under the authority of the HHS Secretary.

For example, Section 1135 waivers have offered essential relief and assistance for health-care providers during the pandemic by relaxing several requirements, including practice across state lines and timelines for federal reporting requirements. For the 1135 waivers to remain in effect, both a public health emergency and a national emergency must be declared by the HHS Secretary and President, respectively. The AAMC recommends that all health-related flexibilities be under the direction of the HHS Secretary, and not reliant upon the declaration of a national emergency.

Conclusion

The AAMC is very grateful for the work that this Committee, the Congress, and the Administration have done to provide important flexibilities to allow for the expansion of health-care delivery during the COVID–19 pandemic. We appreciate that the Senate Finance Committee is reviewing many of these flexibilities and thinking about how to incorporate them into the health-care system beyond the end of the public health emergency.

Please feel free to contact AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org) or AAMC Senior Director of Government Relations Leonard Marquez (lmarquez@aamc.org) with any questions or if we can provide more information. We look forward to continuing to work with you on these important issues.

BETTER MEDICARE ALLIANCE
1411 K Street, NW, Suite 1400
Washington, DC 20005
202–735–0037 (office)
202–885–9968 (fax)
BetterMedicareAlliance.org

Statement of Allyson Y. Schwartz, President and CEO

Better Medicare Alliance, on behalf of our Alliance and the 26 million beneficiaries enrolled in Medicare Advantage, is pleased to submit the following statement for the record related to the May 19, 2021 Committee on Finance hearing titled *COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned.*

Better Medicare Alliance is a community of 160 ally organizations and more than 500,000 grassroots beneficiary advocates who value Medicare Advantage and the affordable, high-quality, coordinated care it provides to over 26 million beneficiaries. Together, our diverse alliance of health plans, provider groups, aging service organizations, and beneficiaries share a commitment to ensuring Medicare Advantage is a high-quality, cost-effective option for current and future beneficiaries.

As a public-private partnership where seniors and individuals with disabilities receive Medicare benefits through a private integrated managed care plan, Medicare Advantage plans are paid a capitated monthly amount per beneficiary by the Centers for Medicare and Medicaid Services (CMS). The health plans then take full financial risk for care and services to enrollees. Capitated payments are determined six months prior to the start of the contract year and are used to provide coverage of health-care benefits to enrolled beneficiaries. Payments are adjusted by the health status of each beneficiary to ensure health plans receive adequate payment to cover the costs of all beneficiaries.

To ensure the capitated payments reflect the health status and demographic characteristics of individual beneficiaries, payment to Medicare Advantage plans are risk adjusted using demographic and diagnostic information. Risk assessment is required annually for each beneficiary to calculate a risk score that predicts costs for the upcoming year. For the risk adjustment process to function properly, it is necessary to collect data on beneficiaries each year through in-person office visits, telehealth visits, or in-home health risk assessments. Accurate documentation of diagnoses by clinicians is a critical component of the risk adjustment process and ensures bene-

ficiaries receive the appropriate care management and quality of services based on their conditions.

Transition to Telehealth During COVID–19 Pandemic

The COVID–19 pandemic, stay-at-home guidance, and advice to avoid clinical in-person settings unless necessary, particularly for at-risk populations like those over 65 years old and those with chronic conditions, led to a nationwide avoidance of in-person clinical care and delay of elective services. Among Medicare beneficiaries, 8 percent report forgoing care despite needing health-care services because of the pandemic.[1] Reports like this highlight the importance of providing patients access to health-care services outside the physician office and resulted in a dramatic and rapid transition of clinical care being offered through telehealth visits starting in 2020. The use of telehealth visits has contributed meaningfully to allowing providers and health plans to reach out to beneficiaries and replace in-person visits—ensuring those with new medical concerns and those with ongoing chronic conditions have been able to interact with their providers to manage their health. Yet, while providers and health plans work together to provide needed care and reduce the impact of this pandemic for their patients, utilization of care and services was significantly lower in 2020 and has not yet fully returned to pre-pandemic levels.[2]

Between May 2019 and June 2020, the University of Michigan's National Poll on Healthy Aging found telehealth visit participation increased from 4 percent to 30 percent, respectively, among older adults.[3] The same poll found the number of providers offering telehealth services increased from 14 percent to 62 percent during the same period of time.[4] More recently, CMS found 64 percent of Medicare beneficiaries report their provider currently offers telehealth visits, and 45 percent had a telehealth visit since July 2020.[5]

In Medicare Advantage, recent polling shows 40 percent of beneficiaries used telehealth services during the pandemic and gave the experience a 91 percent satisfactory rating.[6] The risk-bearing payment arrangements in Medicare Advantage further facilitated the implementation and expansion of telehealth visits during the pandemic. Compared to Traditional fee-for-service (FFS) Medicare, Medicare Advantage had a quicker transition to telehealth visits.[7] Looking forward, 48 percent of people 65 years and older report a willingness to use telehealth despite not having used telehealth before, and 35 percent expect to use telehealth with more frequency in the future.[8]

Impact on Risk Adjustment

Medicare Advantage is unique in requiring an accurate assessment of each beneficiary every year to determine their health conditions and ensure risk adjusted payments reflect a beneficiary's current diagnoses and conditions. It is critical to make use of the tools available to obtain this data.

Action has been taken by CMS to permit data obtained during audio-video telehealth visits to provide diagnoses for risk assessment, but the same is not allowed for data obtained during audio-only visits. Better Medicare Alliance urges Congress to address this inequity and permit the same use for audio-only telehealth visits. There are numerous reasons to support this allowance, most prominently because beneficiaries do not have equal ability or equivalent access to the technology needed for audio-video visits. Moreover, providers use audio-video and audio-only telehealth visits interchangeably to account for patient preference or capabilities. The distinction for risk assessment purposes inhibits the ability of providers to utilize these patient visits to obtain data required under Medicare Advantage.

---

[1] *https://www.cms.gov/files/document/medicare-current-beneficiary-survey-covid-19-data-snapshot-infographic-fall-2020.pdf* .

[2] *https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidcostsuse_marchupdate_3.*

[3] *https://www.healthyagingpoll.org/report/telehealth-use-among-older-adults-and-during-covid-19.*

[4] *Id.*

[5] *https://www.cms.gov/files/document/medicare-current-beneficiary-survey-covid-19-data-snapshot-infographic-fall-2020.pdf.*

[6] *https://bettermedicarealliance.org/wp-content/uploads/2021/01/BMA_Seniors-on-Medicare-Memo_.pdf.*

[7] *https://bettermedicarealliance.org/wp-content/uploads/2020/07/CIMA-July-2020-Telehealth-Report-FIN.pdf.*

[8] *https://static.americanwell.com/app/uploads/2020/09/Amwell-2020-Physician-and-Consumer-Survey.pdf.*

Omitting the use of data obtained during audio-only telehealth visits unreasonably limits the use of available, timely, and clinically accurate data on these patients that could be used to provide the required information for millions of Medicare beneficiaries. Without this information, the data required by CMS to inform adequate payment based on health status will be incomplete and may impact payment stability for health plans and providers in subsequent years, as well as out-of-pocket costs and supplemental benefits for beneficiaries.

Better Medicare Alliance appreciates the opportunities provided to Medicare Advantage plans to offer telehealth visits and provide audio-video devices to beneficiaries. Over the last year, health plans and providers have been able to routinely hold virtual visits with beneficiaries to ensure those most at risk due to chronic conditions have the attention and medications they need. In addition, health plans and providers have been able to assess general wellness and identify and address social risk factors as part of care management available in Medicare Advantage. Medicare Advantage has been a leader in the rapid transition to telehealth and in providing attention to non-clinical needs of beneficiaries to better help beneficiaries maintain their health and well-being during this unprecedented public health emergency. Telehealth has ensured continuity of care for millions of Medicare Advantage beneficiaries during COVID–19.

Barriers to Use of Telehealth Visits

The transition to virtual visits accelerated by the pandemic has revealed the reality that many older, lower-income, and rural seniors lack the tools or access necessary to complete audio-video telehealth visits.[9]

The rapid uptake in telehealth visits showed the flexibility and innovation of health plans, providers, and beneficiaries during this critical time. Nevertheless, the transition is not without barriers, and the distinction between audio-video and audio-only visits has highlighted the disparities present in telehealth. Though half of people over age 65 are willing to try telehealth, many beneficiaries have limitations that inhibit the use of audio-video telehealth visits.[10] The reasons vary, but the potential barriers must be considered to ensure over 26 million Medicare Advantage beneficiaries continue to receive care without disruption.

Beneficiaries must be able to access the technology and devices necessary for telehealth visits. Access also includes having adequate Internet, financial means, and functional and cognitive ability. Together, such limitations of access inhibit a beneficiary's use of telehealth visits, specifically audio-video visits. While 92 percent of seniors own a cellphone, only 61 percent have a smartphone.[11] The distinction between having a cellphone and smartphone is important because unlike cellphones, smartphones have the video capability necessary for an audio-video telehealth visit. Lower income beneficiaries are less likely to have a smartphone, further limiting access to audio-video telehealth visits.[12] A recent study found 32 percent of people 65 and older do not have a smartphone, tablet, or computer with Internet access at home.[13]

According to the FCC's 2018 Broadband Deployment Report, 24 million Americans do not have access to broadband Internet at the benchmark speed of 25 Mbps/3Mbps, which is considered the minimum speed standard and offers good Internet access. Additionally, the same report found rural areas lag behind urban areas in the deployment of mobile broadband and fixed broadband with 68.6 percent of people in rural areas having access to both compared to 97.9 percent in urban areas.[14] Limited, or inadequate access to Internet prevents beneficiaries from using audio-video telehealth visits.

Access problems are not limited to the Internet or devices, as some beneficiaries with functional or cognitive impairments are unable to utilize audio-video tech-

---

[9] *https://bettermedicarealliance.org/wp-content/uploads/2020/07/CIMA-July-2020-Telehealth-Report.pdf.*

[10] *https://static.americanwell.com/app/uploads/2019/07/American-Well-Telehealth-Index-2019-Consumer-Survey-eBook2.pdf.*

[11] *https://www.pewresearch.org/Internet/fact-sheet/mobile/.*

[12] *https://bettermedicarealliance.org/wp-content/uploads/2020/07/CIMA-July-2020-Telehealth-Report.pdf.*

[13] *https://www.kff.org/policy-watch/possibilities-and-limits-of-telehealth-for-older-adults-during-the-covid-19-emergency/.*

[14] *https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report.*

nology. These beneficiaries prefer audio-only over audio-video telehealth visits. Others may be limited by financial constraints that prevent them from purchasing the necessary devices and Internet services. Research found 34 percent of Medicare Advantage beneficiaries living under the Federal Poverty Level reported no Internet usage at all.[15]

In addition, not all beneficiaries are comfortable with the necessary technology used for audio-video visits. Nearly seven in ten adults 65 and older say they have a computer, smart phone, or tablet with Internet access at home, but only 11 percent say they have recently used a device to talk to a health-care provider through an audio-video visit.[16] During COVID–19, a survey of more than 1,000 Medicare Advantage beneficiaries in December 2020 found 40 percent used telehealth during the pandemic, an increase from 24 percent in May 2020.[17] However, nearly one-third of beneficiaries said they are uncomfortable using telehealth.[18]

Lack of experience or comfort using audio-video technology appears to influence seniors' preference for audio-only because even those who are willing to use telehealth often choose audio-only rather than audio-video visits. When given the option, 60 percent of Medicare Advantage beneficiaries prefer the telephone over other technology.[19] Health providers are also reporting the usage of audio-only telehealth visits is vastly higher than audio-video telehealth visits. Security Health Plan reported 75 percent of their telehealth visits as audio-only, and Kaiser Permanente reported 85 percent of their telehealth visits as audio-only. CMS found nearly one-third of telehealth visits with Medicare beneficiaries between mid-March and mid-June 2020 were conducted by audio-only telephone.[20] This is equivalent to over 3 million visits and indicates a preference for audio-only telehealth visits.

More recent data show a majority, or 56 percent, of Medicare beneficiaries that had a telehealth visit since July 2020 used audio-only telephone for their visit while only 28 percent used video and 16 percent used both telephone and video.[21] The share of Medicare beneficiaries that used audio-only for their telehealth visit was higher among certain demographics, including beneficiaries 75 years or older (65 percent), enrolled in both Medicare and Medicaid (67 percent), or living in rural areas (65 percent).[22] Additionally, the share of Hispanic (61 percent) and non-Hispanic Black (61 percent) beneficiaries using audio-only telehealth visits is higher than White beneficiaries (54 percent).[23] The differences among demographics further highlight the disparities present in telehealth and illustrate the impact omitting data obtained during audio-only telehealth visits may have on Medicare Advantage beneficiaries.

Action Needed to Address Constraints on Use of Audio-Only Telehealth Visits

The public health emergency has led to the recognition of the need to eliminate barriers and burdens in accessing clinically appropriate care, especially for those in the Medicare Advantage population. The importance of telehealth visits during the pandemic in 2020 and 2021 is unquestionable and calls for Congress to take action to eliminate the unnecessary and potentially harmful constraints on the assessment and documentation of current health status to ensure the continuity of care for millions of people.

Bipartisan legislation introduced in the Senate, the Ensuring Parity in Medicare Advantage and PACE for Audio-Only Telehealth Act of 2021, acknowledges and addresses the disparities in the use of telehealth visits for data collection essential for risk assessments. Audio-only telehealth has proven to be an extremely valuable tool to ensure ongoing care is available during this unprecedented national public health emergency to beneficiaries who cannot access or use audio-video technology. Clini-

---

[15] *https://bettermedicarealliance.org/wp-content/uploads/2020/07/CIMA-July-2020-Telehealth-Report-FIN.pdf.*

[16] *https://www.kff.org/policy-watch/possibilities-and-limits-of-telehealth-for-older-adults-during-the-covid-19-emergency/.*

[17] *https://bettermedicarealliance.org/news/poll-seniors-give-telehealth-high-marks-medicare-advantage-satisfaction-smashes-new-record-2/.*

[18] *Id.*

[19] *https://bettermedicarealliance.org/wp-content/uploads/2020/07/CIMA-July-2020-Telehealth-Report-FIN.pdf.*

[20] *https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.*

[21] *https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/.*

[22] *Id.*

[23] *Id.*

cians have been conducting audio-only visits in response to the needs and abilities of beneficiaries and these visits have been vital to the provision of necessary ongoing care for beneficiaries. Earlier research showed that telehealth visits produce similar outcomes as face-to-face appointments for chronic care management and the diagnoses and treatment were also equivalent. Research also shows that risk scores do not fluctuate much year over year.[24] Excluding clinical data from audio-only visits that may not have been obtained otherwise means the data may be entirely absent for those beneficiaries utilizing audio-only visits, despite being available for reporting in each year of the pandemic.

Call for Congress to Act

Data obtained during audio-only visits should be permitted to be used for risk adjustment purposes as it is essential for accurate risk adjustment for beneficiaries in the following year and may not have been collected in any other way due to the pandemic. These visits are recognized as clinical encounters in every other sense, making it only reasonable for diagnoses obtained through these patient-clinician encounters to be permitted to be used for risk adjustment.

By allowing audio-only visits during the ongoing pandemic to be used for risk assessment purposes, the health and well-being of over 26 million Medicare Advantage beneficiaries will be protected now and in the future. We strongly urge Congress to take action that recognizes beneficiary circumstances with respect to and preference for audio-only telehealth technology and necessitates the flexibility to use audio-only technology in the collection of clinical and diagnostic data for risk adjustment purposes.

Better Medicare Alliance thanks the Committee for the opportunity to submit these comments. We recognize the sponsors of the legislation, Ensuring Parity in Medicare Advantage and PACE for Audio-Only Telehealth Act of 2021, for their leadership. We hope to see the Committee consider this bill in the near future and support its passage in the Senate. We welcome the opportunity to continue to engage with the Committee on this important and timely issue.

CENTER FOR FISCAL EQUITY
14448 Parkvale Road, Suite 6
Rockville, MD 20853
fiscalequitycenter@yahoo.com

Statement of Michael G. Bindner

Chairman Wyden and Ranking Member Crapo, thank you for the opportunity to submit these comments for the record to the Committee. These comments are similar to those provided on Telehealth to the Ways and Means Subcommittee on Health on April 28, 2021.

Flexible health-care delivery, especially Telehealth is part of increased automation in medicine. It began with electronic charting. The emergence of telehealth predates the pandemic. It started as a cutting edge way for experts to consult on cases. In recent years, it has included using radiologists in South Asia to read all manner of X-Rays and scans, delivering a diagnosis to emergency rooms, urgent care and doctor's offices.

The question of taxation must be discussed at this point. Perhaps duties should be included for such off-shore medicine. They certainly must be in the event value added taxes are established in the United States. This would bring us into the OECD norm. Senator Hatch has retired, so it is now safe to talk of such things.

If we adopt Medicare for All, such taxes would be counter-productive. Without some kind of employer-paid subtraction value added tax, it is hard to see the creation of an affordable public option, let alone Medicare for All. Part of any transition would have to include an asset value added tax, which would include ending Pease and *Affordable Care Act* SMI taxes on non-wage income over $200,000. See the attachment for more information on these proposals.

The pandemic has made telemedicine the new normal. I will be glad to see it go, or at least play a smaller role. It is hard to get a good medical history and list of

---

[24] Flodgren G, Rachas A, Farmer AJ, Inzitari M, Sheppard S. Interactive telemedicine: effects of professional practice and health-care outcomes. Cochrane Database of Systematic Reviews 2015, Issue 9. Art. No.: CD002098. DOI: 10.1002/14651858.CD002098.pub2 .

symptoms on a video conference or phone call. People likely died, either of complications from the pandemic (like suicide) or SARS–Cov–2. This requires explanation.

The disease occurs in five phases. In phase one, the patient experiences symptoms of a heavy cold which goes away after a week. This phase is largely ignored by the medical community because it is impossible to get to see a doctor in person. To be fair, most patients manage these symptoms with over-the-counter medication. Symptoms last for a week. Phase two is asymptotic.

People believe they are well, even if they assume they were suffering from COVID. In reality, most of the spread of the disease happens during phases one and two. During this period, people do not have fevers, coughing and all but one of the symptoms which are used to screen for COVID.

The intense symptoms start with phase three (SARS2) or phase four (assuming individuals have some degree of immunity from pulmonary disease, or possess inhalers—especially steroids—to manage them.

The patients who eventually die do not know that they have COVID. They believe that symptoms will go away in a week, just as they did in phase one. Access to primary care at this stage, as well as vital information on the disease would have saved lives at this point. Add fear of dying of COVID in the Intensive Care Unit and this fear became a self-fulfilling prophesy.

The main feature of phase four is crushing fatigue, either from lung symptoms or the development of immunity. These symptoms are a two week version of the reaction to either the first shot (for people who have had the disease) or the booster (for people who have not been sick previously).

Phase five is the long-term healing, which includes coughing up mucus. Medications, such as Robitussin, are valuable for these symptoms. This phase takes a long time to clear.

Deaths are still declining, as the current available vectors are less likely to die. For a few weeks, they just wish they would. Younger patients are experiencing the third wave. Minnesota, Michigan and Ontario are likely still experiencing their first wave. This disease is spread by sneezing on people you know, usually at home or work. It has spread from Seattle and New York to the rest of the nation, meeting in the southwest and moving north. It is running out of places to go.

As more and more people get vaccinated or simply have the disease and recover, it likely will disappear, like magic. When it does, we can get back to normal medical practice. Quite a bit of care has been foregone during the pandemic. There is a lot of catching up to do.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment —Tax Reform, Center for Fiscal Equity, March 5, 2021

Individual payroll taxes. These are optional taxes for Old-Age and Survivors Insurance after age 60 for widows or 62 for retirees. We say optional because the collection of these taxes occurs if an income sensitive retirement income is deemed necessary for program acceptance. Higher incomes for most seniors would result if an employer contribution funded by the Subtraction VAT described below were credited on an equal dollar basis to all workers. If employee taxes are retained, the ceiling should be lowered to $85,000 to reduce benefits paid to wealthier individuals and a $16,000 floor should be established so that Earned Income Tax Credits are no longer needed. Subsidies for single workers should be abandoned in favor of radically higher minimum wages.

Wage Surtaxes. Individual income taxes on salaries, which exclude business taxes, above an individual standard deduction of $85,000 per year, will range from 6.5% to 26%. This tax will fund net interest on the debt (which will no longer be rolled over into new borrowing), redemption of the Social Security Trust Fund, strategic, sea and non-continental U.S. military deployments, veterans' health benefits as the result of battlefield injuries, including mental health and addiction and eventual debt reduction. Transferring OASDI employer funding from existing payroll taxes would increase the rate but would allow it to decline over time. So would peace.

Asset Value-Added Tax (A–VAT). A replacement for capital gains taxes, dividend taxes, and the estate tax. It will apply to asset sales, dividend distributions, exercised options, rental income, inherited and gifted assets and the profits from short sales. Tax payments for option exercises and inherited assets will be reset, with

prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed.

As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock Ownership Plan will be tax free. These taxes will fund the same spending items as income or S–VAT surtaxes. This tax will end Tax Gap issues owed by high income individuals. A 26% rate is between the GOP 24% rate (including ACA–SM and Pease surtaxes) and the Democratic 28% rate. It's time to quit playing football with tax rates to attract side bets.

Subtraction Value-Added Tax (S–VAT). These are employer paid Net Business Receipts Taxes. S–VAT is a vehicle for tax benefits, including

- Health insurance or direct care, including veterans' health care for non-battlefield injuries and long term care.
- Employer paid educational costs in lieu of taxes are provided as either employee-directed contributions to the public or private unionized school of their choice or direct tuition payments for employee children or for workers (including ESL and remedial skills). Wages will be paid to students to meet opportunity costs.
- Most importantly, a refundable child tax credit at median income levels (with inflation adjustments) distributed with pay.

Subsistence level benefits force the poor into servile labor. Wages and benefits must be high enough to provide justice and human dignity. This allows the ending of state administered subsidy programs and discourages abortions, and as such enactment must be scored as a must pass in voting rankings by pro-life organizations (and feminist organizations as well). To assure child subsidies are distributed, S–VAT will not be border adjustable.

The S–VAT is also used for personal accounts in Social Security, provided that these accounts are insured through an insurance fund for all such accounts, that accounts go toward employee-ownership rather than for a subsidy for the investment industry. Both employers and employees must consent to a shift to these accounts, which will occur if corporate democracy in existing ESOPs is given a thorough test. So far it has not. S–VAT funded retirement accounts will be equal-dollar credited for every worker. They also have the advantage of drawing on both payroll and profit, making it less regressive.

A multi-tier S–VAT could replace income surtaxes in the same range. Some will use corporations to avoid these taxes, but that corporation would then pay all invoice and subtraction VAT payments (which would distribute tax benefits. Distributions from such corporations will be considered salary, not dividends.

Invoice Value-Added Tax (I–VAT). Border adjustable taxes will appear on purchase invoices. The rate varies according to what is being financed. If Medicare for All does not contain offsets for employers who fund their own medical personnel or for personal retirement accounts, both of which would otherwise be funded by an S–VAT, then they would be funded by the I–VAT to take advantage of border adjustability. I–VAT also forces everyone, from the working poor to the beneficiaries of inherited wealth, to pay taxes and share in the cost of government. Enactment of both the A-VAT and I–VAT ends the need for capital gains and inheritance taxes (apart from any initial payout). This tax would take care of the low-income Tax Gap.

I–VAT will fund domestic discretionary spending, equal dollar employer OASI contributions, and non-nuclear, non-deployed military spending, possibly on a regional basis. Regional I–VAT would both require a constitutional amendment to change the requirement that all excises be national and to discourage unnecessary spending, especially when allocated for electoral reasons rather than program needs. The latter could also be funded by the asset VAT (decreasing the rate by from 19.5% to 13%).

As part of enactment, gross wages will be reduced to take into account the shift to S–VAT and I–VAT, however net income will be increased by the same percentage as the I–VAT. Adoption of S–VAT and I–VAT will replace pass-through and proprietary business and corporate income taxes.

Carbon Value-Added Tax (C–VAT). A Carbon tax with receipt visibility, which allows comparison shopping based on carbon content, even if it means a more expensive item with lower carbon is purchased. C–VAT would also replace fuel taxes. It will fund transportation costs, including mass transit, and research into alternative fuels (including fusion). This tax would not be border adjustable.

Summary

This plan can be summarized as a list of specific actions:

1. Increase the standard deduction to workers making salaried income of $425,001 and over, shifting business filing to a separate tax on employers and eliminating all credits and deductions—starting at 6.5%, going up to 26%, in $85,000 brackets.
2. Shift special rate taxes on capital income and gains from the income tax to an asset VAT. Expand the exclusion for sales to an ESOP to cooperatives and include sales of common and preferred stock. Mark option exercise and the first sale after inheritance, gift or donation to market.
3. End personal filing for incomes under $425,000.
4. Employers distribute the child tax credit with wages as an offset to their quarterly tax filing (ending annual filings).
5. Employers collect and pay lower tier income taxes, starting at $85,000 at 6.5%, with an increase to 13% for all salary payments over $170,000 going up 6.5% for every $85,000—up to $340,000.
6. Shift payment of HI, DI, SM (ACA) payroll taxes employee taxes to employers, remove caps on employer payroll taxes and credit them to workers on an equal dollar basis.
7. Employer paid taxes could as easily be called a subtraction VAT, abolishing corporate income taxes. These should not be zero rated at the border.
8. Expand current state/federal intergovernmental subtraction VAT to a full GST with limited exclusions (food would be taxed) and add a federal portion, which would also be collected by the states. Make these taxes zero rated at the border. Rate should be 19.5% and replace employer OASI contributions. Credit workers on an equal dollar basis.
9. Change employee OASI of 6.5% from $18,000 to $85,000 income.

ERISA INDUSTRY COMMITTEE
701 8th Street, NW, Suite 610
Washington, DC 20001
Main 202–789–1400
http://www.eric.org/

Introduction and About ERIC

Chairman Wyden, Ranking Member Crapo, and members of the Committee, thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." **This is a critical hearing, because the Senate Finance Committee's jurisdiction far exceeds Medicare—policies determined by this Committee govern the benefits provided by employers,** especially as they affect the rules regarding high deductible health plans (HDHPs) and the Affordable Care Act (ACA). Our statement details ways that the Committee and Congress can take decisive action to consolidate the telehealth gains made by private sector employers during COVID and consider expanding telehealth policies to the private sector so that employees and their families can access virtual care.

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. ERIC's member companies voluntarily provide benefits that cover millions of active and retired workers and their families across the country. With member companies that are leaders in every sector of the economy and with stores, factories, offices, warehouses, and other operations in every state, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA's protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

You are likely to engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

ERIC member companies voluntarily offer comprehensive health benefits to millions of active and retired workers and their families across the country. Our members offer these great health benefits to attract and retain employees, be competitive for human capital, and improve health and provide peace of mind. On average, large employers pay around 85 percent of health-care costs on behalf of our beneficiaries—that would be a gold or platinum plan if bought on anExchange. But we don't buy or sell health insurance; these plans are self-insured. In other words, ultimately it is the company that is on the hook for the vast majority of the costs of our patients' care. Prior to COVID–19, there were an estimated 181 million Americans who got health care through their job, with about 110 million of them in self-insured plans like ours.

Employers like ERIC member companies roll up their sleeves to improve how health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and adopting a myriad of other innovations that improve quality and value to drive down costs. These efforts often use networks to guide our employees and their family members to providers that offer high value care. ERIC member companies' ERISA plans are not subject to many of the state and local requirements that apply to fully-insured products such as those sold on an ACA Exchange, because employers do not profit from health benefits—in fact, they're a huge expense.

The entire purpose of these benefits is to meet the needs of plan beneficiaries. Large employers have been essential in connecting employees and their families to programs and care such as through telehealth benefits. ERIC's member companies have been pioneers in offering robust access to telehealth. Telehealth enables our beneficiaries to obtain the care they need, when and where they need it, affordably and conveniently. It reduces the need to leave home or work and risk infection at a physician's office, provides a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages, especially related to mental health, and improve choice and competition in health care. And telehealth is an important tool to help minority communities connect with doctors who share identity and culture, thus helping these individuals feel comfortable accessing the health-care system, no matter where they may be.

Nearly every ERIC member company offers comprehensive telehealth benefits and did so long before the COVID pandemic. As in most aspects of health insurance and value-driven plan design, self-insured employers have been the early adopters and drivers of telehealth expansion. With the onset of the pandemic, ERIC's member companies led the way in rolling out telehealth improvements—held back only by various federal and state government barriers. **Congress should take decisive action to consolidate the telehealth gains made by private sector employees during COVID and consider expanding telehealth policies to the private sector so that employees and their families can access virtual care.**

Federal Actions Greatly Improve Telehealth for Medicare Beneficiaries but Leave the Private Sector Behind

Early on in the pandemic, the Administration and Congress quickly realized that unnecessary barriers to telehealth care would be a significant problem for Medicare beneficiaries. Many of those individuals were quarantined or in areas undergoing lockdowns. Many were in different states and regions that were experiencing peaks in hospital and provider capacity. And Medicare's own coverage of telehealth was nowhere near broad enough to replace much of the care that would otherwise be foregone due to medical facilities being closed to non-COVID patients.

The Administration and Congress acted quickly and decisively:

- Medicare promptly eliminated state licensure barriers, allowing a willing and qualified provider to see a willing Medicare patient via telehealth, without regard to their locations;
- Medicare promptly eliminated state telehealth barriers, such as requirements that patients travel to specific originating sites before they can access telehealth, limitations related to modality (*e.g.,* video-only requirements, etc.), requirements that the provider and patient have a pre-existing relationship, and more; and
- Medicare expanded coverage to include more services for more patients, covered via telehealth.

These changes massively improved telehealth benefits for Medicare beneficiaries, instantly unleashing telehealth's vast potential to fill the voids created by the pandemic and its response—and paving the way for permanent improvement. In fact, in a December 4, 2020 letter, 49 Congressional leaders called for making these changes permanent. While ERIC member companies are primarily outside of the Medicare system, we support making these Medicare improvements permanent. We have endorsed Senator Schatz's *CONNECT for Health Act* (S. 1512) to do just this. Medicare's embrace of telehealth is a boon to private sector patients, because it advances the creation of infrastructure, the adoption of telehealth by more providers, and provides proof that telehealth expansion can produce better access to care and savings.

Unfortunately, very few improvements have been made for patients in the private sector not covered by Medicare, despite employer efforts to expand and improve telehealth. Below we detail how private-sector patients are harmed by the current situation and what the Committee and Congress can do about it:

Care is still limited in many states only to a patient and provider both physically located in that state. Many states have failed to join interstate medical licensing compacts that provide reciprocity for mental health and other medical providers in other states, expanding the network of available providers for state beneficiaries to access. Congress waived these requirements for Medicare and should do the same for private sector beneficiaries or otherwise effectuate interstate practice. While some states have signed limited interstate reciprocity compacts, to recognize limited practice by limited types of providers, many have provided little or no licensure relief.

Restrictive licensure rules help some providers by essentially outlawing competition from out of state, but it hinders other providers from expanding their practice. The failure to recognize interstate medical licensure reciprocity for telehealth means that for many patients, the state government has banned them from logging on to their computer or smartphone and connecting with a readily available and qualified provider.

Many states still impose unnecessary barriers to the use of telemedicine. These barriers can range from requiring that a patient travel to a specific telehealth site before they can connect to a provider, limiting telehealth to specific technologies (for instance, requiring two-way video, which may be out of reach by those in rural or other areas without broadband access or the sophistication to work it, outlawing the use of "portals" and store-and-forward communications particularly helpful to identify skin conditions, pink eye, etc.), mandating that a patient can only do a telehealth visit with a doctor they already have a relationship with, and other barriers. While these barriers may be imposed under the guise of setting a standard of care or protecting patients, these requirements really serve to stymie telehealth, driving more care to (more expensive) in-person settings—or preventing patients from obtaining care at all—and hampering wider telehealth adoption.

These restrictions also have significant equity impact creating barriers that disproportionately affect low-income populations, persons of color, or those with disabilities. At the same time, they serve to protect profits for high-income professions.

Rules imposed by the federal government prevent employers from offering telehealth to many beneficiaries. Employers generally cannot offer telehealth as an employee benefit, separate from health coverage, because, under Department of Labor regulations, telehealth benefits are deemed to be "a plan" for the purposes of ACA rules. This determination requires telehealth benefits to be paired with a full medical benefit that meets all of the different ACA requirements—1st-dollar coverage of vaccines, essential health benefits and annual limit rules, and much more. Because telehealth is, by definition, limited and conducted remotely, it simply cannot meet all of the ACA requirements on its own.

To be clear, telehealth is not a "modality" of care. For employers, it is often an entirely different benefit, part of a suite of programs that are offered to employees and their families. In fact, employers often use a separate vendor to design and administer their telehealth benefits, rather than the insurance company or third-party administrator that services their full medical plan. But the result of treating this separate benefit as a "group health plan" is that telehealth cannot be offered as a standalone to anyone not enrolled in the full medical plan, which effectively bans employers from extending telehealth to all populations, including:

- Full-time employees who are not enrolled in the medical plan, or employees' family members, if the employee is on a self-only plan;

- Part-time employees ineligible for the medical benefit;
- Seasonal, agricultural, or other temporary workers;
- Interns, trainees, and the like; and,
- New employees on a waiting period for the full medical plan, among others.

ERIC notes that this is a serious anomaly—perhaps the first time in living memory that beneficiaries of government programs have more access, more flexibility, and in some ways, better benefits than private sector workers on employer-sponsored plans. Employers are generally the pioneers in health benefits, experimenting with and leading the way in driving value, innovation, quality, and flexibility for patients. **Now, because of government barriers, private sector workers are being left behind.**

Administrative action has provided limited relief. On June 23, 2020, the Department of Labor issued a Frequently Asked Question (FAQ Part 43)[1] that for the first time, allowed employers to expand standalone telehealth offerings, but with two key debilitating restrictions:

(1) Standalone telehealth may **only** be offered to individuals **ineligible for the full medical/surgical benefit;** and

(2) Standalone telehealth may be offered to these individuals **only until the end of the public health emergency.**

While this FAQ was a step in the right direction, it unfortunately leaves a number of potential beneficiary cohorts behind (again, younger workers and those of less economic means are hardest hit), while the temporary nature served as a significant disincentive for large employers to implement a major benefit change. **It is critical that Congress make permanent the allowance to offer standalone telehealth benefits, and expand the offering to unenrolled individuals, in addition to just those who are ineligible.** If not, millions of people will lose this benefit that has enabled them to access providers, especially mental health providers, in a timely manner.

We will note one considerable improvement in telehealth that Congress has made for private sector workers: individuals enrolled in a HDHP with a health savings account (HSA) can now benefit from 1st-dollar coverage of telehealth, thanks to the enactment of the *"Telehealth Expansion Act"* (S. 3539), which was passed into law as part of the CARES Act (H.R. 748). Unfortunately, this telehealth improvement is time-limited and set to expire at the end of 2021.

Senators Daines (R–MT) and Cortez Masto (D–NV) have introduced a new version of the *Telehealth Expansion Act,* which would make the CARES Act policy permanent. ERIC strongly supports this legislation. **We urge Congress to swiftly pass the Daines-Cortez Masto bill, and make 1st-dollar coverage of telehealth permanent, so that workers in these plans can receive the care they need.**

Key Steps the Finance Committee Should Consider to Improve Telehealth

The solutions to many of these problems are within the Committee's jurisdiction, and employers look forward to continuing to provide technical assistance to Congress to implement solutions. We urge the Committee to advance provisions to address each of these barriers to care for private sector workers and put them on equal footing with Medicare beneficiaries.

First, Congress should pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 168) and enable providers to practice telehealth across state lines during the COVID–19 pandemic. Telehealth use has drastically increased over the past year, and some state licensing restrictions continue to disrupt patients' care. The TREAT Act would provide temporary state licensing reciprocity for all licensed and certified practitioners or professionals (those who treat physical and mental health conditions) in all states for all types of services (in-person and telehealth) during the COVID–19 Public Health Emergency. A provider who has achieved a medical license in their own state should be permitted to practice on the Internet, without states blocking them from seeing patients—and likewise, a patient who goes online to see a doctor should not be prevented by state rules from seeing a qualified provider who is licensed in another state. States should retain their rights to determine whether providers licensed in that state will be

[1] *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf.*

qualified to write prescriptions or otherwise develop a scope of practice. However, if a provider in another state has been deemed qualified, a state should not be permitted to prevent patients from seeing that provider or prevent the provider from operating to the fullest extent of their license in that interaction. For example, not allowing a qualified provider to prescribe medication during a medical visit or discuss treatment options during a mental health visit.

Congress should act immediately to ensure that patients who use telehealth for physical and mental health services will have the best chance of finding a provider ready and willing to see them on the other end during the public health emergency. Mental health-care providers prior to the pandemic were difficult to access, especially for those not living in urban areas. More than 60 percent of rural Americans live in mental health professional shortage areas, and the need for care has only been exacerbated during the COVID–19 pandemic.

Congress' immediate action will enable more competition and access in telehealth, creating incentives for providers to improve quality and affordable access for patients. At a time when anxiety and depressive disorders are at an ultimate high, access for patients is sorely needed in offering mental health-care services through telehealth.

In the longer term, **we urge Congress to enact a permanent solution to interstate licensure.** While this will require addressing some thorny questions, we have seen significant leadership in the past with respect to the issue. For instance, in a previous Congress, Congressmen Pallone and Nunes introduced the *TELE-MED Act* [2] to permanently allow interstate practice for Medicare providers. Congress previously fixed this issue in the realm of sports medicine as well. While there are different possible paths forward (national reciprocity, a national license, one comprehensive interstate compact with financial incentives for states), employers urge Congress to work through this challenge and come to consensus on a solution.

Second, Congress should establish a simple set of federal standards for telehealth, eliminating state barriers. We can think of no better example of interstate commerce than a willing doctor and willing patient connecting electronically via the Internet to do a telehealth visit. While it is entirely appropriate for a state to place standards to regulate the practice of medicine at brick-and-mortar medical facilities within the state's geographic boundaries, it makes little sense to have 50 different sets of rules for telehealth (practiced remotely on the Internet or via phone) depending on where a provider or patient may be located at any given moment.

Congress can also develop a set of rules that protect patients while maximizing flexibility and care, rather than some of the current protectionist rules that serve to block patients from care on the state level. The new set of rules should:

- Allow telehealth to establish a patient-provider relationship through an initial telehealth visit;
- Apply the same medical standard of care used for in-person to telehealth visits;
- Ensure that reimbursement is privately negotiated between providers and payers;
- Encourage cross state practice among providers;
- Promote continuity of care by encouraging telehealth providers to coordinate with a patient's primary care provider and interdisciplinary care team;
- Implement "technology-neutral" rules for telehealth, to "future-proof" rules for advances in technology and best practices, and eliminate discrimination for patients who may not have access to broadband Internet or the sophistication to operate video, forward information, etc.;
- Eliminate all "originating site" requirements that arbitrarily limit patient access to telehealth;
- Preserve the same informed consent requirements for patients in telehealth that apply in person; and
- Ensure that telehealth providers may prescribe medication to patients with reasonable limits.

---

[2] *https://pallone.house.gov/press-release/pallone-and-nunes-introduce-tele-med-act.*

This simple, streamlined set of rules will provide clarity to providers and maximize access for patients.

Third, Congress should designate standalone telehealth as an "excepted benefit" so that it can be offered to more patients. This is the way Congress treats other "add-on" benefits like vision, dental, long-term care, cancer-only plans, hospital indemnity insurance, and other benefits that are health-related but do not constitute a full medical plan. It would be a simple change by adding the word "telehealth" into the appropriate sections of the Internal Revenue Code (IRC), the Public Health Service Act (PHSA), and the Employee Retirement Income Security Act (ERISA).

Doing so would not affect an employer's responsibility to offer minimum essential coverage to employees, nor would it weaken an individual's responsibility to enroll in such. Employers or insurers could not swap out telehealth, which is limited in scope and closer to a supplement than a full medical plan, for a full medical benefit. It would simply open up employers' ability to offer telehealth benefits to millions of patients who currently are not allowed—by Congress—to access those benefits. There is precedent for Congress expanding the definition of excepted benefits (*e.g.,* Congress previously acted to allow "limited duration long term care" benefits to be offered outside a medical plan).

In a recent survey, more than 25 percent of ERIC member companies stated that they would expand telehealth offerings immediately if Congress permitted it to be offered as a standalone benefit. This represents billions of dollars in private sector money that is currently being left on the table, and millions of Americans who could have access to telehealth coverage and care, if only the government would get out of the way. Many ERIC member companies are currently taking advantage of the DOL FAQ allowing limited telehealth expansion, but action by Congress could greatly increase these numbers, and thus, greatly increase patients' access to care.

While the Committee considers telehealth advancements for the private sector, more can be done for the millions of workers (approximately half the workforce) with HDHP plans. **Congress should allow patients with a HDHP paired with a HSA to access worksite health centers via 1st-dollar coverage as well.** Worksite health and wellness centers are more critical today than ever before, as employers provide their employees with more widespread and easy access to preventive and primary care services, including vaccination and diagnostic testing services at the workplace. And during COVID, many of these health centers have gone virtual, providing care to workers throughout a given region, not just confined to a specific worksite. However, under current law, individual taxpayers may not contribute pretax dollars to an HSA if they also receive certain supplemental health benefits, which currently includes access to care at a worksite health center. The resulting policy is that individuals with an HDHP are required to pay the full price, no discounts, until they have paid through their full deductible. It's unfair and counterproductive, when employers want our beneficiaries to use the clinics. ERIC encourages Congress to address the inequity by permitting individuals to both benefit from discounted services offered at worksite employee centers and still be eligible to participate in and provide pre-tax contributions to HSAs.

Counterproductive, Protectionist, Anti-Market Proposals: Worse Than Doing Nothing

Meanwhile, some stakeholders are asking Congress to implement telehealth changes that would go in the exact opposite direction, eliminating competitive markets, promoting low-value care, and reducing the potential for telehealth to be transformational for the medical system.

For instance, the *Health Care at Home Act* would mandate ERISA health plans to cover telehealth for any service that is covered in person, as well as mandate that telehealth services be reimbursed at the same amount as in-person services. Both of these changes fail to expand and improve telehealth and instead would uproot the blossoming market.

Large employers that offer health coverage through ERISA plans make decisions on services to cover based on clinical guidelines, evidence, and best practices. We learn from experience, advice from medical professional societies, bodies that evaluate quality and efficiency in health care, and other sources, and then use this information to develop benefits that drive the most value for our beneficiaries. The prospect of government imposition of a sweeping coverage mandate within ERISA plans would be an extreme break from precedent, not to mention a counterproductive endeavor that would inject more unproven and potentially low-value care into

employer-sponsored coverage. This, in turn, would reduce the quality of coverage, while increasing costs for participants. It should be the responsibility of ERISA plan sponsors, not the government, to determine what care is appropriate to cover via telehealth settings.

Under current law, providers are free to negotiate telemedicine rates with payers—which has given rise to a thriving market in which competition drives cost efficiency, value, quality, and innovation. So, it should come as no surprise that certain provider groups are eager to destroy this market and instead set reimbursement by government fiat. It is wholly inappropriate and unprecedented for the federal government to mandate payment rates between two private parties.

Further, telehealth is cheaper than in-person care. Telehealth enables providers to treat more patients more efficiently, with less overhead cost, fewer staff, and lower expenses associated with operating brick-and-mortar retail health settings. This has enabled telehealth providers to offer more competitive rates than in-person, which has been in no small part responsible for the telehealth renaissance. This has caused many employers to adopt and offer telehealth benefits long before the COVID emergency and driven the continuing exploration and innovation that serves to produce ongoing improvements for patients. Losing this successful competitive market would be a significant setback for patients and employers, and ultimately for up-and-coming providers who otherwise could cultivate opportunities in the telehealth space.

Conclusion

Thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to working with Congress to expand and improve telehealth for millions of patients in the private sector, and to defeat proposals that would impose government mandates that make the situation worse, not better. We look forward to working with you to develop and perfect telehealth proposals that can be passed in Congress and signed into law by President Biden.

HEALTHCARE LEADERSHIP COUNCIL
750 9th St., NW, Suite 500
Washington, DC 20001
202–452–8700

May 20, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned."

HLC is a coalition of chief executives from all disciplines within American health care. It is the exclusive forum for the nation's health-care leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health-care system that makes affordable high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies—advocate for measures to increase the quality and efficiency of health care through a patient-centered approach.

The COVID–19 public health emergency (PHE) has highlighted significant challenges to current models of care delivery. The unprecedented cooperation between private and public partners creating innovations in care delivery, information sharing and improved coordination have served as a guide for future pandemics. HLC thanks Congress and federal agencies for their work on providing flexibilities so that stakeholders were able to swiftly adjust to a changing environment. HLC encourages the Committee to examine lessons learned from the following areas to make meaningful improvement to health outcomes after the PHE ends:

Data Sharing

A successful COVID–19 response has required coordination among a diverse set of public and private stakeholders. Each of these groups is uniquely situated to respond to disaster scenarios. Leveraging their individual strengths in a systemic, coordinated manner will lead to greater successes. One critical area where such coordination could be used is in data access and exchange. Public health officials require real-time information on a variety of metrics (*e.g.,* PPE levels, hospital bed count, number of individuals vaccinated) so that they can tailor their responses as necessary. Private sector health-care organizations stand at the ready to provide input to government officials on how best to share information in times of emergency to support supply chain management and surge redeployment.

Telehealth

One of the greatest lessons from the COVID–19 health pandemic has been the opportunity to deliver care through telehealth. State imposed stay-at-home orders limited access to care to vulnerable populations, but increased use of telehealth has helped to deliver care to these populations. A recent study found that telehealth use increased over 3,000% during the 12 month period between October 2019 and October 2020.[1] We greatly appreciate the flexibilities permitted by Congress and the Department of Health and Human Services (HHS) to expand access to telehealth services. These waivers, however, are only temporary and are set to expire at the end of the current PHE. HLC encourages the Committee to examine regulatory barriers to long-term telehealth use, particularly the existing prohibition under Section 1834(m) of the Social Security Act that prevents patients from receiving telehealth services in their homes and other locations. Limiting where a patient can access telehealth unnecessarily reduces care options for patients already underserved by the U.S. health-care system. HLC also encourages the Committee to examine how to further encourage telehealth use after the PHE ends. Patients have been overwhelmingly satisfied with their telehealth experiences and imposing additional regulatory barriers would limit the ease of such care.[2] HLC has concerns that adding clinically unnecessary in-person requirements as a prerequisite to receiving virtual care would limit the ability of providers to meet patients where they are and extend access to underserved patient populations that do not have an existing relationship with a provider. We encourage the Committee to examine the impact on care for vulnerable populations before any regulatory guardrails are imposed.

Workforce

The PHE has highlighted the need for a robust health-care workforce so that it can be quickly scaled and deployed during future disaster events. HLC supports legislation that would implement a federal waiver of state licensure and allow for practice at the top of the scope of license for physicians, nurses, pharmacists, pharmacy technicians and other health-care professionals in times of disaster. This should also allow health professionals to work in centralized locations to provide services, including remote patient monitoring across state lines. We also encourage Congress to examine legislation that would expedite the visa authorization process for highly trained nurses who could support hospitals facing staffing shortages, ensuring hospitals are better able to respond to rising COVID–19 caseloads in the months ahead. An adequate supply of nursing staff is critical for hospitals to maintain services while ensuring that patients are properly cared for during the public health emergency. The Healthcare Workforce Resilience Act is critical to strengthening health systems' capacity as we continue to combat the COVID–19 pandemic, the growing opioid crisis, and other significant health challenges.

HLC, through its National Dialogue for Healthcare Innovation (NDHI) initiative on Disaster Preparedness and Response has also partnered with the Duke-Margolis Center for Health Policy to recommend future strategies that will lead to better disaster readiness efforts. In this report,[3] we focus on three different areas: improving data and evidence generation, strengthening innovation and supply chain readiness and improving care delivery approaches. The report highlights many of the current challenges public and private entities have had in responding to the COVID–19 health pandemic and makes recommendations on how to ease future burdens. HLC

---

[1] Iain Carlos, *Telehealth claim lines jump 3,000% in 1 year,* Becker's Hospital Review (January 7, 2021), *https://www.beckershospitalreview.com/telehealth/telehealth-claim-lines-jump-3-000-in-1-year.html.*

[2] *Telehealth Patient Satisfaction Surges During Pandemic but Barriers to Access Persist, J.D. Power Finds,* J.D. Power (October 1, 2020), *https://www.jdpower.com/business/press-releases/2020-us-telehealth-satisfaction-study.*

[3] *https://www.ndhi.org/files/1816/1281/7553/disaster_preparedness_report_FINAL.pdf.*

has also compiled a compendium [4] of best practices, highlighting the efforts of our members in responding to disaster events such as the COVID–19 pandemic as well as natural disasters.

HLC looks forward to working with you on developing lasting flexibilities for healthcare stakeholders so they can quickly respond to disaster events. Please feel free to contact Tina Grande at tgrande@hlc.org or 202–449–3433 with any questions.

Sincerely,

Mary R. Grealy
President

HEALTHEQUITY
15 W. Scenic Pointe Dr.
Draper, UT 84020
P. 855–437–4727
F. 801–727–1005
https://www.healthequity.com/
info@healthequity.com

May 18, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Dear Chairman Wyden and Ranking Member Crapo:

We write to you today to thank you for holding a hearing entitled, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." Your attention to this critical issue is appreciated by HealthEquity and by the millions of Americans who utilize telehealth services.

HealthEquity administers health savings accounts ("HSAs") and other consumer-directed benefits for more than 12 million accounts on behalf of American workers. We partner with employers, benefits advisors, and health and retirement plan providers who share our mission to connect health and wealth and value our culture of remarkable "Purple" service.

In response to the COVID–19 pandemic, Congress included temporary provisions in the CARES Act (Pub. L. 116–136) permitting an HSA-eligible high deductible health plan to cover telehealth and other remote services without a deductible or before the deductible has been met. These temporary provisions providing access to vital care expire at the end of 2021.

While these provisions are temporary, the growth in telehealth is likely not. Surveys have shown explosive growth in telehealth since the pandemic began:

- A study in *Health Affairs* found that 30.1% of all health care visits—a 23-fold increase—were conducted via telemedicine between January and June 2020;[1]
- A coalition of self-insured plan sponsors reported a 28-fold increase in telemedicine visits between January and May 2020;[2] and
- A major telemedicine company reported a 156% increase in appointments for 2020 compared to 2019.[3]

These statistics show how critically important telemedicine has become. Few observers believe the practice of medicine will return to the way it was before COVID. As society and technology evolve, so should health and tax policy.

---

[4] *https://www.hlc.org/wp-content/uploads/2021/02/DP-Compendium-Final-Final.pdf.*

[1] Population of 16.7 million participants with commercial insurance or a Medicare Advantage plan. *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01786?journalCode=hlthaff.*

[2] *https://www.prnewswire.com/news-releases/patient-officehospital-visits-down-telemedicine-visits-up-for-non-covid-19-health-issues-based-on-claims-analysis-by-health-transformation-alliance-301236052.html.*

[3] *https://ir.teladochealth.com/news-and-events/investor-news/press-release-details/2021/Teladoc-Health-Reports-Fourth-Quarter-and-Full-Year-2020-Results/default.aspx.*

We respectfully request that you make the CARES Act telehealth provisions permanent and support the millions of Americans who have found telemedicine to be a safe and effective means of receiving medical care.

Thank you for your attention to this issue. We are happy to be of assistance in any way.

Sincerely,

Jody L. Dietel, ACFCI, CAS, HSAe
Senior Vice President, Advocacy and Government Affairs
jdietel@healthequity.com
650–577–6372

KAISER PERMANENTE
One Kaiser Plaza, 27th Floor
Oakland, CA 94612
510–271–5999

June 3, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

RE: Kaiser Permanente statement for the record on the committee's May 19, 2021, hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

Dear Chair Wyden and Ranking Member Crapo:

On behalf of Kaiser Permanente, we thank you for holding the "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned" hearing on May 19, 2021. We commend the committee for addressing these important issues and offer this statement for the record.

Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside of California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and 724 clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that employ more than 23,000 physicians and exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's 12.5 million members.

The COVID–19 pandemic has demonstrated the potential of programs that provide acute-level care in the home and the inherent value of making such programs a durable feature of our health care delivery system. We hope that you will find our experiences in implementing our Kaiser Permanente Advanced Care at Home programs useful—particularly in the dynamic and demanding environment of the COVID–19 pandemic—as you consider policies to expand the availability of these beneficial innovations to all patients.

Innovating home-based care. Over the past decade, Kaiser Permanente and several other prominent, well-respected health-care organizations have pioneered care models that enable patients to receive, from the comfort of their own homes, care for acute and chronic conditions that traditionally has been provided in hospital and other medical facility settings. Many patients benefit immensely from this model of care, including those with cancer, COVID–19, organ transplants, and chronic illnesses such as renal failure. The model brings a range of hospital equipment and services into the patient's home. This can include infusions; skilled nursing services; medication delivery; and laboratory, imaging, behavioral health, and rehabilitation services.

Kaiser Permanente at home. At Kaiser Permanente, we have provided safe and effective advanced care at home for more than 500 patients across several Kaiser Permanente regions since 2020, and we are working to expand availability in the coming years. Leveraging advances in technology that support the virtual delivery of health-care services, the Kaiser Permanente Advanced Care at Home program temporarily installs state-of-the-art technology in patients' homes, and our care at home "command centers" direct and coordinate care delivered by our Permanente Medical Group physicians and care teams. Our specialized health-care teams deliver the same high-quality, hospital-level care in patients' homes that they would receive during a traditional hospital stay.

Through our programs, home-based patients can access their care teams around-the-clock by phone and video; have their vital signs monitored virtually; receive in-home visits with a nurse practitioner and other clinicians such as community paramedics; and have diagnostic testing, mobile imaging, and various therapies performed safely in their homes. To facilitate patients' connections to their care teams, we also equip them with devices and technology, which may include: a computer tablet for video visits with their care team, a phone with a direct line to their care team, an emergency-response bracelet, remote-monitoring devices, and backup Internet access and power supply. Personnel entering the home are trained to provide excellent patient care, identify and address challenges associated with the social determinants of health, and attend to any information technology questions that might arise during the course of a medical episode. The command center is staffed by physician specialists in hospital medicine, inpatient nurses, and program coordinators who can assist patients with the logistics of timely delivery of medications, materials, and personnel into the home.

Better outcomes for patients. Programs that provide hospital-level care at home have been shown to produce better outcomes for patients when compared with in-hospital care. Several studies have found that home-based patients had improved outcomes, including reduced lengths of stay, readmissions, and mortality.[1] These programs also mitigate the health risks that patients can face during a traditional hospitalization, including those from health care—acquired conditions such as nosocomial infections, delirium, and other harm events. Hospital care at home takes the infection prevention principles afforded by a single room in a hospital to the next level of safety. Delirium events can be reduced because elderly patients are not removed from their familiar environment.[2] Nationally, a third of hospitalized patients will decline from their baseline functional status after a traditional hospitalization.[3] These patient harms—which can be the direct result of hospital stays—are known to be costly, and they can be reduced or avoided altogether by enrolling the patient in a program that provides hospital-level care at home.

Studies confirm that acute-care-at-home programs can result in cost savings. For example, one study determined that the average cost of hospital-level care at home was $5,081, compared with $7,480 for acute hospital care.[4] On average, these programs reduced costs by more than $2,000, or 32%.[5]

Increased patient satisfaction. Acute care-at-home programs have also been shown to enhance patient satisfaction with their care experience. Patients overwhelmingly prefer to receive care at home when possible. According to one national poll, 77% of Americans over the age of 40 would prefer to receive care in the familiar surroundings of their homes.[6] In our own experience with Kaiser Permanente Advanced Care at Home, patients report satisfaction levels across key areas consistently at or above national averages. On a scale of 1 to 100, our surveyed patients

---

[1] Johns Hopkins Medicine, "Hospital at Home," *www.johnshopkinssolutions.com/solution/hospital-at-home;* The Commonwealth Fund, "'Hospital at Home' Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers," *www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance.*

[2] Caplan GA, Coconis J, Board N, Sayers A, Woods J. Does home treatment affect delirium? A randomised controlled trial of rehabilitation of elderly and care at home or usual treatment (The REACH-OUT trial). *Age Ageing.* 2006 Jan;35(1):53–60.

[3] Chodos AH, Kushel MB, Greyson SR, et al. Hospitalization-associated disability in adults admitted to a safety net hospital. *J Gen Intern Med.* 2015; Covinsky KE, Pierluissi E, Johnson CB. Hospitalization-associated disability. *JAMA* Oct. 26, 2011;306(16).

[4] *Ibid.*

[5] *Ibid.*

[6] Associated Press and National Opinion Research Center at University of Chicago, "Long-Term Care in America: Expectations and Preferences for Care and Caregiving," *www.longtermcarepoll.org/long-term-care-in-america-expectations-and-preferences-for-care-and-caregiving.*

rated their overall experience with Kaiser Permanente Advanced Care at Home at 78 (compared with 73, nationally for all hospitalized patients) and their willingness to recommend the program at 78 (compared with 72, nationally for all hospitalized patients).[7]

Advancing health equity. Programs that provide hospital-level care in the home also advance health-care equity by enabling additional support for more-vulnerable patients. Understanding patients' home environments firsthand allows us to better assess patient needs related to social determinants of health and enables the care team to treat the whole person. When a patient needs additional support, such as healthy food or transportation assistance, Kaiser Permanente can integrate this critical information into their care plan and connect the patient to available community resources to meet these needs, thereby promoting better care and outcomes. The care team visiting a patient in the home can assess the patient's diet, medication regimen, safety risks, and other factors; and, where appropriate, they may intervene in those underlying contributors to the medical condition in ways that are not possible for facility-based patients. These valuable insights into the patient's home environment and our enhanced ability to provide extra support for their recovery would not be possible with a traditional hospitalization.

Investments in advanced care at home. Kaiser Permanente has long been an industry leader in developing and implementing home-based care models, and we believe that this approach will continue to grow in importance. For years we have provided traditional post-acute hospital care, home health care, hospice services, and home therapies using intravenous medications. Today's technologies now facilitate more advanced, real-time monitoring that is scalable and cost effective. The regulatory flexibilities issued in response to the pandemic have allowed additional practitioners to extend the reach of traditional, hospital-based care teams. The future holds tremendous opportunity to provide seamless, high-quality, patient-centered care outside of the four walls of a hospital. Programs that safely bring acute care into the home environment are most likely to be successful in the context of an integrated care system that manages the continuum of care, inclusive of traditional inpatient and outpatient services. Kaiser Permanente will continue to leverage our clinical expertise in developing and improving these care delivery models for our patients and communities and to share our insights for the benefit of the health-care system at-large.

Policy investment in home-based care innovation. The COVID–19 pandemic has accelerated the revolution in virtual health care, and these advancements have been hard-won. In response to the pandemic, the Department of Health and Human Services and the Centers for Medicare and Medicaid Services implemented key policy waivers—Hospital Without Walls and Acute Hospital Care at Home—that enabled providers such as Kaiser Permanente to deliver patient-centered, high-quality acute care seamlessly and safely in patients' homes. Currently, these waivers are set to expire at the end of the public health emergency.

We believe that the time is now to make the investments that those waivers have enabled a permanent part of health-care delivery in the United States. We look forward to working with Congress, the Department of Health and Human Services, and the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation, to accelerate the realization of the future of health-care delivery and develop a permanent hospital-at-home model for Medicare and Medicaid beneficiaries.

We thank you and the committee for your engagement on these critically important issues affecting the future of our health care delivery system. We would value the opportunity to provide additional information to you and your staff. Please do not hesitate to contact Laird Burnett in our Washington, DC office by calling (202) 236–7883, or to contact either of us.

Very respectfully,

Anthony A. Barrueta
Senior Vice President
Government Relations
Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals

Stephen Parodi, M.D.
Executive Vice President
External Affairs
The Permanente Federation

[7] Internal Kaiser Permanente data.

MEDICALLY HOME GROUP, INC.
133 Brookline Avenue
Boston, MA 02215

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for allowing Medically Home the opportunity to submit a statement for the record on COVID–19 health-care flexibilities, perspectives, experiences, and lessons learned. Particularly, our statement will address Hospital Without Walls and Acute Hospital Care at Home waivers and their impact on driving patient centered care during the COVID–19 public health emergency (PHE).

Medically Home is a Boston-based company that enables hospitals and health systems to safely care for acutely ill patients in the comfort and safety of their own homes. Many patients benefit from this model of care, also referred to as "Hospital at Home," including cancer patients, COVID–19 patients, transplant patients, and patients with the exacerbation of chronic illnesses that plague millions of Americans (*e.g.,* COPD, heart failure, pneumonia, cellulitis, and many other conditions acute enough to require inpatient level care and safe enough to be provided at home).

Leading medical providers including Mayo Clinic and Kaiser Permanente have relied on Medically Home to provide a platform to successfully implement Hospital at Home programs that improve patients' health, well-being, and experience, while reducing costs at the same time. Medically Home's platform achieves these goals by providing clinical and technological support to hospitals, and by coordinating the delivery of medically appropriate and necessary equipment, medication, and supplies to patients' homes on behalf of its hospital customers. Our hospital partners, currently operating in 7 States, are using their clinicians to provide care to their patients and receive reimbursement from public and private payers. Given our unique experience working with hospitals/providers to safely shift advanced medical care to the home setting before and during the COVID–19 PHE, we believe we can provide valuable input on the need to extend the telehealth, Hospital Without Walls, and Acute Hospital Care at Home flexibilities on behalf of patients across the country.

Unprecedented collaborations driven by COVID–19 and the opportunity to expand hospital inpatient care in the home are important to note—specifically Mayo Clinic and Kaiser Permanente announced last week their partnership to enable more patients to receive acute care and recovery services in the comfort, convenience, and safety of their homes through their investment in, and partnership with, Medically Home. Their collective goal is prioritizing the democratization of the finest level of care by providing real time access to Hospital at Home to rural and underserved communities, including Medicaid beneficiaries. Today, Mayo Clinic, using Medically Home's platform is already providing patient care in rural Wisconsin, with patients being referred by multiple hospitals there, including a critical access hospital.

Perspectives: Background on Hospital at Home

Caring for acutely ill patients in their homes is not a new concept and has existed for decades. However, the PHE has heightened and reaffirmed the necessity for acute level services in the home. The telehealth, Hospital Without Walls, and Acute Hospital Care at Home flexibilities alleviated hospital overcrowding and, hence, mitigated the spread of COVID–19.

With over 65 clinical trials published on Hospital at Home models, previous research on Hospital at Home has indicated that patients who received hospital care in the home had improved outcomes including reductions in lengths of stay (LOS), readmissions, and mortality, as well as increased patient satisfaction.[1] Studies have also shown that providing hospital services in the home has resulted in cost savings and lower utilization. More specifically, they found the average cost for Hospital at Home care was $5,081 compared to the average $7,480 for acute hospital care.[2]

Prior to the PHE, Hospital at Home had not been widely adopted due to current regulatory barriers that limit Medicare reimbursement, and therefore, discourage investment in the program. Specifically, the interpretation of Section 482.23 of the Medicare Condition of Participation for Nursing Services, which requires 24-hour nursing services to be provided in person.

---

[1] *https://www.johnshopkinssolutions.com/solution/hospital-at-home/; https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance.*

[2] *Ibid.*

Experiences: Hospital Without Walls and Acute Hospital Care at Home Waiver

Upon the onset of the COVID–19 pandemic, several leading health systems took the initiative to implement Hospital at Home models to address the emerging needs of their patients and communities.[3] CMS announced Hospital Without Walls to enable hospitals to provide inpatient services outside of traditional inpatient settings, including the patient's home. However, the interpretation of Section 482.23 of the Medicare Condition of Participation for Nursing Services remained a barrier.

We applaud HHS for subsequently waiving this requirement via the Acute Hospital Care at Home waiver, and we request Congress and HHS to consider permanently extending this waiver to allow the 24-hour nursing requirement to be fulfilled virtually. According to CMS data,[4] since announced in December 2020, the number of approved waivers has increased to 129 hospitals, 56 hospital systems, in 30 states.

Due to this waiver being specific to the COVID–19 PHE and the upfront investment (cost, time, etc.) required to operate a Hospital at Home program, we believe participation will likely level off in the future if there is no long-term extension of the waiver (or worse, without CMS participation, some of these hospitals may stop offering the program altogether). As well, those currently operating programs will lose their investment and no longer receive Medicare payment for hospital inpatient care provided in the home.

Lessons Learned: Regulatory Barriers Continue Outside of Current Waivers

After the PHE ends, the home will no longer be a permissible originating site for telemedicine and telehealth services, as well as for acute level of care services. Extending the Hospital Without Walls and telehealth flexibilities to allow the home to be a permissible originating site for these services is critical to reduce stress on the system, allow providers to determine the best and safest setting for their patients to receive care, and improve access for patients in rural and underserved communities.

We believe these regulatory flexibilities should be made permanent beyond the PHE and will be an effective foundation for establishing Medicare reimbursement that is specific to Hospital at Home services. We applaud HHS for providing these flexibilities to ensure hospital services in the home during the PHE, and we encourage Congress and HHS to consider extending these flexibilities as a new model of care that prioritizes patient safety, patient choice, and patient care needs while providing access to those who need it most.

Recommendations: Future of Patient Centered Care Post-PHE

Beyond the PHE, the United States health system should move towards a more resilient health-care delivery future where patients are empowered to choose their homes as a location for their care because we now have the technical and logistical capabilities to make safe and cost-effective high quality inpatient care in the home a reality nationwide. Moreover, equipping patients and hospitals with the flexibility to determine the best and safest setting to receive care has been and will continue to be critical for access to care and resiliency as hospitals address the variations in patient demands, facility capacity, and staffing following the PHE.

Maintaining the current waivers and flexibilities beyond the PHE will be critical to optimize all efforts by our health-care systems to meet the changing needs of their communities. The COVID–19 PHE has changed the landscape of health-care delivery. The industry has discussed innovations in telehealth and health-care delivery outside of traditional care settings for some time, and the PHE has been a catalyst for the industry's implementation of these new care delivery methods (after all, Hospital at Home is not a new concept in health care and has been practiced by some systems for the last 20 years). These flexibilities have proven to be effective methods for care delivery during the PHE and we are advocating for the extension of these regulatory flexibilities to allow the model to fully scale. Indeed, these tools make our health-care system more resilient and accessible, enabling it to meet the operational

---

[3] *See, e.g.,* At-Home Care Designed for COVID Likely Here to Stay at Cleveland Hospital, available at, *https://khn.org/news/at-home-care-designed-for-covid-likely-here-to-stay-at-cleveland-hospital/;* Mayo Clinic to Launch National Hospital-at-Home Model, available at, *https://l.e.crainalerts.com/rts/go2.aspx?h=686177&tp=i-1NGB-E0-7AV-HEuj8-1n-1efb-1c-HEsTa-l4mTpLeEm0-dJjLK;* Pandemic Forced Insurers to Pay for In-Home Treatments. Will They Now Disappear?, available at, *https://www.leavenworthtimes.com/zz/news/20200616/pandemic-forced-insurers-to-pay-for-in-home-treatments-will-they-now-disappear.*

[4] *https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.*

and financial challenges presented by the pandemic and other potential health emergencies.

Extending these waivers is an important step towards advancing the future of health-care delivery. Hospital at Home can offer a future where patients and their providers can determine the most appropriate care settings and provide population-specific targeted approaches to care delivery. In 2017, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended two Hospital at Home proposals to the HHS Secretary for implementation: Mt. Sinai's Hospital at Home Plus Model (HaH-Plus) and Marshfield Clinic's the Home Hospitalization: An Alternative Payment Model for Delivering Care in the Home (HH-APM). Former Secretary Azar had expressed interest in testing home-based, hospital-level of care models and agreed with PTAC that these models hold promise for testing. To date neither model has been implemented. Medically Home and our partners are interested in developing similarly proposed reimbursement pathways for Hospital at Home.

Conclusion

Due to the regulatory barriers outlined above, which will return post-PHE, hospitals have been and/or will again be wary about and disincentivized from implementing or scaling hospital at home. This includes the access to care for underserved communities, and the innovations and superior financial, clinical, and satisfaction outcomes of providing acute level care in the home that Hospital at Home provides. Therefore, we request Congress and HHS to consider a permanent extension of the telehealth, Hospital Without Walls, and Acute Hospital Care at Home waivers beyond the PHE to mitigate the residual impacts of COVID–19 on public health and encourage broader adoption of providing patient centered health-care services in the home.

We again thank you for the opportunity to submit a statement for the record to the Committee, on behalf of our hospital customers and their patients across the country, we look forward to continuing to work with Congress and HHS to ensure that access and quality care are available to citizens during and beyond the PHE, as well as to further provide groundwork for greater innovations in health-care delivery for the future.

MOVING HEALTH HOME COALITION
1100 H Street, NW
Washington, DC 20005
https://movinghealthhome.org/

June 2, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC 20515

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20515

RE: Moving Health Home Testimony for Senate Finance Committee Hearing on "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

On behalf of Moving Health Home (MHH), we appreciate your thoughtful consideration of the COVID–19 flexibilities that allow clinical care to be provided in the home during the Committee's hearing entitled, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned" held on Wednesday, May 19, 2021. MHH is a coalition of pioneering health-care organizations with a bold vision to make the home a site of clinical service. We are thankful for the opportunity to submit testimony outlining the need for a temporary extension of the Hospitals Without Walls (HWW) flexibilities to collect additional data and lessons learned. However, a comprehensive Hospital at Home model is needed to fully leverage the promise of home as a clinical site for care.

We ask that Congress temporarily extend the HWW program for an additional two years while simultaneously authorizing a permanent model that allows hospitals to deliver inpatient hospital services to Medicare beneficiaries at home.

The value of home care was demonstrated during the COVID–19 pandemic, as continued to be seen as hospitals leverage temporary waivers to offer a greater range of inpatient services in alternate sites of care, including the home. To date, more than 100 hospitals have leveraged temporary authority to deliver care outside their four walls; 132 hospitals and 58 health systems across 31 states are delivering care to patients in their homes through the Acute Hospital Care at Home (AHCAM) waiver.[1, 2] Hospital at Home programs have been studied for decades both in the United States and internationally. The research overwhelmingly demonstrates that Hospital at Home programs are at least as safe as traditional in-patient care, improve clinical outcomes and patient satisfaction, and reduce the total cost of care.

Background: Hospitals Without Walls Flexibilities and Acute Hospital Care at Home Waiver

In March 2020, the Centers for Medicare and Medicaid Services (CMS) introduced the **Hospitals Without Walls (HWW)** initiative, which provided broad regulatory flexibility for hospitals to provide services in locations beyond their existing walls. This temporary, blanket waiver authority is focused on reducing hospital capacity to better address COVID–19.

Later that year in November, CMS announced the **Acute Hospital Care at Home (AHCAH)** program that would cover hospital-level care at home for Medicare fee-for-service (FFS) beneficiaries at approved sites. This temporary, individual waiver requires that prospective health systems apply to the program and are subject to approval by CMS based on their ability to meet certain requirements. The HWW initiative built the foundation for the AHCAH program, operating sequentially.

Comprehensive Hospital at Home Model Is Needed

With the help of nearly 25 leading health-care organizations and experts in the field, MHH is advocating for legislation that would permanently implement a Medicare Hospital at Home program, which is currently in draft form. MHH's proposal is built on decades of research and would allow for sustainable, long-term adoption of inpatient services at home designed to improve patient experience and outcomes, reduce federal spending, and increase access and patient choice.

That said, MHH asks that Congress temporarily extend the HWW program for an additional 2 years while simultaneously authorizing a permanent model that allows hospitals to deliver inpatient hospital services to Medicare beneficiaries at home. While MHH is supportive of a two-year extension of the HWW flexibilities, including the AHCAH program, we believe it is not the correct long-term solution for broad adoption of inpatient services at home for the following reasons:

- **We Should Not Build Programs Based on Waivers**—Temporary waivers are a bridge to enable care in the home to continue for a time-limited period post-pandemic, but do not fully leverage the promise of home-based care. They continue to rely on fee-for-service payment, while our goal would be to integrate a value-based mechanism into the program.
- **Hospital at Home Models Reduce Costs**—Home care models that combine inpatient hospital services with post-acute care post-discharge from the home can result in 44 percent lower total cost of care.[3] In general, Hospital at Home programs have realized savings of 30 percent or more per admission, while maintaining equivalent or better outcomes.[4]
- **Hospital at Home Models Improve Quality**—Quality results for care in the home are comparable to or better than those realized for facility-based care. Published data of Hospital at Home programs from across the U.S. demonstrate reduction in average length of stay by one-third, readmissions by 24 percent,

---

[1] *https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.*
[2] *https://www.gao.gov/assets/gao-21-575t.pdf.*
[3] *https://www.carecentrix.com/news/avalere-report-finds-carecentrix-model-of-post-acute-care-lowers-total-cost-of-care-by-improving-outcomes-and-reducing-readmissions-ed-visits.*
[4] *https://pubmed.ncbi.nlm.nih.gov/16330791/.*

mortality by 20 percent, complications (*e.g.,* delirium and falls), and emergency department visits.[5, 6, 7, 8]

– **Consumers Prefer to Receive Care in the Home**—The pandemic has taught us that home-based care is preferred by many patients. According to a recent study, 61 percent of seniors would like to receive health-care services in their home.[9] Long before COVID–19, evidence pointed to home as a preferred site of care, including a study that found three in four adults 50 years and older would prefer to age in their homes and communities.[10]

– **Pandemic Experience Has Further Demonstrated it Is Safe to Provide Care in the Home**—The pandemic caused an explosion of home-based care, in part due to regulatory flexibilities such as the AHCAH waiver. Early data comparing pre-pandemic to now show that utilization of home- based services, such as home visits, has increased sevenfold in some cases.[11] These experiences demonstrate that care in the home is possible and safe.

Building on the longstanding evidence base, the success of delivering more care at home during the pandemic, and patient preference for home-based care, Congress has an opportunity to act by temporarily extending the HWW program for an additional two years while simultaneously authorizing a permanent model that allows hospitals to deliver inpatient hospital to Medicare beneficiaries at home.

Thank you again for holding this important hearing and for your thoughtful deliberation on how your committee can enable Americans the freedom to choose home as a clinical site of care. We look forward to working with you on this critical effort. Please contact Jeremiah McCoy at jmccoy@movinghealthhome.org with any questions.

Sincerely,

Krista Drobac
Founder

NATIONAL ASSOCIATION OF CHAIN DRUG STORES
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703–549–3001
www.nacds.org

Statement of Steven C. Anderson, FASAE, CAE, IOM,
President and Chief Executive Officer

Introduction

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement for the record for the Senate Finance Committee's hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." NACDS represents nearly 40,000 pharmacies (traditional drug stores, supermarkets and mass merchants with four or more pharmacies) who employ nearly 3 million individuals, including pharmacists and pharmacy technicians, among others.

NACDS commends the Committee's work to build better health by considering flexibilities granted during the Public Health Emergency. The nation called on pharmacies to deliver COVID–19 testing, vaccination, and other critical preventive care services to communities during the pandemic. Pharmacies seamlessly rose to the challenge, in large part due to more than a decade of pandemic preparedness and collaborative planning. Importantly, the COVID–19 flexibilities granted to pharmacies were instrumental in driving better health and fostering equity across communities. In reviewing lessons learned with an eye toward the future, these flexibili-

---

[5] *https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-program-new-mexico-improves-care-quality-and-patient.*
[6] *https://www.acpjournals.org/doi/10.7326/M19-0600.*
[7] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143103/.*
[8] *https://pubmed.ncbi.nlm.nih.gov/16330791/.*
[9] *https://www.signifyhealth.com/blog/for-older-americans-the-home-must-become-a-choice-for-patients.*
[10] *https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html.*
[11] *https://academic.oup.com/gerontologist/article/61/1/78/5921231.*

ties should be made permanent to foster sustained and equitable access to pharmacy care.

I. A Decade of Pharmacy Preparedness Significantly Strengthened the Nation's COVID Response

Pharmacies have spent the last decade building upon lessons learned from the 2009 H1N1 pandemic, including piloting pharmacy vaccination strategies. These planning efforts across industry and government paved the way for pharmacy's central position in the nation's COVID–19 response.

Consider these highlights demonstrating how this preparedness translated into results for communities across America:

- **Vaccination:** Building on years of pandemic planning and exercises, the Federal Retail Pharmacy Program (FRPP) was established to leverage pharmacy's strengths for public benefit:
  - Americans can conveniently get COVID–19 vaccines at 40,000 pharmacies nationally thanks to the FRPP, leveraging 21 national pharmacy chains and independent pharmacy networks.[1]
  - More than 40% of these sites are already in zip codes with high social vulnerability—a Centers for Disease Control and Prevention (CDC) index identifying communities needing more care.[2]
  - In March, a fraction of these pharmacies provided over 5 million vaccinations in just 4 days.[3] And, recent data show that of all FRPP vaccination doses 46% have been administered to people of color.[4]
- **Testing:** Pharmacies ramped up across states establishing more than 6,000 live testing sites that processed nearly 10 million samples under a public-private partnership with the Department of Health and Human Services (HHS).[5]
  - Nearly three-quarters of these sites serve areas with moderate to high-social vulnerability.[6]
- **Everyday Care:** Beyond providing COVID–19 vaccinations and testing, pharmacies kept their doors open throughout the pandemic, offering needed preventive care, dispensing critical medications, administering routine and catch-up vaccinations to adults and children, and providing patients with education and referrals.

II. Critical Flexibilities Paved Way for Expanded Access to COVID–19 Care at Pharmacies

The significant contributions made by pharmacies in supporting their communities throughout the COVID–19 pandemic were largely made possible by flexibilities granted during the Public Health Emergency. Specifically, federal actions taken under the PREP Act[7, 8, 9] leveraged pharmacies to provide enhanced public access to COVID–19 testing, COVID–19 vaccines, and routine and catchup vaccines for those 3–18 years old. Such actions, along with Congress requiring health insurers to cover COVID–19 testing and vaccination costs without out-of-pocket expenses,[10] were monumental. Collectively, these actions unleashed pharmacy teams from onerous and unnecessary federal and state barriers that have historically prohibited

---

[1] *https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html.*

[2] *https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/29/fact-sheet-president-biden-announces-90-of-the-adult-u-s-population-will-be-eligible-for-vaccination-and-90-will-have-a-vaccination-site-within-5-miles-of-home-by-april-19/.*

[3] *https://www.politico.com/news/2021/03/29/covid-vaccine-sites-478233.*

[4] President Biden Meets Virtually with a Bipartisan Group of Governors. Remarks by Dr. Nunez-Smith. May 11, 2021. *https://www.youtube.com/watch?v=e-8oTbbPA94.*

[5] By the Numbers—Coronavirus Pandemic Whole-of-America Response. March 8, 2021. *https://content.govdelivery.com/attachments/USDHSFEMA/2021/03/09/file_attachments/1717220/By%20the%20Numbers.COVID.FINAL.Mar.%208.2021.pdf.*

[6] *https://www.hhs.gov/about/news/2021/01/07/hhs-continues-community-based-testing-sites-covid-19.html.*

[7] U.S. Department of Health and Human Services, August 2020, *available at* HHS Expands Access to Childhood Vaccines during COVID–19 Pandemic.

[8] U.S. Department of Health and Human Services, October 2020, *available at* Advisory Opinion 20–03 on the Public Readiness and Emergency Preparedness Act and the Secretary's Declaration under the Act.

[9] U.S. Department of Health and Human Services. (December 2020). Fourth Amendment to the Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID–19 and Republication of the Declaration, available at *https://www.phe.gov/Preparedness/legal/prepact/Pages/4-PREP-Act.aspx.*

[10] *https://www.healthaffairs.org/do/10.1377/hblog20200326.765600/full/.*

them from providing such services to populations more broadly. These actions also removed cost barriers for patients.

Briefly, a high-level overview of flexibilities that were instrumental for expanding access to care at pharmacies include:

- **COVID–19 Testing at Community Pharmacies:** Critical actions taken by Congress, HHS, and the Centers for Medicare and Medicaid Services (CMS) abolished barriers in a stepwise manner to accelerate availability of pharmacy-based COVID–19 testing locations. Effectively, this helped spearhead efforts to break down barriers to pharmacy-based testing across many states and expand community access to the clinical expertise of pharmacies.
  - Through multiple actions under the PREP Act, HHS authorized pharmacists to order and administer COVID–19 tests, and to leverage pharmacy technicians for COVID–19 testing.[11, 12] HHS further clarified that federal guidance under the PREP Act preempts any state or local restrictions.[13] Additionally, CMS released guidance supporting pharmacy enrollment in Medicare as CLIA labs[14] and limiting cost sharing for COVID–19 testing.
- **COVID–19 Vaccinations and Routine Childhood Vaccinations at Pharmacies:** Similar to testing, the federal government took critical actions to clear the pathway for vaccinations at pharmacies throughout the pandemic. Doing so removed barriers that otherwise would have greatly limited the pharmacy team's ability to serve the public.
  - In addition to expanding access to COVID–19 vaccination, HHS aimed to improve childhood vaccination rates—hindered by stay-at-home orders and a decline in provider office visits. This was accomplished by expanding the ability for the pharmacy team (pharmacists, pharmacy interns, and pharmacy technicians) to provide immunizations to children more comprehensively across states.[15] This action was further clarified and reaffirmed by the agency.[16, 17]
  - Specifically, these actions authorized:
    - Pharmacists to order and administer, and appropriate pharmacy staff to administer, Advisory Committee on Immunization Practices (ACIP)-recommended childhood vaccines for persons 3–18 years old; and Food and Drug Administration (FDA)-authorized or FDA-licensed COVID–19 vaccinations to persons ages 3 and older.[18]

These government actions supporting pharmacy-based immunization and COVID–19 testing have been paramount in helping smooth the complex and erratic nature of state-by-state rules and regulations. The existing patchwork outside of temporary flexibilities can create significant patient access barriers, especially in states that have yet to modernize their statutory limits. While not all barriers have been abolished, pharmacies have leveraged these flexibilities effectively to operationalize broader delivery of care services.

---

[11] Guidance for Licensed Pharmacists, COVID–19 Testing, and Immunity under the PREP Act. (April 2020). *https://www.phe.gov/Preparedness/legal/prepact/Documents/pharmacist-guidance-COVID19-PREP-Act.pdf.*

[12] U.S. Department of Health and Human Services Office of the Assistant Secretary for Health. October 20, 2020. Guidance for PREP Act Coverage for Qualified Pharmacy Technicians and State-Authorized Pharmacy Interns for Childhood Vaccines, COVID–19 Vaccines, and COVID–19 Testing. *https://www.hhs.gov/sites/default/files/prep-act-guidance.pdf.*

[13] *https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/advisory-opinion-20-02-hhs-ogc-prep-act.pdf.*

[14] *See* Section 6003 of the Families First Coronavirus Response Act and Section 3713 of the CARES Act.

[15] U.S. Department of Health and Human Services. (August 2020). HHS Expands Access to Childhood Vaccines during COVID–19 Pandemic.

[16] U.S. Department of Health and Human Services. (October 2020). Advisory Opinion 20–03 on the Public Readiness and Emergency Preparedness Act and the Secretary's Declaration under the Act.

[17] U.S. Department of Health and Human Services. (December 2020). Fourth Amendment to the Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID–19 and Republication of the Declaration. *https://www.phe.gov/Preparedness/legal/prepact/Pages/4-PREP-Act.aspx.*

[18] *https://www.hhs.gov/sites/default/files/third-amendment-declaration.pdf; https://www.hhs.gov/sites/default/files/licensed-pharmacists-and-pharmacy-interns-regarding-covid-19-vaccines-immunity.pdf;* and *https://www.hhs.gov/sites/default/files/prep-act-guidance.pdf.*

III. Recommended Permanent Changes to Drive Health and Foster Equity Beyond the COVID–19 Pandemic

Communities have long relied on pharmacies to deliver quality care to all populations, including the high-risk and socially vulnerable.[19, 20] Through the COVID–19 response, the nation has built an infrastructure that allows Americans to benefit from quality, accessible, and equitable pharmacy care services. As we shift to COVID–19 becoming endemic and a return toward a focus on routine care services, communities ought to maintain their access to pharmacy care. And, as we look ahead to the next pandemic, tremendous opportunities exist to transform these flexibilities from temporary to permanent, preventing duplicative efforts in the future. *NACDS urges Congress to retain and build on the existing flexibilities to implement permanent pharmacy authority and payment mechanisms. Doing so would help Americans continue reaping the benefits of care services at pharmacies they know and trust into the future.*

Conclusion

As we look beyond the COVID–19 pandemic, pharmacies will continue to be important care destinations for patients. Health equity will rightfully remain a driving force in health care moving forward with care destinations, like pharmacies, meeting patients where they are. Further, mental health and substance abuse likely will emerge as lasting behavioral health impacts of the pandemic. We raise these forward leaning issues to say that pharmacies have experience providing destigmatizing care and routinely provide for patients essential screenings, counseling, treatment, and linkage to care. Oftentimes, pharmacies are the entry point for patients into the health-care system, further underscoring their value on a patient's health-care team. As the COVID–19 response shifts into recovery, pharmacies continue to serve their communities on the frontlines to meet their evolving health-care needs.

NACDS thanks the committee for the opportunity to offer our support for your tremendous work. We implore you to build on these lessons learned by transforming temporary flexibilities into *permanent pharmacy authority and payment mechanisms* to support the health and wellness of Americans beyond the pandemic. We welcome the opportunity to discuss these issues further. Please reach out to NACDS' Chris Krese, Senior Vice President of Congressional Relations and Communications at CKrese@NACDS.org or 703–837–4650.

NATIONAL INDIAN HEALTH BOARD
910 Pennsylvania Ave., SE
Washington, DC 20003

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for holding this critical hearing "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

Background—COVID–19 Flexibilities and Impact in Indian Country

As of June 1, 2021, the Indian Health Service (IHS) reported 197,459 positive COVID–19 cases, with a cumulative percent positive rate of 8.8% across all 12 IHS Areas.[1] However, IHS numbers are highly likely to be underrepresented because case reporting by Tribally-operated health programs, which constitute roughly two-thirds of the Indian health system, are voluntary. According to data analysis by APM Research Lab, AI/ANs are experiencing the second highest aggregated COVID–19 death rate at 51.3 deaths per 100,000. On March 12, 2021, the CDC reported that AI/ANs were 3.7 times more likely than non-Hispanic white people to be hospitalized and 2.4 times more likely to die from COVID–19 infection. Reporting by state health departments has further highlighted disparities among AI/ANs

---

[19] Gaskins RE. Innovating Medicaid: The North Carolina Experience, *NC Med J.* 2017, available at *https://www.ncbi.nlm.nih.gov/pubmed/28115558.*

[20] Berenbrok LA, Gabriel N, Coley KC, Hernandez I., Evaluation of Frequency of Encounters With Primary Care Physicians vs Visits to Community Pharmacies Among Medicare Beneficiaries, *JAMA Netw Open.* 2020;3(7):e209132, available at doi:10.1001/jamanetworkopen.2020.9132.

[1] Indian Health Service. COVID–19 Cases by IHS Area. *https://www.ihs.gov/coronavirus/*.

- According to the Centers for Disease Control and Prevention (CDC), AI/AN People are 1.7 times (70%) more likely to be diagnosed with COVID–19 when compared to non-Hispanic white people.
- According to the CDC, AI/ANs are 3.7 times (370%) more likely to require hospitalization when compared to non-Hispanic white people.
- According to the CDC, AI/ANs are 2.4 times (240%) more likely to die from COVID–19-related infection when compared to non-Hispanic white people.
- There have been 6,206 AI/AN deaths related to COVID–19 complications since the pandemic was declared. Nearly 60% of these deaths are from New Mexico, Arizona, and Oklahoma.[2]
- In Alaska, 34.8% of the total state's deaths are reported to be AI/ANs.[3]
- The disparity in COVID–19-related death rates is not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the most significant disparities. Among AI/ANs aged 20–29 years, 30–39 years, and 40–49 years, the COVID–19-related mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts.[4]
- Across 23 states, the cumulative incidence rate of laboratory-confirmed COVID–19 infections was 3.5 times (350%) higher among AI/ANs persons than non-Hispanic white persons.[5]

Unfortunately, the adverse effects of COVID–19 in Indian Country extend beyond these sobering public health statistics. Collectively, the IHS, Tribal, and Urban health system (known as the I/T/U), has been chronicly underfunded since its inception, and has relied on third-party revenue to stay afloat. Despite its underfunding, Indian Health Care Providers (IHCPs) have found innovative ways to provide quality care, even during the pandemic. The I/T/U system has taken full advantage of the flexibilities that CMS extended, allowing for leverage of new technologies; and recouping what would have otherwise been lost revenue, which is sorely needed.

One key flexibility is the "Four Walls" waiver that is extended through October 2021.This waiver, while not direcetly a result of the pandemic, has been crucial for the I/T/U system in dealing with COVID–19 This extension allows I/T/U clinics to receive the Medicaid 100% Federal Matching Assistance Percentage (FMAP) for services provided to an AI/AN Medicaid Beneficiary at sites outside the "for walls" of a clinic. These external sites can include remote vaccination and testing sites that have been commonplace in the public health emergency and allow treatment in otherwise underserved communities. These ancillary sites for care have long been important to providing quality care throughout Indian Country. Still, once this extension expires, an essential source of revenue for the I/T/U system will be diminished.

Telehealth has proven to be an invaluable tool to provide quality care during the public health emergency, and the flexibilities for its usage and reimbursement have been crucial to its expanded adoption. According to IHS, since initiating telehealth expansion, the agency has experienced an 33-fold increase in telehealth visits.[6] Additionally, the Government Accountability Office (GAO) released a report analyzing the federal response to COVID–19, showing IHS allocated $95 million of the $1.032 billion in total funding received under the CARES Act toward telehealth. While this adoption of telehealth as an alternative to in-person care is useful, much of Indian Country faces structural challenges to leveraging this new technology. Due to a significant lack of broadband infrastructure, only 46.6% of houses on Tribal lands have access to fixed terrestrial broadband at standard speeds established by the Federal

---

[2] National Indian Health Board. May 26, 2021. CDC Provisional Death Report, 6,533 Deaths, an increase of 51 weekly Deaths. *https://public.tableau.com/app/profile/nihb.edward.fox/viz/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths* .

[3] National Indian Health Board. May 26, 2021. CDC Provisional Death Report, 6,533 Deaths, an increase of 51 weekly Deaths. *https://public.tableau.com/app/profile/nihb.edward.fox/viz/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths* .

[4] Arrazola J, Masiello MM, Joshi S, et al. COVID–19 Mortality Among American Indian and Alaska Native Persons—14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1853–1856. DOI: *http://dx.doi.org/10.15585/mmwr.mm6949a3external icon.*

[5] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID–19 Among American Indian and Alaska Native Persons—23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169. DOI: *http://dx.doi.org/10.15585/mmwr.mm6934e1.*

[6] Todet, R.A.M. (2021, April 28). IHS expanded telehealth to provide care during COVID–19 pandemic. Indian Health Service Newsroom. *https://www.ihs.gov/newsroom/ihs-blog/april2021/ihs-expanded-telehealth-to-provide-care-during-covid-19-pandemic/*.

Communications Commission (FCC).[7] Many of our Tribal citizens are unable to access necessary telehealth-based care from the safety of their homes.

Our Tribal communities have endured a great many pandemics and tragedies in our history. Our people experience significant historical and intergenerational trauma resulting from genocide, forced relocation from our homelands, forced assimilation into western culture, and persecution of our Native cultures, customs, and languages. As a result, AI/ANs experience some of the highest rates of suicide, drug overdose, post-traumatic stress, and mental illness compared to all other races. While Indian Country remains resilient and committed to solutions, the COVID–19 emergency has reignited the historical trauma experienced at the hands of historical plagues such as smallpox and tuberculosis.

Congress reaffirmed the federal trust responsibility for health care under the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) when it declared that *". . . it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources to effect that policy."*

It is essential to remember that these obligations exist in perpetuity. As such, the federal government must ensure that Tribes are meaningfully and comprehensively included in any congressional review of COVID–19 flexibilities and support. While we appreciate the resources and flexibilities allocated for Indian Country thus far—including the $1.032 billion appropriated to Indian Health Service (IHS) under the CARES Act, the $64 million under the Families First Coronavirus Response Act, the $1 billion under the Consolidated Appropriations Act of 2021, and the $6.094 billion under the American Rescue Plan—these one-time additional funding increases and temporary regulatory flexibilities are not sufficient to stem the tide of decades of underfunding and neglect.

Policy Recommendations

To ensure that the efficiencies in health-care delivery, put in place as a response to the public health emergency, are built upon and not lost, we urge the committee to pass the following policy priorities.

1. **Amend the Social Security Act to ensure that all services provided through an Indian health-care program are eligible for reimbursement at the OMB all-inclusive rate.**

In 2016, CMS issued a Dear State Health Official (SHO) letter explaining that only services rendered within the Four Walls of an IHS or Tribal (I/T) clinic are eligible for Medicaid reimbursement at the all-inclusive rate (100% FMAP). CMS's interpretation means that if a service is rendered *outside* the Four Walls of a clinic by an IHS or contracted provider, the provided health service is not eligible for the same reimbursement under Medicaid. It is common practice within the Indian health-care system to use an ancillary site (like a school) or send providers into the community to deliver health-care services. In the SHO letter, CMS offered a solution that requires two actions, one by the Indian health program and another by the State Medicaid Agency. If IHS or Tribal clinics want to receive the "clinic" rate for Medicaid services provided outside the four walls, the I/T facilities must first convert to Federally Qualified Health Centers (FQHC). The state also needs to file a State Plan Amendment (SPA) to grant the Tribal FQHCs authority to bill at the "clinic" rate. With CMS approval, the Indian health program can receive the encounter rate, and the state is automatically paid at the 100% FMAP—increasing reimbursement to the I/T clinics while reducing the state's contribution to Medicaid

This presents multiple issues—first, Indian health programs may not want to convert to FQHCs for reasons other than to receive the reimbursement, as the conversion itself is burdensome. Second, not all States have good working relationships with the Tribes, and if no relationship (or a poor one) exists, the state may not see the benefits of amending its Plan. (One advantage is that Medicaid services to AI/ANs are reimbursed at 100 percent FMAP). Because this reimbursement depends on the state's action, it adds to the uncertainty for the Tribes, and in some ways, undermines the Tribes' status as sovereign governments.

This year CMS authorized an extension to its four walls grace period through October 31, 2021, to allow more I/T clinics to convert to Tribal FQHCs. One can expect

[7] U.S. Department of the Interior. (2020). Expanding Broadband Access. Indian Affairs. *https://www.bia.gov/service/infrastructure/expanding-broadband-access.*

that another extension will be requested given the CMS solution's onerous burden. The solution CMS proposed in its SHO letter and subsequent Frequently Asked Questions (FAQs) was only a band-aid. The agency's actions do not sufficiently address the reimbursement parity Tribes seek for delivering Medicaid services in a community-centered way. NIHB and other Tribal Organizations have advocated for a permanent fix to CMS's Four Walls issue for more than three years.

2. **Expand the Medicaid 100% FMAP to Urban Indian Organizations.**

The COVID–19 pandemic has created significant financial hardships for IHCPs. While I/T/U clinics receive 100% FMAP for services provided to AI/AN Medicaid beneficiaries, this FMAP does not permanently extend to Urban Indian Organizations (UIOs). In the American Rescue Plan, signed into law on March 11th, the 100% FMAP was expanded to UIOs for two years. While this temporary extension is crucial in providing additional federal dollars to UIOs to provide quality care, this FMAP increase must be made permanent to fulfill the Federal Government's trust responsibilities to AI/AN individuals.

3. **Increase flexibility in Medicare Definition of Telemedicine Services.**

COVID–19 has demonstrated the importance of telehealth to increase access to providers during the pandemic. But it has also demonstrated it can increase access to needed primary, specialty, and behavioral health services, particularly in rural areas. The telehealth flexibilities Medicare has made available during the public health emergency should be made permanent to the maximum extent possible. In addition, much of Indian Country is located in rural areas and lacks access to more advanced audio and video real-time communication methods. As a result, Medicare should allow telehealth to be provided through audio-only telephonic and two-way radio communication methods when necessary, and grant maximum reimbursement for services rendered through these modalities.

4. **Expand access to telehealth in the Indian Health System through increased funding and technical fixes.**

Limitations in the availability of AI/AN-specific COVID–19 data are contributing to the invisibility of the adverse impacts of the pandemic in Indian Country within the general public. Senior IHS officials, including Chief Medical Officer Dr. Michael Toedt, have stated publicly that existing deficiencies with the IHS health IT system are inhibiting the agency's ability to adequately conduct COVID–19 disease surveillance and reporting efforts.[8] Lack of health IT infrastructure has also seriously hampered the ability of IHS and Tribal sites to transition to a telehealth-based care delivery system. While mainstream hospitals have been able to take advantage of new flexibilities under Medicare for the use of telehealth during the COVID–19 pandemic, IHS and Tribal facilities have not because of insufficient broadband deployment and health IT capabilities. The IHS Tribal Budget Formulation Working Group previously outlined the need for a roughly $3 billion investment to fully equip the Indian health system with an interoperable and modern health IT system. It is critical that Congress provide meaningful investments in health IT technologies for the Indian health system to ensure accurate assessment of AI/AN COVID–19 health disparities and equip IHCPs with the tools to seamlessly provide telehealth-based health services.

5. **Permanently Extend Waivers under Medicare for Use of Telehealth**

CMS has temporarily waived Medicare restrictions on the use of telemedicine. *Yet, for many Tribes that lack broadband and/or telehealth capacity and infrastructure, it is not financially feasible to purchase expensive telehealth equipment for a short-term authority.* Making the telehealth waivers permanent would ensure that the telehealth delivery system remains a viable option for delivering essential medical, mental and behavioral health services in Indian Country, and helps close the gap in access to care.

Conclusion

The federal government's trust responsibility to provide quality and comprehensive health services for all AI/AN Peoples extends to every federal agency and department. As the only national Tribal organization dedicated exclusively to advocating

[8] Toedt, R.A.M. (2021, May 21). Testimony from RADM Michael Toedt on Examining the COVID–19 Response in Native Communities: Native Health Systems One Year Later before Senate Committee on Indian Affairs. HHS.gov. *https://www.hhs.gov/about/agencies/asl/testimony/2021/04/14/examining-covid-19-response-native-communities-native-health-systems-one-year-later.html.*

for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for those affected with COVID–19 and all Indian Country. We continue to appreciate your dedication to Indian health priorities and remain committed to working with you to protect and preserve the mental, physical, behavioral, and spiritual health of Indian peoples in the future.

98POINT6
701 5th Ave, #2300
Seattle, WA 98104
(866) 657–7991
https://www.98point6.com/

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

RE: Hearing held Wednesday, May 19, 2021, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

To Members of the Senate Finance Committee:

98point6 is pioneering a new approach to primary care. By pairing artificial intelligence (AI) and machine learning technology with board-certified physicians, our vision is to make primary care more accessible and affordable, leading to better health outcomes. 98point6 believes in meeting patients where they are by offering private, modern communication-enabled diagnosis and treatment via a HIPAA-compliant mobile application to increase primary care utilization and enable earlier medical intervention with reduced costs of overall care. As Congress debates lessons learned from the COVID–19 pandemic, we believe there are two changes that should become long term policy improvements: (1) making telehealth benefits an "excepted benefit" under Employee Retirement Income Security Act (ERISA), which is consistent and in-line with a current Tri-Agency (Department of Labor (DOL), Department of Health and Human Services (HHS), and Department of Treasury) temporary relief; and (2) making permanent a waiver that allows a high deductible health plan (HDHP) to retain its status as an health savings account (HSA)-qualified HDHP—wherein participants may make contributions to a HSA—if telehealth coverage is provided before the deductible. These changes will allow for continuity of coverage and access to virtual care for many individuals.

During the COVID–19 medical demand surge, 98point6 clinic volume exceeded 200% growth from the start of the year, with COVID-related concerns accounting for over 40% of all patient visits. The physician team at 98point6 and our technology-assisted approach to care enabled quality care delivered expediently, with the platform incorporating standards based on research, outcomes, and clinical quality monitoring of pandemic guidelines. Telehealth services offer a transformative paradigm shift for the uninsured, underinsured, and populations with limited access to physician care to readily access quality, inexpensive basic medical and primary care services. Amid the COVID–19 pandemic, telehealth has emerged as a viable and cost-effective solution across all demographic groups, including racial and ethnic minorities and rural populations lacking access to brick and mortar medical facilities.

Health disparities among racial and ethnic minority populations have been both highlighted and exacerbated by the COVID–19 pandemic. Disproportionately represented among "essential worker" categories, racial and ethnic minorities experience lower rates of employer-provided or other private health-care coverage. Employers representing more than three million part-time, non-benefits-eligible employees stand ready and willing to provide telehealth or virtual care benefit options at no cost to these employees, but are prohibited from doing so without exposure to penalties under, for example, the ERISA.

Under current law, when telehealth or virtual health-care services are provided by an employer, the benefit is considered a "group health plan" under ERISA (subject to mandates absent an exception, which trigger per-day penalties). ERISA § 733 and DOL regulations (29 CFR § 2590.732)—and conforming Internal Revenue Service (IRS) and HHS statutes and regulations—do not include telehealth or virtual care as an excepted benefit under ERISA. On June 23, 2020, DOL, HHS, and Treasury jointly issued an FAQ pertaining to the Families First Coronavirus Response Act,

the Coronavirus Aid, Relief, and Economic Security Act (CARES) and other health coverage issues related to COVID–19, that provided temporary relief from most group market reforms under part 7 of ERISA, title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code to employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan. This temporary relief has proven to be beneficial as a short-term fix, subject to the public health emergency, but a permanent solution is required to ensure long-term benefits of telehealth services can be accessed, across the spectrum of Americans in need.

Telehealth and remote care services should be an ERISA-excepted benefit when paid entirely by the employer or other plan sponsor. To that end, Representative Jackie Walorski (R–IN) introduced legislation in the 116th Congressional session, the Telehealth Benefit Expansion for Workers Act, to permit telehealth services offered under a group plan or group health insurance coverage as ERISA-excepted benefits (by adding, "Benefits for telehealth services" to Section 2791(c)(2)). This legislation is expected to be re-introduced in the current Congressional session.

In addition, the CARES Act clarified in Section 3701 that a HDHP retains its status as an HSA-qualified HDHP—wherein participants may make contributions to a savings account (HSA)—if telehealth coverage is provided before the deductible. This exception ends December 31, 2021. Most employers have taken advantage of this provision to waive fair market value charges for telehealth and remote care services through December 31, 2021, further enabling the policy goal of health-care access and inclusivity.

As employers begin preparing for coverage requirements and changes affecting off-calendar year plan years, however, potential mid-year changes may subject unwitting participants to billing inconsistencies upon termination of the CARES Act telehealth deductible waiver (impacting HDHP/HSAs). Similarly, employers utilizing calendar year plans are now considering how and when to communicate the impending elimination of the CARES Act telehealth or other remote care services waiver. Elimination of the waiver will require employees to pay the fair market value for telehealth benefits if the employees participate in a HSA-qualified HDHP. To address this irregularity and the fact that employees' out-of-pocket expenses are increased, the Internal Revenue Code should be amended to provide a permanent exemption for telehealth services by adding, "or telehealth and other remote care," to Section 223(c)(1)(B).

Permanent relief for telehealth services under ERISA penalties and HDHP waivers would enable employers to continue to provide important access to safe, high-quality health care for many of the 21 million part-time workers in America as well as the 28 million uninsured. Provision of telehealth services will improve health outcomes across the demographic spectrum, with highest gains among ethnic and racial minorities and those most impacted by the COVID–19 pandemic. Telehealth is estimated to save the health-care system up to $6 billion, factoring preemptive care and early detection, as well as ensuring communities have a lifeline to reliable health information. The statutory corrections requested would neither add to the federal budget nor be subject to a Congressional Budget Office score, as the telehealth services contemplated would continue to be employer-funded.

The COVID–19 pandemic has illustrated the immense benefits of telehealth services. The technology is available now to ensure that more Americans, including part-time "essential" workers—and the racial and ethnic minorities disproportionately comprising this category—as well as rural Americans without ready access to medical care, can access quality basic medical and primary health-care services.

Telehealth has proven benefits and public policy should reflect the technological shifts and consumer preferences that incentivize employers to provide telehealth services for expanded groups of employees (part-time workers) and at lower employee cost (in HDHP/HSA models). These two minor changes would bring significant benefits across the U.S. public health landscape.

Sincerely,

Robbie Cape
CEO and co-founder

OCHSNER HEALTH
1514 Jefferson Highway
New Orleans, LA 70121
phone (504) 842–3000
www.ochsner.org

Hon. Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Hon. Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: May 19th Hearing: "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of Ochsner Health (Ochsner), our physicians, nurses, and other health professionals and the tens of thousands of patients and communities we serve in Louisiana and Mississippi, we thank you for this opportunity to submit to you and your Senate Committee on Finance colleagues comments regarding **the May 19th hearing on "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned."** We commend you for your recognition to take time now to hold a hearing to examine the impact of telehealth on the COVID–19 response, and how those lessons learned may inform future federal policy with respect to telehealth.

We thank you in advance for your attention to our recommendations and the comments that may be submitted by our colleagues from associations representing health and hospital systems. Making permanent a number of the current federal telehealth waivers and other policy changes, expanding coverage and payment for telehealth and digital medicine services and devices, and otherwise supporting and facilitating the utilization of virtual care will help ensure that more patients have access to care, not just during emergency circumstances. These much-needed changes will help facilitate access to care for individuals from underserved and/or rural communities, and enable better access for those with mobility, transportation, and other challenges.

We stand ready to share our lessons learned over the past 14 months as we have addressed the myriad challenges associated with COVID–19 and how we have successfully deployed telehealth and digital medicine to care for patients with COVID–19 as well as maintain continuity of primary and specialty care for patients, families, and communities during this challenging and unprecedented time. We welcome the opportunity to be a resource to you, your staff, and Finance Committee members as you examine this critically important topic.

Summary of Policy Recommendations

We know that the topic of telehealth is an incredibly important and time sensitive issue and as such, wish to draw your immediate attention to our policy recommendations below, which can be found in further detail on pages 6–10 of this document. Background on Ochsner and our digital medicine and telehealth programs can be found on pages 2–5. Our COVID–19 telehealth and virtual care lessons learned are enumerated on pages 5–6.

The following provides a summary of the policy changes we urge Congress and CMS to support. These recommendations are informed by our experience in providing care throughout the public health emergency (PHE) and, in particular, being an early "hot spot" for the pandemic. With these changes, patients will have improved access to the primary, specialty, urgent, and emergency care they need and deserve.

- Make permanent the range of waivers associated with the provision of telehealth. Specifically, make permanent the flexibilities associated with: patient location, relationship between patient and provider, and the types of services that can be provided via telehealth. Further, maintain reimbursement for telehealth services at the in-person rate and permanently waive the application of copayments to remote patient monitoring services and other non-face-to-face services.
  - *Given the significant focus during the hearing on audio-only telehealth, we wish to note that the provision of audio-only telehealth services is an important aspect of telehealth, particularly for individuals who may not have access to broadband, smart devices, or other technology that enable a video-visit. Audio-only telehealth can help bridge the health care digital divide, address equity, and otherwise expand access to care for certain individuals*

and communities. Audio-only also is a clinically appropriate way to conduct low acuity visits, communicate with established patients, and coordinate care with patients as part of a remote patient monitoring program. To that end, we urge that reimbursement for audio-only telehealth be maintained under traditional Medicare (fee-for-service) beyond the PHE.

- Ensure that during a PHE cross jurisdictional licensure can be automatic, presuming certain conditions are met.
- Modify the Emergency Medical Treatment and Labor Act (EMTALA) to allow new types of medical screenings, such as pre-screenings that use technology that can help divert non-emergent cases to other, appropriate settings.
- Expand covered remote monitoring services to allow for beneficiary participation and Medicare coverage and reimbursement for more than one program, which will increase access, ease patient day-to-day care, and improve health outcomes.
- Provide digital medicine and telehealth tools/devices to Medicare patients at no cost to increase patient uptake of these services.
- Ensure patient access to TeleStroke services by establishing separate Medicare payment for providers giving both TeleStroke consult and same day inpatient care to Medicare beneficiaries experiencing acute stroke.
- Expand Medicare beneficiary access to non-stroke telehealth services for acute neurological conditions.
- Expand access to intensive care unit (ICU) telehealth.
- Provide payment to providers who are offering additional levels of remote monitoring for patients through programs such as TeleStork.

About Ochsner

Ochsner, headquartered in New Orleans, is one of the nation's leading integrated not-for-profit academic health systems. Ochsner—as a leader in value-based care and delivery system innovation—provides a comprehensive range of services through its clinically integrated network of a combination of owned, managed and affiliated hospitals, and nearly 200 total sites of care located throughout Louisiana and Mississippi. We are proud that our innovative partnership model through the Ochsner Health Network (OHN) allows many communities to maintain local ownership and control of their hospitals, while bringing to bear the benefit of the experience and breadth of the Ochsner clinical and operational teams. Ochsner offers a wide array of specialized and nationally ranked services with its 4,500 affiliated physicians, including more than 1,600 employed physicians practicing in over 90 specialties and subspecialties, and more than 30,000 employees. Each year Ochsner and its physician partners serve over 1 million individual patients who come from every state in the nation and more than 70 countries.

Louisiana regularly ranks near the bottom of the United States in nearly all health indicators, with a population that has a high prevalence of a number of risk factors for poor health outcomes, including obesity, tobacco use, poverty, diabetes, and cardiovascular disease. More than five years ago, Ochsner leaders recognized that it would take innovative strategies and deployment of new technologies and interventions to tackle these myriad challenges.

In response to the demand for better care at a lower cost and greater convenience to patients, Ochsner created an innovation lab, innovationOchsner (iO) to improve health through innovation with the following quadruple aim: improve the patient experience of care, improve the health of populations, reduce the per capita cost of health care, and improve the work life of the provider of care. The strategies to achieve these goals are: operational efficiency, differentiate product or service, create customer intimacy, and improve quality and safety. We are proud that our investment and focus in this area has resulted in ground-breaking innovations, which are measurably improving patient care and outcomes, and are reducing inefficiencies and costs.

iO has developed numerous digital medicine programs, particularly for those affected by chronic disease, in particular hypertension and diabetes, that are transforming the patient experience, enhancing health, and well-being, while reducing costs. More than 19,000 patients have been cared for in the Digital Medicine program, 80% of which are still enrolled. In addition, Ochsner provides more than 100 telehealth services to more than 185 hospital and clinic partners. Further, Ochsner continues to innovate in the direct-to-consumer market, with offerings such as Ochsner Anywhere Care for primary and urgent care needs.

Ochsner's innovative digital medicine approach using wearable technologies, remote monitoring, and virtual provider visits is substantially improving patient health out-

comes at a lower cost. Particularly for patients who are managing complex diagnoses and chronic disease we are easing the patient care experience by allowing them to receive the care they need, when and where they need it. And, critically, our pioneering telehealth program is meaningfully increasing patient access to medical services in rural areas of Louisiana and Mississippi where, in certain cases, no such access existed before. For many—and a growing population of our patients—telehealth and digital medicine are the standard of care and a preferred way in which they interface with the health-care system.

Examples of Ochsner Digital Medicine Offerings [1]

Ochsner's Hypertension Digital Medicine (HTNDM) program uses a connected blood pressure cuff to transmit blood pressure readings from the patient's home to be monitored by an Ochsner care team, which includes a pharmacist and health coach. This program has been shown to be three times more effective than traditional care at having patients achieve blood pressure control over 180 days, while also increasing patients' medication adherence and patient activation, and reducing the total cost of care.

An analysis by Blue Cross Blue Shield found that participants in the HTNDM medication adherence program led to an overall decrease in emergency department visits and inpatient hospital stays. The same analysis also found that the program saved $77 per member, per month, based on claims data and total cost of care.

Our Digital Diabetes Medicine (DDM) program uses a prescription, Bluetooth-enabled digital glucometer to monitor a patient's blood sugar levels and other health indicators. This program also has achieved results that are better than traditional care methods, including reductions in A1C, decreases in hypoglycemic events and diabetes distress, and increases in adherence to recommended health maintenance activities.

The Connected Maternity Online Monitoring (MOM) program provides pregnant patients with a Bluetooth-enabled blood pressure cuff and scale that interfaces with the electronic health record. This allows patients to perform remote monitoring during pregnancy, and as appropriate, decrease the number of in person prenatal visits, while increasing the frequency of monitoring for potential pregnancy complications. Analysis of data from early implementation of the program demonstrates that not only does it allow for earlier detection of hypertension in pregnancy, but also increases compliance with post-partum blood pressure monitoring in the initial days and weeks following delivery.

Examples of Ochsner's Telehealth Offerings

Ochsner deploys telehealth to deliver specialty, primary, and urgent care to patients near and far. We are proud to have created a network of hundreds of physicians who reside out of state and who—through multi-state licensure and the telehealth licensure compact—can deliver high quality care to our patients via telehealth, helping to ensure better access to care for underserved communities.

Access to specialty care has been expanded through the utilization of physicians with multi-state licensure who can treat patients via telehealth. Our "hub" and "spoke" model allows us to leverage our specialty physician workforce and expertise located in New Orleans to locations throughout Louisiana and Mississippi. For example, Ochsner provides emergency virtual psychiatric services, cutting emergency room wait times for psychiatric care at our partner sites by 50%. Telehealth can meaningfully increase patient access to telepsychiatry and telebehavioral health services for many patients in rural and underserved areas who are currently without access to such care.

Ochsner's TeleStroke program provides 24-hour/7-days per week coverage by vascular neurologists who—through telehealth—are immediately available to emergency department physicians in rural hospitals to help them quickly diagnose and treat patients presenting with symptoms of a possible stroke. The program has been instrumental in successfully treating thousands of patients (more than 300 patients per month) in a timely manner, and allows these facilities to remain open and successfully caring for patients in their own communities. **Seventy percent of Tele-**

[1] To learn more about Ochsner's digital medicine programs *see* the following article: *Washington Post: https://www.washingtonpost.com/business/economy/these-louisiana-physicians-can-monitor-your-blood-pressure--and-you-dont-even-have-to-leave-your-living-room/2018/07/11/6d57f198-7beb-11e8-93cc-6d3beccdd7a3_story.html.*

Stroke patients now stay local; prior to the program's implementation, nearly all patients were transferred.

Ochsner's TeleStork program, using live streaming of maternal and fetal health records, provides 24/7 monitoring to laboring mothers. Rapid detection of labor distress and maternal or fetal decompensation and facilitating early interventions by our specialty care team is helping reduce adverse maternal and neonatal outcomes. Since initiated in August 2016, there has been a 50% decrease in term unexpected Neonatal Intensive Care Unit (NICU) admissions in TeleStork facilities. Not only are the interventions effective in improving outcomes, but they have also been successful in driving changes in clinical practice that result in a decrease in the need for interventions, all of which ultimately lead to improvements in birth outcomes of newborns within the program.

In 2019, we announced a partnership with Tyto Care, the health-care industry's first all-in-one modular device for remote medical exams. This partnership expands Ochsner's current telehealth offering, a consumer-facing virtual visit platform called Ochsner Anywhere Care, which is powered by national telehealth leader American Well®. The Ochsner Anywhere Care Health Kit, powered by Tyto Care, is a portable health kit that enables patients to capture physical examination data at home using a handheld device with a digital camera and various attachments and then share it with a provider using the Ochsner Anywhere Care app. It is designed to replicate the exams performed during an in- office visit, by providing high-quality digital sounds of the heart and lungs, digital images and video of the ears, throat and skin, and body temperature. Special adaptors are included for examining the ears, throat, skin for taking body temperature, and listening to heart and lung sounds. To see a demonstration video visit: *https://ochsner.tytocare.com/*.

Since the pandemic began, we have sold thousands of Ochsner Anywhere Care Health Kits and through their deployment expanded access to primary and urgent care, allowing these patients to have access to care from the safety of their own homes. It is important to note that an Ochsner Anywhere Health Kit is not required for an Ochsner Anywhere Care or other telehealth visit, but it does provide tools to capture and share exam data, which can prove to be helpful for a provider making a diagnosis and treatment recommendation.[2] This offering has potential to expand access to care, particularly for individuals with mobility limitations, including disabilities and transportation challenges, as well as provide access to individual and families in rural and underserved communities. Further, through funding we received through the Federal Communications Commission (FCC) COVID–19 Telehealth Program, we have been able to purchase and are actively disseminating—at no cost to patients—nearly 12,000 devices to support patients in participating in our HTNDM, DDM, and Connected MOM programs.

Having additional resources allowed us to expand the reach of our digital medicine programs, which in turn, supported our ability to maintain continuity of care—and in some cases begin important health monitoring—of patients with hypertension and/or diabetes as well as support our patients during an important time during their pregnancy. With the availability of the FCC telehealth device funding, we are particularly pleased that we have been able to expand enrollment of Medicare and Medicaid beneficiaries in our digital medicine programs, as making the devices available free of charge has removed a significant participation barrier for many patients.

Lessons Learned from COVID–19

Prior to the COVID–19 PHE, Ochsner had long-advocated that Congress, the U.S. Department of Health and Human Services (HHS), and the Centers for Medicare and Medicaid Services (CMS) expand coverage and reimbursement for telehealth and digital medicine services and associated connected devices. We theorized that improvement in how these services and the associated devices are covered and reimbursed would accelerate their adoption, increase access to care, and in turn, leverage their potential in supporting patient engagement, expand provider access to more accurate and timely patient data, and enhance the patient experience.

---

[2] The Ochsner Anywhere Health Kit, powered by Tyto Care, retails for $299 with $10 flat shipping if ordered online at *www.ochsner.org/healthkit.* It is also available for purchase at Ochsner pharmacy locations *https://www.ochsner.org/services/pharmacy/,* O Bar retail stores *https://www.ochsner.org/shop/o-bar*, Ochsner Fitness Centers *https://www.ochsnerfitness.com/*, and Ochsner Total Health Solutions *https://www.ochsner.org/locations/ochsner-total-health-solutions*. Some insurance providers may provide a discount or partial reimbursement; it is recommended that consumers contact their insurance provider for more information.

Now, more than a year into the pandemic, we have real world experience and have seen this theory come to fruition. These technologies and care delivery modalities are making a difference in the lives of people diagnosed with COVID–19, those suspected as having COVID–19, and for patients who need access to non-COVID-related primary or specialty care. Fully deploying telehealth and digital medicine to our Medicare, Medicaid, and commercially insured patients has helped to maintain continuity and coordination of care, as well as allowed for expanded access to care to patients who previously had been underserved. In many cases, Ochsner has been able to reach patients who previously have had limited or no access to such services—particularly in rural and underserved areas where health-care disparities persist.

Over the course of the COVID–19 pandemic, Ochsner has observed in patient reported data a significant increase in utilization of telehealth services by minority populations, particularly among Blacks, where the percentage of patients completing virtual visits doubled. At the height of the COVID–19 outbreak in the "hot spot" state of Louisiana, Ochsner delivered more than 60 percent of visits to patients via telehealth—making Ochsner the leading health-care system in the South in the delivery of telehealth during the public health crisis. From the March to December 2020 period, we are proud to have deployed virtual visits in a robust manner to sustain continuity of care and reduce the risk of COVID–19 exposure for patients, family members, and providers. Specifically, during this period:

- We provided an estimated 291,100 total virtual visits to adult and pediatric patients;
- Virtual visits were delivered across all primary, medical and surgical specialties, with the bulk of care being primary care, behavioral health, and medical specialties;
- Approximately 30% (87,389) of our virtual visits were with Medicare beneficiaries; and
- Almost 40,000, or 14%, of virtual visits were with people with Medicaid coverage.

While Ochsner was able to quickly and adeptly expand our telehealth and digital medicine offerings due to our existing programs and infrastructure, other hospitals, health systems, and providers required significant time, resources, equipment, and training—of health professionals and patients—to scale up their remote care offerings, which in turn, caused some delay in patients receiving health-care services and outpatient treatment. We feel strongly that the nation's health-care system must maintain these advances during non-pandemic times to ensure that the infrastructure, practice, familiarity, and resources are in place so irrespective of what threat may emerge—natural disaster, bioterrorism, or infectious disease—that we have a strong, existing system so physicians, nurses, and hospitals can continue to provide health-care services across the care continuum.

Ochsner Policy Recommendations

The telehealth waivers granted by HHS and CMS have been critical to Ochsner's quick expansion and implementation of telehealth and digital medicine services. Since the start of the PHE and the advent of the waivers, in our telehealth program, we have seen an 89% increase in Louisiana patients from rural areas, as defined by the Health Resources and Services Administration. This increase is due to numerous factors, including a significant boost in patient interest in remote care and quick patient adoption to remote care. We commend HHS and CMS for providing these flexibilities and respectfully request that the Congress work with CMS and HHS to enact legislation and modify regulations, as applicable, to make these waivers permanent and ensure that we do not lose the gains made in telehealth and virtual care.

Telehealth Waivers Prioritized for Permanent Change

While all of the telehealth waivers provided by HHS and CMS have enhanced our ability to serve patients throughout the COVID–19 public health crisis, Ochsner believes that the following waivers, in particular, have enabled and fostered successful deployment of telehealth services to patients and these policy changes should be maintained once the pandemic has abated so that more patients—especially those in rural and underserved areas—can access treatment and receive more comprehensive and coordinated care.

1. **Patient location:** The ability of patients to receive telehealth services from any location, including their homes, has given patients access to services where in many cases they could not have accessed care. Telehealth has reduced the

need to travel for patients who are not as mobile and provides scheduled or on demand care and support through difficult stages of well-being. For example, telehealth has allowed patients in rural and remote areas without reliable transportation to more easily receive treatment by eliminating travel burden. For those patients with limited resources, telehealth has eliminated the cost of travel time and additional time away from work to receive an in-person visit. Further, for institutional-based patients such as those residing in skilled nursing facilities (SNFs), telehealth has given them the ability to remain in their care setting, minimizing both health risk and burden. Hence, making permanent the waiver permitting patients to receive telehealth from any location will eliminate a significant barrier for many patients who, before the telehealth expansion, faced challenges in accessing the services they need to get well and stay healthy.

2. **Reimbursement at the in-person visit rate:** Reimbursing for telehealth visits at the in-person rate has enabled Ochsner to offer services to patients in a financially sustainable and scalable manner. Adequate reimbursement for telehealth at the in-person visit rate ensures that providers receive appropriate payment for the full range of care they provide in the context of a remote visit. For example, often patients submit photographs, videos, and other medical information (*e.g.,* blood pressure readings, blood sugar data, etc.) in advance that their providers take time to review and analyze prior to—or following—a telehealth encounter. In a face-to-face encounter this often is done in real time and is reflected in the in-person payment amount. Further, providing reimbursement at the same rate as in-person care recognizes that the provision of telehealth services requires resources, such as technology and other infrastructure.
3. **New services eligible for telehealth delivery:** The significant expansion in the types of health-care services that can be delivered via telehealth has given Ochsner a way to reach patients previously not possible in many instances. For example, delivering occupational, speech/language, and physical therapy services via telehealth to patients in their homes or in SNFs has given patients new or increased access to care that improves quality of life and health outcomes. Pain management and palliative care and hospice patients and families have also benefited from the ability to connect with their providers through telehealth.
4. **No required established relationship between practitioner and patient:** Without the requirement of an established relationship between the patient and provider, Ochsner has been able to immediately serve a wider population of patients and address their care needs. Many patients living in rural and underserved communities do not have a regular source of health care and therefore do not have an established relationship with a provider. Making this waiver permanent will remove a significant barrier in access to treatment, especially for those many patients in rural and underserved communities who in many cases historically have received fragmented care.
5. **Waiver of Medicare remote patient monitoring and other non-face-to-face services copayments:** The HHS Office of the Inspector General (OIG)'s waiver of the Anti-Kickback Statute (AKS) for cost-sharing obligations for non-face-to-face services furnished through various modalities, including remote patient monitoring, remote monthly care management, virtual check-ins, and telehealth visits has eliminated a substantial barrier in patient access to care where, in many cases, patients simply do not have the resources to pay for services that are not immediate care needs but who could benefit from the care provided.

For example, as noted earlier, primary and secondary preventive services like Ochsner's DDM and HTNDM programs have reduced unnecessary emergency department visits, decreased inpatient admissions, increased medication adherence, and improved annual screening compliance, but unfortunately have been hindered by copayment barriers. Given the demographics of the Ochsner patient population, affordability of care is a serious impediment to our ability to manage chronic disease for too many of our patients. According to Kaiser Family Foundation, approximately 20% of Medicare beneficiaries in fee-for-service have no type of supplemental coverage, which makes paying out-of-pocket costs more challenging. Coinsurance often stands in the way of patients seeking and receiving the care they need, particularly for Medicare patients with limited resources.

Remote monitoring, such as our hypertension program, typically involves a monthly "charge" to cover the costs of having the data reviewed by the health-care team and

additional involvement by the physician should any adjustments to treatment or the care plan need to be made. We know from our clinical experience that for many beneficiaries the cost of the monthly out-of-pocket fee caused them to decline the opportunity to enroll in a digital medicine program. Yet, over the past 14 months, with the copayments waived, we have noted a significant increase in enrollment and participation among patients who need these programs, which in turn will help improve their health and reduce costs over time. Permanently waiving the copayment requirement for these non-face-to-face services will meaningfully improve access and much better enable Ochsner to more effectively and comprehensively care for patients, especially for patients in rural and underserved areas where significant disparities in care remain and must be addressed.

Other Waiver Related Policy Recommendations

In addition to the telehealth waivers enumerated above, HHS and CMS have provided additional waivers during the PHE that have strengthened our ability to continue to provide health-care services and outpatient treatment during the pandemic. Based on our experience with these waivers, we recommend that Congress and CMS work together to address the following:

1. **Cross jurisdictional licensure in the event of a PHE:** In the event of a PHE, there should be automatic allowance of CMS physician or non-physician practitioner licensing requirements when the following four conditions are met: (1) must be enrolled as such in the Medicare program; (2) must possess a valid license to practice in the state, which relates to his or her Medicare enrollment; (3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and (4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area. This change would have no effect on state licensure requirements.
2. **Modify EMTALA:** The 1135 emergency waiver authority has allowed the Secretary to waive enforcement of EMTALA. In response to the current PHE the Secretary allowed hospitals to redirect patients who present at the emergency department to an alternative screening site and to transfer individuals with an unstable emergency medical condition. To use these waivers, many health systems relied on technology to screen patients upon emergency department arrival. Outside of a PHE, such screening tools would not typically meet the medical screening requirements under EMTALA.

   While EMTALA is necessary to ensure that all patients have access to emergency medical care, **we urge Congress to revise the statute to allow for new types of medical screenings.** Specifically, many health systems hope to employ pre-screenings that use technology that can help divert non-emergent cases to other settings. The current medical screening requirements are so extensive that patients remain in the full queue of emergency department patients before it is determined that they could be diverted to another setting of care. More often than not, the patient is treated in the hospital after long wait times rather than being directed to nearby outpatient departments or physician practices, where the patient could have received appropriate care in a timelier manner and at lower cost to the patient and health-care system. We envision appropriate guardrails could be put in place by requiring hospitals to have their pre-screening approaches approved by CMS and requiring additional data submissions on patient diversion.

Other Policy and Payment Recommendations

1. **Expand covered remote monitoring services to allow for beneficiary participation and Medicare coverage and reimbursement for more than one program, which will increase access, ease patient day-to-day care, and improve health outcomes:** Federal health programs should permit patients to participate in as many remote monitoring programs as their health needs dictate. A significant number of patients have more than one chronic condition (*e.g.,* hypertension and diabetes) that would benefit from remote monitoring. Currently, Medicare only provides payment for one remote monitoring program/initiative, generally resulting in the provider receiving reimbursement for the program to which the patient consents first. Ochsner treats patients who would benefit from being enrolled in both our HTNDM and DDM programs because they have both hypertension and diabetes. For example, in Louisiana among Medicare beneficiaries aged 65 and older 65.63% have

hypertension and 27.99% have diabetes.[3] Hypertension is twice as common among people with diabetes as those without it and an estimated two-thirds of people with diabetes have elevated blood pressure and/or are treated for hypertension.[4] Among the population we treat at Ochsner, an estimated 75% of patients with diabetes also have hypertension. Many chronic care Medicare beneficiaries have multiple comorbid conditions. CMS data for Louisiana show that 28.63% of Medicare beneficiaries in the state have 2–3 chronic conditions and annual Medicare per capita spending for this group of patients is $5,999.[5] As such, the Medicare program and patients could benefit from allowing providers to offer a variety of remote monitoring services at the same time for all applicable documented diagnoses. Federal health programs should permit providers to bill for all remote monitoring services applicable to a patient's diagnoses to foster increased patient access to more coordinated and more comprehensive care, ultimately, resulting in improved patient health outcomes at a lower total cost-of-care.

2. **Provide digital medicine and telehealth tools/devices to Medicare patients at no cost to increase patient uptake of these services:** Patients often need technology or tools to support their health and well-being and allow for better care management by their provider team. As explained above, Ochsner's successful digital medicine programs require the use of connected smart devices that communicate with the care team. Patients must purchase these devices—in some cases entirely out-of-pocket and in other cases with some cost-sharing and some coverage. Unfortunately, as noted above, out-of-pocket expenses often preclude patients from accessing to the care, services, and tools they need to stay healthy and prevent catastrophic episodes of care. In our experience, approximately 10% of patients decline to participate in our digital medicine programs when they learn they have to pay for the device out-of-pocket. Therefore, Congress should expand Medicare payment policy to include full coverage of digital medicine devices (*e.g.,* Bluetooth-enabled blood pressure cuff, Bluetooth-enabled digital scale, Bluetooth-enabled digital glucometer) and telehealth devices (*e.g.,* Tyto Anywhere Care kit) and do so without any cost-sharing requirements. The overwhelming response to the Congressionally established COVID–19 Telehealth Program at the FCC has demonstrated the need for a funding mechanism for these devices. Ochsner has seen firsthand the willingness of patients to participate in these beneficial programs when they have affordable access to them. Expanding access to these important patient engagement and support tools will help providers leverage the full value and improved patient health outcomes that digital medicine and telehealth care can offer.

3. **Ensure patient access to TeleStroke services by establishing separate Medicare payment for providers giving both TeleStroke consult and same day inpatient care to Medicare beneficiaries experiencing acute stroke:** Ochsner commends the Congress for expanding Medicare beneficiary access to TeleStroke services as part of the Bipartisan Budget Act (BBA) of 2018. To foster further Medicare beneficiary access to TeleStroke services, Congress should permit Medicare to make two separate payments to a single provider for both a TeleStroke consult and the work of a subsequent stroke admission on the same day if the admitting hospital both provides the initial TeleStroke consult and later admits the patient after transfer due to the acuity level of the patient's stroke.

4. **Expand Medicare beneficiary access to non-stroke telehealth services for acute neurological conditions:** Patients in rural and underserved communities typically have significantly less access to treatment for acute neurological diseases. To build on the important expansion of TeleStroke care, Ochsner requests that Medicare provide *unrestricted* telehealth coverage for other non-stroke acute neurological conditions that typically require consulta-

---

[3] *https://portal.cms.gov/wps/portal/unauthportal/unauthmicrostrategyreportslink?evt=2048001&src=mstrWeb.2048001&documentID=69E5BACC452E9CC0D72D6DA872A90AF6&visMode=0&currentViewMedia=1&Server=E48V126P&Project=OIPDA-BI_Prod&Port=0&connmode=8&ru=1&share=1&hiddensections=header,path,dockTop,dockLeft,footer.*

[4] *https://www.hopkinsmedicine.org/health/conditions-and-diseases/diabetes/diabetes-and-high-blood-pressure.*

[5] *https://portal.cms.gov/wps/portal/unauthportal/unauthmicrostrategyreportslink?evt=2048001&src=mstrWeb.2048001&documentID=69E5BACC452E9CC0D72D6DA872A90AF6&visMode=0&currentViewMedia=1&Server=E48V126P&Project=OIPDA-BI_Prod&Port=0&connmode=8&ru=1&share=1&hiddensections=header,path,dockTop,dockLeft,footer.*

tions with emergency departments to achieve optimal patient health outcomes. These include diagnostic questions of numbness, weakness, vertigo, confusion, headache, tremors and seizures, leading to treatment of complications of spinal cord injury, nerve compression, brain tumors, Multiple Sclerosis (MS), Parkinson's disease, Alzheimer's disease, epilepsy, Amyotrophic Lateral Sclerosis (ALS), and many other conditions. Similar to the request for TeleStroke above, Congress should allow Medicare to make two separate payments to a single provider for both a non-stroke telehealth consult of an acute neurological condition and the work of a subsequent inpatient admission on the same day related to that condition if the admitting hospital provides both the initial telehealth consult and later admits the patient after transfer due to the acuity level of his or her neurological condition. Patient access to acute neurological telehealth services should not be limited by geographic or originating site requirements in the original Medicare telehealth statute.

5. **Expand access to intensive care unit (ICU) telehealth:** In many cases, patients in rural and underserved areas have to travel significant distances to receive emergency care. Through Ochsner's innovative telehealth offerings, we can give telehealth ICU consults that save meaningful time to treatment in many instances where immediate access to care can result in the likelihood of significantly better patient health outcomes. Congress should provide *unrestricted* Medicare coverage for telehealth ICU consults (*i.e.,* no originating or geographic site limitations) so that all beneficiaries can access the emergent care they need as quickly as possible.
6. **Provide payment to providers who are offering additional levels of remote monitoring for patients through programs such as TeleStork.** Offerings like TeleStork provide an additional level of specialized monitoring and clinical support to providers who are caring for maternity patients who may be at higher-risk for poor maternal and fetal outcomes. Because the care is not delivered directly to the patient there is no reimbursement provided for the service, yet in our experience it is cost-effective and cost-saving.

Conclusion

The federal waivers outlined above have allowed Ochsner's telehealth and virtual care programs to operate at their full potential, and in doing so, have demonstrated that telehealth and virtual care are high quality, efficient, and effective ways to treat patients safely both inside and outside of the clinic and hospital settings. Ochsner urges the permanent extension of these critically important waivers; making these changes permanent will allow us to continue providing care to patients that may otherwise go unserved.

Further, we thank you for considering our additional recommendations for ways to modify federal coverage and reimbursement policy to facilitate the provision of virtual care and patient monitoring in a cost effective and convenient manner and in a way that also reduces patients' unnecessary exposure to infectious disease, such as COVID–19. We believe that by strengthening our nation's telehealth, virtual care, and digital medicine infrastructure we will be able to maintain the access to care gains made over the past year and support hospitals and providers in continuing to provide care throughout the PHE and otherwise.

We thank you for your consideration of our recommendations and stand ready to serve as a resource. Sincerely,

Will Crump
Director of Public Health Policy

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE
1212 New York Avenue, Suite 1100
Washington, DC 20005

The Partnership for Employer-Sponsored Coverage (P4ESC) appreciates the Senate Finance Committee holding this hearing to discuss options for continuing healthcare delivery and policy flexibilities implored during the COVID–19 pandemic. P4ESC believes that the time is ripe to modernize laws to increase access to telehealth services as patients, health providers, and coverage plan sponsors adapted to remote working and social distancing measures by utilizing this care delivery method and benefit offered by many employers.

As an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and millions of Americans who rely on employer-sponsored health coverage every day, P4ESC is working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

P4ESC appreciates the COVID-related policies adopted over the last year to help employees and businesses, including expanding telemedicine availability to employees. Congress should build on this policy to provide employers with the ability to enhance employee coverage permanently. P4ESC is eager to work on bipartisan legislation to expand employee access to telemedicine, including enabling employers to offer a telehealth service plan to all employees regardless of their enrollment in the employer's medical coverage.

P4ESC supports: (1) treating telehealth services as an excepted benefit which would enable employers to offer this type of coverage to part-time and variable workforces, and other employees not enrolled in the employers' medical plan; (2) reforming licensure requirements to enable services to be offered across state lines; (3) establishing a national set of standards for telemedicine services to address state-based requirements that have not kept pace with technology, practice site and remote working advances, including eliminating originating site and prior provider relationship requirements; and (4) clarifying that CARES Act telemedicine provisions are effective for plan years on or after January 1, 2019 (employer plan years vary between non-calendar and calendar year basis).

According to the Society for Human Resource Management's (SHRM) *Navigating COVID–19: Impact of the Pandemic on Mental Health,*[1] "the COVID–19 pandemic has put unprecedented strain on workers' mental health the research finds that a majority of employees are experiencing symptoms of depression, but very few are receiving care." Findings include:

- Two out of three employees report experiencing symptoms of depression sometimes amid widespread lockdowns
- More than two in five employees feel burned out, drained, or exhausted by work
- 37 percent of employees have not done anything to cope with depression-related symptoms and only 7 percent have reached out to a mental health professional

The pandemic has offered employees the ability to receive mental and behavioral health services via telemedicine, and we strongly support making this access permanent. As noted in testimony before the House Education and Labor Committee hearing[2] on April 15, 2021, James Gelfand of the ERISA Industry Committee (ERIC) stated "[w]hen COVID–19 caused many employers to shift to remote work or reduced employee presence onsite, many worksite clinics went virtual, offering mental and behavioral health via telehealth. Some clinics expanded eligibility to other employees in the same state, who may not be based at the same site. This helped create continuity for employees undergoing care, and a new access point for many others."

Further, in an op-ed published in *The Hill*[3] on May 28, 2020, SHRM's Emily M. Dickens, Chief of Staff, Head of Government Affairs and Corporate Secretary, wrote "[g]reater access to telemedicine, including telepsychiatry, will provide the resources for employees to navigate all health-care options and privately seek the help that they need. The convenience of this offering will benefit employers and their employees because such services can be received at home and after work hours during a time when personal and professional schedules are anything but definite for so many workers."

In the employer benefits space, telehealth services come in different forms, such as: the ability for employees to be treated by a health provider or practice, with whom they already have a relationship, in a telemedicine setting instead of through a traditional in-office visit; and access to a telehealth service vendor which is included in a benefits package offering, similar to a dental or vision plan, that is separate from the medical plan but provides the ability to be connected to a physician or health professional for a consultation.

---

[1] *https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/documents/shrm%20cv19%20mental%20health%20research%20presentation%20v1.pdf.*

[2] *04–15–21 ERIC Testimony—E&L Mental Health Hearing [Final].pdf.*

[3] *https://thehill.com/opinion/healthcare/500017-assist-mental-health-of-workers-by-increasing-access-to-telemedicine.*

In the later example, the separate telehealth vendor program can legally be provided to full-time employees enrolled in the employer medical plan but not to other groups of the workforce. Part-time and seasonal employees, and full-time employees who declined the employer medical plan cannot access the telehealth vendor program because this type of stand-alone benefit would violate the coverage rules under the Affordable Care Act's (ACA) employer mandate. P4ESC supports legislation to enable employers to offer these excepted benefit telehealth service plans to all employees, regardless of their eligibility for or enrollment in an employer's medical plan. Offering this type of telehealth service to employees is not at all meant to circumvent an employer's responsibility to offer a medical plan to full-time employees under the ACA's employer mandate.

Additionally, as the Committee considers ways to improve access to telehealth services, P4ESC urges you to also consider network access and availability of behavioral and mental health providers. Employers and employees face challenges in finding available and affordable behavioral and mental health-care providers. Some behavioral and mental health providers—particularly those in rural areas—decline to participate in health insurance networks. In the case of most self-insured plans under the Employee Retirement Income Security Act of 1974 (ERISA), employers rent insurance carriers' provider networks. The decision to join a network lies with the provider, subject to network standards.

Because so many behavioral and mental health providers choose not to go in-network, employees can often face large out-of-network bills for care sought. It is important to stress that efforts to evaluate the availability of behavioral and mental health providers in health insurance networks must also consider whether these providers make themselves available and affordable to employees. Coverage requirements and civil monetary penalties on employers and insurance carriers are counterproductive, particularly regarding access and affordability, unless there is a countervailing requirement enforced by equal penalties for providers to participate in one or more networks.

The Partnership for Employer-Sponsored Coverage welcomes the opportunity to provide input and speak in further detail. Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers themselves. There is no one-size-fits-all employer plan, and the functionality of a business is centered around a productive, thriving, and healthy workforce. As a coalition representing businesses of all sizes, we have the unique ability to provide operational input across the full spectrum of the employer system—from the smallest family business to the largest corporation.

American Health Policy Institute
American Hotel and Lodging Association
American Rental Association
Associated Builders and Contractors, Inc.
Associated General Contractors of America
Auto Care Association
Business Group on Health
The Council of Insurance Agents and Brokers
The ERISA Industry Committee (ERIC)
FMI—The Food Industry Association
HR Policy Association
National Association of Health Underwriters
National Association of Wholesaler-Distributors
NFIB—National Federation of Independent Business
National Restaurant Association
National Retail Federation
Retail Industry Leaders Association
Society for Human Resource Management

PREMIER INC.
444 North Capitol Street, NW, Suite 625
Washington, DC 20001
T 202–393–0860
F 202–393–6499
https://www.premierinc.com/

The Premier health-care alliance appreciates the opportunity to submit a statement for the record on the Senate Finance Committee hearing titled "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned" on May 19, 2021. We applaud the leadership of Chairman Wyden and Ranking Member Crapo and members of the Committee for holding this hearing to evaluate the lessons learned during the pandemic and what the important flexibilities that have played in safely expanding access to care during the pandemic and options to extend telehealth capabilities into the future.

Many of the waivers and temporary regulatory changes granted during this period have significantly improved health-care providers' ability to combat the epidemic. These actions have also highlighted key opportunities to modernize health-care delivery by removing outdated regulations. Premier's hope is that by identifying temporary policies that proved successful in improving and innovating health care for Americans during this challenging time, we can pinpoint changes that should be made permanent or implemented on a broader scale beyond the pandemic.

Safely Treating Patients through Telehealth

Premier greatly appreciates Congress acting to broadly expand permitted uses of telemedicine and telehealth during the public health emergency in the *Coronavirus Preparedness and Response Supplemental Appropriations Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.* These provisions have allowed beneficiaries beyond just those in rural areas to receive telehealth services in their home from an expanded set of providers, including through audio-only communications, and provided payments to match in-office rate for clinicians who typically provide care in an office. As such, telehealth has provided a lifeline during the pandemic for individuals in all geographic areas who still need access to health care when traditional care delivery approaches are interrupted.

Premier data for more than 30,000 ambulatory providers nationwide shows that the use of virtual visits in the outpatient space have averaged 14.2 percent since the pandemic (an increase of nearly 30X compared to pre-pandemic) with a 31 percent better no-show rate than in-person visits. With this concentrated experience over the past year, providers have learned how to best deploy telehealth and patients are overwhelmingly reporting high satisfaction with their virtual care visits. As a result, it is now seen as a valuable and potentially cost-effective addition to health-care delivery.

As health systems and providers continue to support their communities and navigate a new normal after the pandemic, they are concerned that a retreat to prior rules will limit provider care delivery innovation for Medicare beneficiaries. A permanent expansion of telehealth policies will require appropriate guardrails. Recognizing more time is needed to determine the best approaches for permanent telehealth expansion in fee-for-service, **Premier urges Congress to permanently extend to all alternative payment models (APMs) the telehealth coverage and payment policies that were operationalized under the public health emergency.** Providers in APMs are incented to use telehealth only when it is most appropriate as they are responsible for the cost of care and improving quality. A survey[1] conducted by Premier found that providers participating in accountable care organizations (ACOs) drew heavily on their population health capabilities to manage COVID–19 cases and keep people staying at home healthy, including by quickly ramping up the use of telehealth.

We believe Congress should immediately start with allowing greater flexibility around the types of technology that can be used, adopting additional services, and exploring additional telehealth flexibilities through Center for Medicare and Medicaid Innovation (CMMI) models and other Medicare APMs. While telehealth waivers are available for APMs, they are far more limited than the waivers provided during the public health emergency. The greatest flexibility should be awarded in models in which providers bear downside risk, such as in global budgets and

[1] *https://www.premierinc.com/newsroom/press-releases/premier-inc-survey-clinically-integrated-networks-in-alternative-payment-models-expanded-value-based-care-capabilities-to-manage-covid-19-surge.*

capitated payments. Providing greater telehealth flexibility in models will be a tremendous incentive for providers to transition from fee-for-service to value and total-cost-of-care and other risk-based models.

As Congress considers how to make expanded telehealth a permanent part of our health-care system, we also encourage lawmakers to explore increasing telehealth access across all of Medicare fee-for-service and Medicare Advantage by granting Centers for Medicare & Medicaid (CMS) greater authority to set regulation on allowable health services and payment for telehealth services.

With appropriate guardrails, Congress should also take action to:

- Provide temporary state licensing reciprocity for telehealth during the pandemic by passing the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 168/H.R. 708).[2,3]
- Ensure audio-only telehealth continues to be an effective source of health care for all seniors during the course of the COVID–19 public health emergency by passing the Ensuring Parity in MA for Audio Only-Telehealth Act (S. 150).[4] This bill would count diagnoses obtained from audio-only telehealth services for risk adjustment purposes under the Medicare Advantage program to ensure that health costs are adequately covered while providing the information care teams need to manage patient care.

Ensuring Continued Movement to Value-Based Care

The pandemic has required greater care coordination across the traditional health-care silos as providers work to manage infected patients in the most effective settings. According to a Premier survey,[1] leading health systems and providers operating in value models were able to rapidly implement strategies to respond to COVID–19, expanding care management, call centers and remote/home monitoring and other capabilities to respond to COVID–19. Moreover, if we had made more progress in value-based care prior to COVID–19, with more entities in global budgets or capitation, we could have avoided the financial challenges many providers faced. We urge Congress to support a continued emphasis on movement to value by:

- Incenting providers to move to downside risk arrangements by extending the Advanced APM bonus by five years and giving CMS the authority to set the thresholds to qualify for the bonus;
- Fixing a perverse flaw in the Medicare Shared Savings Program that penalizes organizations in certain communities that are achieving savings for the Medicare program by including their ACO population in their spending benchmark calculation; and
- Removing risk adjustment caps from value models so that the complexity of patients is recognized in the benchmark.

Conclusion

In closing, the COVID–19 public health emergency has illuminated the need to allow more flexibility in Medicare payment and delivery system models so that providers can tailor care to the specific needs of beneficiaries and their communities. This is especially true for providers serving rural and underserved communities. Congress and the Administration can build on the limited flexibilities for telehealth and APMs granted during the public health emergency and make other key changes to open doors to providers who are seeking to better serve their Medicare populations through accountable delivery system models that focus on care coordination, improved outcomes and value.

The Premier health-care alliance appreciates the opportunity to submit a statement for the record on the Senate Finance Committee hearing on COVID–19 health-care flexibilities. Premier is available as a resource and looks forward to working with Congress as it considers policy options to continue to address this very important issue.

If you have any questions regarding our comments or need more information, please contact Blair Childs, Senior Vice President of Public Affairs, at blair—childs@premierinc.com.

---

[2] *https://www.congress.gov/bill/117th-congress/senate-bill/168.*
[3] *https://www.congress.gov/bill/117th-congress/house-bill/708.*
[4] *https://www.congress.gov/bill/117th-congress/senate-bill/150.*

PSYCHIATRIC MEDICAL CARE, LLC
8 Cadillac Drive, #230
Brentwood, TN 37027

May 19, 2021

Dear Chairman Wyden and Ranking Member Crapo:

Psychiatric Medical Care (PMC) appreciates the opportunity to submit a statement for the record to the Senate Finance Committee on "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." PMC applauds the members of the Finance Committee for their rapid action to expand access to telehealth services during the COVID–19 pandemic and strongly believes this expansion of health-care access should be maintained to address other health issues, such as America's ongoing behavioral health needs.

Founded in 2003 and headquartered in Nashville, TN, PMC is a leading behavioral health-care management company. Focused on addressing the needs of rural and underserved communities, PMC manages inpatient behavioral health units, intensive outpatient programs, and telehealth services in more than 25 states. The company's services provide evaluation and treatment for patients suffering from depression, anxiety, mood disorders, memory problems, post-traumatic stress disorder, and other behavioral health problems.

Critical Access Hospitals (CAHs) have provided outpatient hospital services via telecommunications technology during the COVID–19 pandemic by leveraging the Center for Medicare and Medicaid Services (CMS) waiver of the provider-based regulations described in "Hospitals: CMS Flexibilities to Fight COVID–19."[1] CMS clarified that hospitals could use this flexibility to designate a patient's home as provider-based and treat services rendered to such a patient in their home via telecommunications technology as if they were being performed in-person.[2] This flexibility to leverage virtual care to its full potential has proven crucial to meeting surging behavioral health needs during the COVID–19 pandemic. *However, even after the COVID–19 public health emergency comes to an end, America's behavioral health crisis will continue.*

Unfortunately, public health experts expect that the opioid crisis public health emergency, which has been exacerbated by the COVID–19 pandemic and further compounded the country's behavioral health challenges, will also continue. Indeed, in the months since COVID–19 brought the nation to a standstill, more than 40 states have recorded increases in opioid-related deaths.[3] Additionally, approximately 20 percent of the rural population experiences mental illness[4] and are disproportionally impacted by the opioid epidemic (SUD often co-occurring with mental illness).[5] Approximately 48,000 people die by suicide every year—the 10th leading cause of death in the United States.[6] These suicide rates were 40 percent higher in rural areas than in large urban areas (and are increasing at a faster rate).[7]

These challenges are particularly acute for Medicare beneficiaries. Approximately 33 percent of widowers become depressed—and while elderly adults represent only 13 percent of the population, they represent approximately 20 percent of all suicide deaths.[8, 9] At the same time, approximately 68 percent of elderly adults have little awareness about how to recognize and be treated for depression.[10]

---

[1] *https://www.cms.gov/files/document/covid-hospitals.pdf.*
[2] 85 Fed. Reg. 27750, 27563 (May 8, 2020).
[3] *https://www.ama-assn.org/system/files/2020-10/issue-brief-increases-in-opioid-related-overdose.pdf.*
[4] Rural Health Reform Policy Research Center (2014). The 2014 update of the rural-urban chartbook, available on Gateway at *https://www.ruralhealthresearch.org/publications/940.*
[5] Keyes KM, Cerdá M, Brady JE, Havens JR, Galea S. Understanding the rural-urban differences in nonmedical prescription opioid use and abuse in the United States. *Am J Public Health.* 2014;104(2):e52–e59.
[6] National Vital Statistics System—Mortality Data (2018) via CDC, *www.cdc.gov/nchs/fastats/suicide.htm.*
[7] National Advisory Committee on Rural Health and Human Services, Policy Brief and Recommendations, "Understanding the Impact of Suicide in Rural America," December 2017.
[8] National Institute of Mental Health, The Many Dimensions of Depression in Women: Women at Risk (1999).
[9] National Institute of Mental Health, Older Adults: Depression and Suicide Fact Sheet (1999).
[10] Depression in Older Adults: More Facts, Mental Health America (n.d.). Retrieved from *http://www.mentalhealthamerica.net/conditions/depression-older-adults-more-facts.*

In addition to maintaining access to critical services, the ability of CAHs to furnish outpatient behavioral therapy via telehealth has also improved continuity of care by easing some of the transportation barriers intrinsic to rural settings, which are invariably exacerbated during the winter months even in the absence of COVID–19. In other words, CAHs serve communities defined by barriers in accessing medical care, and CMS' flexibilities have enabled CAHs to not only maintain access to outpatient behavioral therapy during the COVID–19 period of health emergency, but these flexibilities have also driven CAHs to identify and implement more efficient and clinically appropriate delivery of care models that leverage telecommunications technology.

These rural behavioral health challenges are both a moral and economic imperative for communities across the nation. These are exactly the issues that Congress intended CAHs to address as providers of essential services in rural communities, and the telecommunications flexibilities granted during the COVID–19 pandemic that enable these facilities to meet these challenges should continue.

Why CAHs Are Different

As you know, CAHs receive their designation because they are viewed as critical health-care hubs within their rural areas and communities. This designation excludes CAHs from the outpatient prospective payment system (OPPS) for outpatient services unless they elect otherwise, because Congress understood that payment under the OPPS would generally not be adequate. Under the standard payment methodology for CAHs, a CAH receives payment for outpatient services under a reasonable ("fair market") cost-based methodology. More specifically, many CAHs as an institution receive payment for outpatient hospital services they furnish to patients and then pay the medical staff according to their own internal policies.

However, the telehealth statute is currently structured to provide fee schedule payment to "physicians" and "practitioners," not reasonable cost payment to *institutions* like CAHs. Specifically, with respect to telehealth services under section 1834(m) of the Medicare statute, section 1834(m)(2) requires that the payment for telehealth services be made "to a physician or practitioner located at the distant site . . .". Further, the terms "physician" and "practitioner" are defined in statute and may not generally include the state-licensed health-care professionals that CAHs rely on, by virtue of their rural location and scarce labor market, to provide outpatient behavioral therapy to their patients.

Unless Congress preserves CAH's existing reasonable cost payment methodology under which they receive payment for behavioral health services furnished via telecommunications technology during the PHE, CAHs will be unable to provide these services after the end of the PHE because Medicare cannot pay CAHs as an institution for "telehealth" services under a reasonable cost methodology. For a CAH to be able to furnish behavioral health services via "telehealth," it would need to affirmatively elect to bill under the OPPS for all outpatient services, which undermines the reimbursement flexibility Congress intended to provide to CAHs in the first place. Even then, the CAH would not be paid reasonable costs, and instead the "physician" or "practitioner" would be paid by Medicare the Medicare fee schedule amount for their professional services. Moreover, as discussed above, CAHs rely on state-licensed providers to furnish behavioral health services, and many of these providers may not be eligible to bill as "physicians" or "practitioners" under the Medicare program. These limitations would leave many Medicare beneficiaries in rural communities served by CAHs without mental health services, and would represent a significant decrease in our national capacity to address rural mental health needs.

Recommendation

Psychiatric Medical Care requests that the Senate Finance Committee take action to ensure that this important strengthening and expansion of rural behavioral health capability is preserved at the end of the public health emergency.

- Our preferred action in response to this problem would be a change to section 1834(g)(1) of the Social Security Act.[i] This approach would retain the standard billing structure that CAHs use and understand, while allowing the Centers for Medicare and Medicaid Services the flexibility to continue the delivery of virtual care by these facilities under that provision (rather than 1834(m)). CMS would retain its authority to make evidence-based decisions as to the services covered under this recommendation.
- Psychiatric Medical Care would also support a two-year extension of CMS's Hospital Without Walls flexibilities that are currently allowing the delivery of these telehealth services by CAHs, so that the Finance Committee can better

understand the importance of these services—particularly with respect to the delivery of behavioral therapy services to seniors in rural areas.

Finally, it is important to understand that while Congress passed legislation allowing the Medicare program to cover the provision of mental health services offered in the patient's home through telehealth in December 2020, that legislation did not make permanent the flexibilities afforded under the "provider-based" waivers that currently allow CAHs to bill telehealth services as if they were furnished in-person during the PHE. Without this flexibility, many CAHs will have significantly reduced capacity to provide behavioral health services through telehealth after the PHE expires.

We strongly encourage the members of the Finance Committee to Act to preserve these services for rural seniors. We look forward to continuing to work with you to expand access to health care for Americans.

Sincerely,

J.R. Greene, FACHE

---

[i] *Legislative Text for Consideration*

(a) EXPANDING TELEHEALTH FOR CRITICAL ACCESS HOSPITALS. Section 1834(g)(1) of the Social Security Act (42U.S.C. 1395m) is amended to read as follows:

"(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services of a critical access hospital is equal to 101 percent of the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

"(A) SPECIAL PAYMENT RULE FOR TELEHEALTH SERVICES.

"(i) IN GENERAL. Notwithstanding subsection (m) critical access hospitals may receive payment under this paragraph for outpatient critical access hospital services that are furnished via telecommunications technology, which may include the use of audio or visual equipment permitting two-way, real-time interactive communication between the patient and health-care professional at the critical access hospital.

"(ii) INITIATION OF OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES VIA TELECOMMUNICATIONS TECHNOLOGY. Services described in clause (i) may also be initiated via telecommunications technology as long as such services complement a plan of care that includes in-person care at some point, as may be appropriate."

(b) EFFECTIVE DATE. The amendments made by this section shall apply to covered outpatient critical access hospital services furnished on or after January 1, 2022.

TECHNET
805 15th Street, NW, Suite 708
Washington, DC 20005
Telephone 202–650–5100
Fax 202–650–5118
www.technet.org

May 19, 2021

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510

RE: "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

Chairman Wyden and Ranking Member Crapo:

Thank you for the opportunity to submit a statement for the record regarding the Senate Committee on Finance Hearing titled "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." We appreciate the efforts you are making to prioritize greater access to health-care services through telehealth as the nation recovers from the devastating COVID–19 pandemic, and we wanted to share with you TechNet's federal policy principles on telehealth.

TechNet is the national, bipartisan network of technology CEOs and senior executives that promotes the growth of the innovation economy by advocating a targeted policy agenda at the federal and 50-state level. Our diverse membership includes dynamic American businesses ranging from startups to the most iconic companies on the planet and represents over three and a half million employees and countless customers in the fields of telehealth, information technology, e-commerce, the sharing and gig economies, advanced energy, cybersecurity, venture capital, and finance.

Telehealth has fundamentally altered how patients experience care. New communication technologies allow health-care professionals to provide patients with medical care and services in convenient, affordable, and accessible ways. TechNet supports efforts that affirmatively enable the use of technology neutral, innovative systems to treat patients remotely and ensure the physician-patient relationship can be maintained and strengthened. The COVID–19 pandemic has demonstrated how critically important this is, as an increasing number of patients need to access safe, timely, and effective care. For example, the number of patients reporting at least one telehealth visit has increased by 57 percent since the start of the pandemic (Doximity).

With the onset of the pandemic, Congress provided the authority for Centers for Medicare and Medicaid Services (CMS) to lift the antiquated restrictions that conditioned eligibility for telehealth services on the location of a patient and the site of care. CMS also significantly expanded telehealth by approving more than 80 services eligible for reimbursement under traditional Medicare while allowing Medicare Advantage plans to use telehealth for the purposes of risk adjustment. These are only a few of the regulatory flexibilities Congress authorized to increase and enhance virtual care, and we believe that many of these temporary measures should be made permanent. Telehealth should be supported as a tool to practice medicine and ensure patients have access to affordable health-care options despite their proximity to health-care facilities or personal barriers restricting accessibility.

We look forward to working with you on this and other critical issues facing our nation. Please don't hesitate to reach out if we can be a resource on these important issues or if you have any questions. I can be reached at cholshouser@technet.org or (202) 372–7000.

Best regards,

Carl Holshouser
Senior Vice President

TELADOC HEALTH, INC.
2 Manhattanville Rd.
Purchase, NY 10577

June 2, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC 20515

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20515

RE: Teladoc Health Statement on the U.S. Senate Committee on Finance Hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

Dear Chairman Wyden and Ranking Member Crapo,

Teladoc Health welcomes the opportunity to submit a statement for the record for the May 19, 2021, U.S. Senate Committee on Finance hearing, "COVID–19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned." We appreciate your interest in leveraging telehealth and virtual care services to improve outcomes, expand access, address disparities, and reduce health-care costs for all Americans.

Founded in 2002, Teladoc Health is the world's only integrated virtual care system for delivering, enabling and empowering whole-person health—from wellness and prevention to acute care to complex health-care needs. The integrated services from Teladoc Health include telehealth, expert medical services, AI and analytics, and licensable platform services. With more than 2,400 employees, the organization delivers care in 175 countries and in more than 40 languages, partnering with employers, hospitals and health systems, and more than 50 health plans in the U.S. to

transform care delivery. Teladoc Health serves more than 40 percent of Fortune 500 employers, as well as thousands of small businesses, labor unions, and public-sector employers, which offer our virtual care services to their employees.

More than 70 million Americans access high-quality health-care support through Teladoc Health and our providers. In 2020, Teladoc Health Medical Group clinicians and therapists delivered more than 10.6 million unique virtual visits. Our hospital and health system clients completed more than 3.5 million patient visits using our technology platform. Additionally, more than 600,000 members use Livongo solutions to manage a range of chronic conditions. Our behavioral health solution saw an increase in use by over 500 percent in 2020.

While clinicians have used telehealth and virtual care services for decades, many Americans were unable to access virtual care due to overly restrictive and outdated policies at the state and federal level. In many cases, these barriers disproportionately impacted urban and underserved communities that rely on Medicare and Medicaid.

Yet, during the COVID–19 pandemic, telehealth proved to be a lifeline—providing Americans with access to critical health-care services while keeping vulnerable patients out of clinics and hospitals. Now, across the United States, at unprecedented levels, clinicians are leveraging virtual services to extend access to mental health, chronic condition management, primary and specialty care, and other critical services for patients who otherwise would not be able to see a physician in person. In terms of our services, Teladoc Health expects total patient visits to be between 12.5 million and 13.5 million for 2021 and we expect similar patient volume growth for our hospital and health system clients as they move to virtualize more aspects of care delivery post pandemic.

From a policy perspective, increased use of telehealth services was augmented by several key policy changes that Congress helped enable through the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act and which the Centers for Medicare and Medicaid Services further encouraged by waiving restrictions on exactly how, where, and who can access and deliver virtual care services.

Prior to the pandemic, only 13,000 Medicare beneficiaries accessed a telehealth service per week. Leveraging emergency flexibilities, providers delivered care to more than nine million beneficiaries via telehealth from March through June 2020. This alone underscores the critical role that virtual care can play in providing expanded, high-quality, convenient, and cost-effective access to many in-demand health-care services.

Without additional legislative changes, many of the temporary flexibilities implemented during the current public health emergency will expire, and patients, including beneficiaries enrolled in traditional fee-for-service Medicare, will continue to face substantial, outdated barriers to obtaining critical virtual care services.

Concerns With Respect to In-Person Requirements for Medicare Telehealth Services

As you and your colleagues consider the path forward for telehealth, we urge you to consider the unintended consequences of relying on in-person requirements as a policy tool. Given the bipartisan objectives of the Committee with respect to Medicare, we believe that restricting telehealth coverage for seniors using mandated prior in-person visits is not a viable strategy and would control costs in much the same manner as the existing statutory restrictions—by arbitrarily restricting access to care for America's seniors. Restrictions on telehealth that mandate a prior in-person relationship are clinically unnecessary, exacerbate health inequities, and would conflict with existing safeguards at the state level that would add to the existing regulatory morass that providers must navigate when delivering care virtually.

Health Equity and Racial Disparities

- As of 2019, 23% of Americans report not having a relationship with a doctor or health-care provider.[1]

[1] KFF. "Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity," October 13, 2020. *https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/*.

- 23% of Black and 39% Hispanic Americans do not have a pre-existing relationship with a health-care provider.
- In Oregon, 42% of Hispanic Americans do not have a pre-existing relationship with a health-care provider.
- Nearly 30% of all Idahoans do not have a pre-existing relationship with a health-care provider.

States Regulate the Practice of Medicine and Have Implemented Robust Safeguards

The use of technology does not alter the ethical, professional, and legal requirements around the provision of appropriate medical care by clinicians. The role of Medicare is to regulate and establish *payment and coverage* for Medicare physician and non-physician provider services, not to regulate *the practice of medicine or nursing,* which has long been the prerogative of the states.

Over the past decade all 50 states and DC have passed legislation to remove requirements for prior in-person consultations to establish a valid physician-patient relationship, so long as the standard of care is upheld. Today, not a single state in the U.S. mandates a prior in-person consult to establish a relationship. The evidence has been clear for some time that in-person requirements were, and remain, unnecessary and have no clinical basis of support. In fact, in 2014, the Federation of State Medical Boards (FSMB), the association of state regulators that oversee standards of medical care, issued guidance and model policy to state medical boards on regulating telehealth, that included safeguards to ensure providers are required to meet the appropriate standards of care when delivering care using technology.[2]

Patient Choice and Continuity of Care

In the past, some state medical associations have expressed concern that telehealth would allow other providers to "come between a patient and their doctor." In response, nearly all states have incorporated requirements into their telehealth statutes to ensure continuity of care by requiring that patients' medical records from telehealth consults be shared with each patient's primary care provider (with patient consent) or be readily and easily accessible to a patient to provide to their primary care provider or specialist.

The solution to enhancing continuity of care is to redouble efforts toward patient-centered health data interoperability rather than mandate that a patient sees a provider in person. The 21st Century Cures Act, the ONC Cures Act Final Rule, and the CMS Interoperability and Patient Access rule have accelerated the ability for a patient to access their personal health information and as implementation proceeds, will facilitate nationwide access to health records for patients, health-care providers, and payers.

Patients should have the choice to see any provider. Survey data from the pandemic shows that more than 70 percent of patients using telehealth saw their own doctor. The remaining 30 percent represent the millions of Americans who did not have a pre-existing relationship with a provider due to widespread Primary Care and Mental Health workforce shortages but were able to use telehealth to establish a relationship and receive care from a provider licensed in their state.

We cannot ignore the importance of providing all Americans, regardless of whether they have a medical provider with whom they have an established relationship, the opportunity to access health care. For years Congress has urged patients and consumers to make smart decisions about their health-care spending. Telehealth is simply a modality and is a safe and economical way to access quality health care with the patient in the driver's seat.

Antitrust Issues

The U.S. Federal Trade Commission (FTC) and the US Department of Justice have conducted numerous investigations into anti-competitive behavior from state medical societies and state medical boards that have used regulatory requirements for a prior in-person visit to restrict access and limit patient choice.

In fact, FTC staff recently submitted comments to CMS and addressed in-person requirements for Medicare telehealth services, noting the impact on competition, innovation, choice, and price:

> As discussed in a number of FTC staff advocacy comments, in-person examination requirements prevent licensed health-care providers from providing

[2] *https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf.*

telehealth care that they otherwise would deem appropriate. Such restrictions potentially reduce competition, innovation, consumer choice, and the supply and quality of care, and may also increase price. Accordingly, FTC staff advocacy comments have opposed proposed laws and regulations that prohibit the use of telehealth for initial, as well as subsequent evaluations. Rather, FTC advocacy has favored flexible provisions that allow the licensed practitioner in the best position to weigh access, health, and safety considerations to decide whether to use telehealth. Such policies, which allow the patient-practitioner relationship to be established by telehealth and typically hold the practitioner to an in person standard of care, are supported by several physicians' organizations.

Program Integrity

Antifraud enforcement and investigations of waste and abuse in federal health programs must be a priority. However, Congress must not allow program integrity concerns to inappropriately limit Medicare beneficiaries' access to needed care. Arbitrarily restricting telehealth coverage for seniors, including mandated prior in-person visits, is not a viable program integrity strategy.

In fact, in a recent statement, Principal Deputy Inspector General Christi A. Grimm stated unequivocally that bad actors using telecommunication services to perpetrate "telefraud" should not be conflated with the legitimate practice of telemedicine or imply that telehealth services are at greater risk of abuse than in-person services under Medicare.

Inspector General Grimm's statement is consistent with an HHS–OIG 2018 audit that found that the limited number of improper telehealth payments were the result of deficiencies in Medicare claims forms or the result of providers who inadvertently billed for telehealth delivered to beneficiaries outside of the 1834(m) geographic site restrictions.

Comprehensive anti-fraud statutes exist at both the federal and state level. HHS OIG and CMS have extensive program integrity policies and procedures in place to leverage existing authorities to address all fraud, waste, and abuse, including improper payments. However, Congress must ensure HHS and CMS have the necessary tools to combat bad actors and provide robust funding for critical antifraud programs.

Bipartisan consensus exists across a range of telehealth and digital health issues. We have presented recommendations in the appended white paper intended to provide a framework for how best to advance telehealth and virtual care both in preparation for future public health emergencies and on a permanent basis to ensure expanded access to quality care in the U.S. As detailed there, and noted previously in this letter, these changes can, and should, be made without unnecessarily limiting patient access to clinically appropriate care.

Thank you for the opportunity to provide a statement for the record. If you have any questions or would like to further discuss our recommendations, please do not hesitate to contact me.

Sincerely,

Claudia Duck Tucker
Senior Vice President
Government Affairs and Public Policy

Expanding Access to Care Through Proven, Quality, and Cost-Effective Digital Health Technology

Federal Policy Recommendations

January 2021

Overview

Health-care providers have long used telehealth and remote technology to provide timely access to needed health services, enhance the patient experience, improve health outcomes and reduce costs. During the COVID–19 pandemic, telehealth has proven to be a lifeline—providing Americans with access to critical health-care services while keeping vulnerable patients out of clinics and hospitals. Now, across the United States, clinicians are leveraging virtual services and platforms to extend ac-

cess to mental health, primary and specialty care, and other critical services for patients who otherwise would not be able to see a physician in person. More Americans than ever have engaged with a provider through synchronous real-time video or asynchronous technologies to access lifesaving prescriptions, receive follow-up care after an in-person procedure, or avoid high-cost ER and urgent care clinics for minor conditions.[1] Providers in underserved communities are deploying telehealth solutions to "beam" in specialists from across the country to rapidly respond and treat critical stroke patients, augment and support ICU's and NICU's, and use remote technologies to monitor long-term care patients and help patients overcome chronic diseases.

These rapid advances in virtual care were made possible, in part, because federal policymakers advanced a number of legislative and regulatory changes to enhance patient access during the COVID–19 public health emergency.

For example, Congress provided the Department of Health and Human Services (HHS) authority to waive Medicare's longstanding geographic and originating site restrictions on telehealth.[2] HHS and the Centers for Medicare and Medicaid Services (CMS) also leveraged emergency authority to waive many of the in-person requirements for services across Medicare programs while allowing Medicare Advantage plans to add new virtual care benefits and use telehealth for risk adjustment purposes.[3, 4] Congress also allowed high-deductible health plans (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching their deductible.[5]

These and other temporary COVID–19 policy changes have, overnight, opened the door to virtual care services that were previously unavailable to many patients in the U.S. In response, Teladoc has worked alongside our clients and partners—health systems, health plans, and employers—to help meet new demand as Americans have embraced virtual care on an unprecedented scale.

As of 2020, more than 70 million Americans have paid access to high-quality healthcare support through Teladoc Health clinicians and therapists. In 2020, Teladoc Health Medical Group clinicians and therapists delivered more than 10.6 million unique visits. Our hospital and health system clients completed more than 3.5 million patient sessions using our technology platform. Additionally, as of Q3 2020, more than 540,000 members use Livongo solutions for chronic conditions. Overall, Teladoc Health has seen utilization of services stabilize at a level that is 40% higher than before the COVID–19 pandemic with total visits expected to exceed 10 million for 2020.

In terms of Medicare, prior to the pandemic, only 13,000 beneficiaries accessed a telehealth service per week. Leveraging emergency flexibilities, providers delivered care to more than 9 million beneficiaries via telehealth from March through June 2020. This alone underscores the critical role that virtual care can play in providing expanded, high-quality, convenient, and cost-effective access to many in-demand health-care services.[6]

This experience has made clear that there is no clinical basis for the long-standing restrictions that have prevented Medicare beneficiaries from accessing services via telehealth from their homes, and it is time for Congress to finally take action to permanently extend access to virtual care.

As policymakers look to the future, it is important to note that telehealth is not a separate care delivery system. From a patient and provider perspective, telehealth is a tool to deliver health-care services by a licensed health-care professional to a

---

[1] "Synchronous" means an exchange of information regarding a patient occurring in real time. "Asynchronous" means an exchange of information regarding a patient that does not occur in real time, including the secure collection and transmission of a patient's medical information, clinical data, clinical images, laboratory results, or a self-reported medical history, *https://www.americantelemed.org/wp-content/uploads/2020/10/ATA-_Medical-Practice-10-5-20.pdf.*

[2] Section 3703, H.R. 748, CARES Act.

[3] *https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.*

[4] Centers for Medicare and Medicaid Services. Applicability of diagnoses from telehealth services for risk adjustment. April 10, 2020, *https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf.*

[5] Section 3701, H.R. 748, CARES Act.

[6] Early Impact of CMS Expansion of Medicare Telehealth During COVID–19, Health Affairs Blog, July 15, 2020, *https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/*.

patient at a different location. Since health care and the practice of medicine are primarily regulated at the state level, state legislatures and professional boards determine how and when clinicians can deliver care remotely. This provides federal policymakers with the opportunity to leverage federal health programs to incentivize and promote access to virtual care.

As Congress and the Administration work to expand access to care, efforts to harmonize federal and state requirements must be a priority to prevent fracturing an already complex patchwork regulatory landscape that has long hindered the uptake and adoption of virtual care. For example, in all 50 states, state law allows physicians to establish a relationship with a patient virtually.[7] However, in recent years some legislative proposals to expand Medicare telehealth services would require a patient to see a provider in-person before they are eligible for telehealth benefits. Not only are such in-person requirements clinically unnecessary, but they are also out of step with a decade of telehealth reform at the state level and would exacerbate the patchwork regulatory environment that hinders patients' access to virtual care.

In short, the challenges and shortcomings revealed by the pandemic have exposed a fragile and inflexible U.S. health-care delivery system. Without additional legislative changes at the state and federal level, many of the temporary flexibilities implemented during the current public health emergency will expire, and patients, including beneficiaries enrolled in traditional fee-for-service Medicare, will continue to face substantial, outdated barriers to obtaining critical virtual care services.

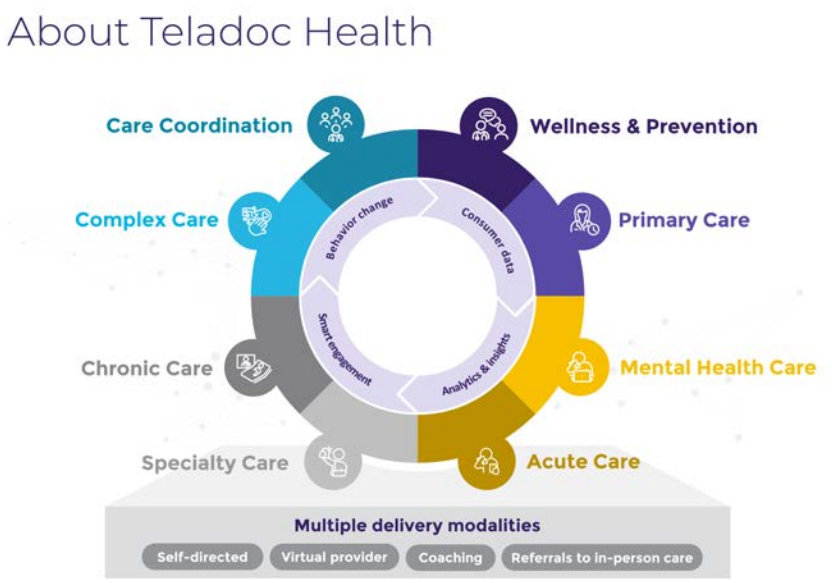
As Congress and the Biden Administration take stock of recent temporary COVID–19 policy changes and consider the important role that virtual care has played in improving care delivery during the pandemic in the U.S., efforts should focus on:

1. Determining if the authorities put in place by Congress and the Administration are sufficient for future public health emergencies, including pandemics.
2. Identifying and permanently extending certain flexibilities and authorities made available during the public health emergency.

As policymakers work to answer these questions, we encourage continued engagement with stakeholders to ensure that post-pandemic policies reflect the preferences of patients and the realities of those on the front lines of care delivery. Bipartisan consensus exists across a range of telehealth and digital health issues. The recommendations proposed in this document are intended to provide a framework for how best to advance telehealth and virtual care both in preparation for future public health emergencies and, perhaps most importantly, on a permanent basis to ensure expanded access to quality care in the U.S.

---

[7] *https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf.*



Teladoc Health is empowering all people everywhere to live healthier lives by transforming the health-care experience. Recognized as the world leader in whole-person virtual care, Teladoc Health leverages clinical expertise, advanced technology and actionable data insights to meet the evolving needs of consumers and health-care professionals.

For more information, please visit teladochealth.com or follow @TeladocHealth on Twitter.

Enhance Health-care Access, Convenience, and Outcomes

Virtual care technology can serve as a powerful equalizer by eliminating the barriers of time, distance, and geography and empowering patients to overcome the challenges and limitations of accessing in-person health care. Post pandemic, federal health programs must ensure that patients can access high-quality telehealth services anywhere, including the home. For a wide range of health-care services, providers utilizing telehealth have demonstrated the ability to provide the same level of care as in-office visits and shown that, in both rural and urban underserved areas, telehealth serves as the only means by which patients can quickly and conveniently access quality care.

Before the waiver authority granted through the Families First Coronavirus Response Act (FFCRA) and expanded under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, traditional Medicare allowed seniors and individuals with disabilities covered under the program to receive telehealth services only when located in certain rural areas of the country and at an eligible "originating site"—usually a clinic or hospital. This regulatory imbalance between in-person care and telehealth prevented the health-care system from leveraging the agility and convenience of virtual care with no clinical basis of support. These unnecessary and outdated restrictions were waived during the COVID–19 pandemic but will require action from Congress to be eliminated permanently.

Recommendation 1.1: Congress must reform 1834(m) of the Social Security Act and permanently eliminate the geographic and originating site requirements to enable Medicare beneficiaries to access telehealth services outside of federally designated rural areas and, importantly, from home.[8]

[8] Social Security Act, Pub. L. No. 104–321. Codified at 42 U.S.C. § 1320b–5.

Recommendation 1.2: Under current authority, CMS should permanently allow Medicare Advantage organizations to use telehealth, including both real-time interactive video and audio, for the purposes of risk adjustment.

Recommendation 1.3: Section 1135 of the Social Security Act provides HHS with authority to waive many of the requirements that could potentially limit the provision of virtual care during a national emergency, including EMTALA, Physician Self-Referral, HIPAA, and requirements that a provider be licensed in the state of the patient as a condition of participation in federal health programs. Under FFCRA and the CARES Act, Congress gave HHS additional authority to waive restrictions on telehealth during the COVID–19 pandemic. However, the waiver authority is limited to the COVID–19 PHE determination. Congress should ensure HHS and CMS can act quickly during future pandemics and natural disasters by granting permanent waiver authority for all public health emergencies under Section 1135 of the Social Security Act.

Incentivize 21st Century Virtual Care

Federal health programs should incentivize the expansion of virtual care and reimburse providers for all forms of telehealth. In addition, patients and payers should have more flexibility to use account-based plans and innovative coverage arrangements to help finance care. Private payers should compensate health-care providers for delivering virtual care; however, a provider and health plan should have the ability and flexibility to agree to reimbursement rates based on market conditions.

Recommendation 2.1: Congress should permanently allow pre-deductible coverage for telehealth and other remote care services for high-deductible health plans (HDHPs) paired with a health savings account (HSA).

Recommendation 2.2: CMS has historically taken a conservative approach to expanding telehealth services under traditional Medicare FFS. In response to COVID–19, CMS broadly expanded the list of eligible telehealth services available to beneficiaries for the duration of the PHE. COVID–19 has demonstrated that providers are able to responsibly deliver care remotely, and CMS should seek to broadly expand the list of eligible Medicare telehealth services that are demonstrated to be safe, effective, and clinically appropriate. For services that CMS needs additional evidence before initiating permanent coverage, the agency should create an additional pathway that would cover telehealth services on a temporary basis and allow providers to develop the evidence that the agency believes necessary for adding a service on a permanent basis.

Recommendation 2.3: Under Medicare FFS, there are two payment rates for many physicians' services based on the site of service: the facility rate; and the non-facility, or office, rate. For telehealth services, Medicare has historically reimbursed the billing provider at the facility rate since the costs (*i.e.,* staff and equipment) for the telehealth service were borne by the originating site where the patient is located, not by the provider at the distant site. This payment methodology has worked for delivery models where networked, affiliated hospitals and practices share costs. However, when the home is made an eligible originating site, payment rates must adequately compensate providers so as not to incentivize and favor in-person visits over virtual.

Recommendation 2.4: While reforming Medicare FFS to allow for telehealth must remain a priority, the power of telehealth to address costs and improve outcomes is best leveraged within risk-bearing payment arrangements. As CMS continues to pilot and expand value-based care models, expanding flexibility to use virtual care must be a cornerstone of key payment reform initiatives moving forward.

Recommendation 2.5: Congress should ensure Medicare enables virtual chronic condition prevention and management, including virtual-only providers in the Diabetes Prevention and the Diabetes Self-Management and Training Programs.

Recommendation 2.6: Congress should designate standalone telehealth as an ERISA excepted benefit to ensure that virtual services can be offered as a supplement to employees and dependents who are eligible for traditional group health coverage and to employees—and their dependents—who are ineligible for employer group health coverage.

Ensure Patient Choice and Provider Autonomy

The paradigm for health care has shifted in response to the rapid growth and ubiquity of digital technology. Prior to COVID–19, patients' expectations for how care is delivered had already significantly changed, and the pandemic further accelerated

these trends. Given the speed and proliferation of digital health, patients should be afforded the ability to choose the technology by which they want to interact and engage with their health-care provider. To expand patient choice, health-care services accessed and delivered remotely should not be held to a different standard than services provided in-person. The form of communication, or modality, should be determined by clinicians, in consultation with their patients, provided that it is sufficient to evaluate and diagnose the condition and meet the standard of care.

As the COVID–19 pandemic has demonstrated, Americans that do not have access to high speed Internet or broadband have challenges in accessing a provider through real-time video, and have come to rely on telephone and interactive audio visits to access care. A clinically appropriate telehealth encounter—when it includes informed consent, affirmative identification of patient and treating provider, a patient evaluation and diagnosis in accordance with the standard of care, and an appropriate treatment plan—should not be limited by arbitrary legislative or regulatory restrictions. Policymakers should pursue a technology neutral approach and allow health-care providers to determine what technology is best to treat patients. Telehealth should not have clinicallyunsubstantiated barriers to technologies if it is safe, effective, appropriate, and complies with HIPAA and all related state privacy requirements.

Recommendations 3.1: As Congress seeks to address the outdated geographic restrictions in traditional Medicare FFS, it should avoid imposing requirements for a prior in-person visit or limits on the type of technology that may be used for a telehealth encounter.

Recommendations 3.2: Congress should not limit Medicare beneficiaries' access to telephone-based communications, which has proven safe and effective across a range of use cases during the COVID–19 pandemic.

Recommendations 3.3: Congress and CMS should expand support for asynchronous telehealth technologies, including remote patient monitoring, to ensure beneficiaries are not limited to accessing virtual care via real-time video.

Recommendations 3.4: To address the ongoing substance abuse crisis, Congress must ensure that DEA finalizes the telemedicine special registration rule which would allow DEA-registered practitioners to prescribe controlled substances, such as certain kinds of medication-assisted treatment, without an in-person medical evaluation. The DEA has temporarily waived requirements during the COVID–19 PHE; however, the agency will need to promulgate and finalize the rule to ensure providers can continue to treat and prescribe controlled substances to patients post-pandemic.

Address Digital Literacy and Expand Telehealth Access to Underserved Communities

Underserved rural and urban communities, tribal nations, racial and ethnic minorities, and vulnerable patient populations all have higher prevalence of chronic conditions and should have equitable access to telehealth and digital health services. The pandemic has revealed that connectivity is a critical health-care resource and a prerequisite for expanding access to high-quality care. A patient should not be denied access to virtual care because they live in a community that lacks sufficient broadband access, cannot afford the appropriate technology, or are not comfortable using a computer or device. Underserved patient populations deserve the same savings, convenience, and access to care as patients elsewhere. Health disparities must be accounted for in federal health programs, and virtual care reform efforts should be coupled with targeted federal investment to help bridge the digital divide and help ensure autonomy and access for all seniors and caregivers that want to use it.

Recommendation 4.1: To address racial, ethnic, and income-based disparities while ensuring Americans in both rural and urban communities are not left behind, Congress must advance a national strategy toconnect all Americans via broadband and 5G, with robust investments targeted toward underserved areas of the US.

Recommendation 4.2: Building on the investments made in recent COVID–19 relief legislation, Congress should continue to invest in telehealth and remote care infrastructure for health systems that serve vulnerable patient populations, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Community Behavioral Health Centers (CCBHC), expand existing HRSA telehealth grant and technical assistance programs, and task HHS with developing a national strategy to support community health workers (CHW) to identify and work with

high-risk patients who need help with understanding how to use technology to ensure all Americans can access virtual care.

Recommendation 4.3: HHS and CMS should work with stakeholders to develop education and training resources that account for age, socio-economic, geographic, cultural and linguistic differences in how beneficiaries interact with technology and ensure seniors and Medicaid beneficiaries can fully leverage digital health technologies.

Recommendation 4.4: Congress and the Administration should revisit cost-sharing requirements for digital health. Monthly recurring copays for remote patient monitoring and other virtual care solutions can serve as a deterrent to those living with chronic and complex conditions that may benefit most from ongoing care management solutions.

Ensure Patient Privacy and Address Cybersecurity Risks

The protection of patient privacy and personal data are critical to the expansion of virtual care. Balanced federal health data privacy and cybersecurity policy are necessary to support innovation; however, telehealth and digital health technologies must be required to mitigate cybersecurity risks and protect patients' privacy and personal health data. Coordinated disclosure, information sharing, patient and provider education, and the development of consensus standards must remain the cornerstone of cybersecurity policy for regulated devices, mobile applications, and related health-care products to ensure that risks to patients and providers are mitigated.

Recommendation 5.1: Post-pandemic, the HHS Office of Civil Rights (OCR) should swiftly end the current COVID–19 PHE HIPAA enforcement discretion policy and ensure virtual care and telehealth encounters are conducted via secure HIPAA-compliant platforms designed to protect PHI. Patients should be assured that health-care providers are complying with HIPAA's privacy, security, and breach notification requirements when receiving care virtually.

Recommendation 5.2: While the Federal Trade Commission (FTC) has some authority to regulate organizations that are not considered covered entities under HIPAA, the FTC's authority is limited to practices that are "unfair or deceptive." To better protect patients and consumers and address the patchwork privacy framework for health data in the U.S., Congress should establish a Commission to study and issue recommendations for the protection of individual privacy that balances the need to preserve innovation, with clear rules of the road for the appropriate use of health information by mobile application and platform developers.

Recommendation 5.3: The Food and Drug Administration (FDA), HHS, and other health-care regulators already have broad authority to strengthen the cybersecurity requirements for regulated devices and products that could potentially be exploited by bad actors. Federal agencies must prioritize the recognition, promotion, and direct participation in the development of private sector consensus standards to ensure manufacturers and developers have a consistent framework for implementing cybersecurity safeguards. Given today's dynamic threat landscape, Congress and relevant agencies should also facilitate collaboration with health-care delivery organizations, medical device manufacturers, independent security experts, and academia through public-private partnerships to ensure that these stakeholders are able to quickly address and resolve emerging cybersecurity threats to patients and providers.

Expand Patient Health Data Portability and Ensure Interoperability of Digital Health Technology

The COVID–19 pandemic has demonstrated the importance of patients and providers having access to health-care data when and where they need it. Over the past decade, progress has been made to incentivize the adoption of technologies that are capable of exchanging electronic health information; however, data remains siloed and inaccessible across much of the health-care system. Congress and the Administration must remain committed to advancing a patient-centered interoperable health-care system that empowers patients and enables providers to deliver safe and efficient care.

Recommendation 6.1: CMS and ONC should remain committed to implementing the 21st Century Cures Act, including robust enforcement of the CMS Interoperability and Patient Access Final Regulation and the ONC Interoperability and Information Blocking Final Regulation—both of which will advance the uptake of patient access application programming interfaces (APIs) and facilitate greater

provider-to-provider and payer-to-payer data exchange. COVID–19 has placed an unprecedented burden on the nation's health-care system, and the agencies should extend implementation deadlines in line with the COVID–19 PHE.

Protect Patients and Taxpayers

The economic benefits of robust antifraud and abuse enforcement under existing federal law are much larger than monetary settlements when accounting for deterrence effects, including long-lasting changes in physician behavior and wasteful medical procedures.[9] Antifraud enforcement and investigations of waste and abuse in federal health programs must be a priority. However, Congress must be cautious about letting program integrity concerns dictate virtual care policy in traditional Medicare FFS. Arbitrarily restricting telehealth coverage for seniors, including mandated prior in-person visits, is not a viable program integrity strategy for Medicare. Such a strategy would cause Medicare Advantage and private health plans members to receive more robust telehealth benefits and could exacerbate health-care disparities. As virtual care is expanded, the federal agencies tasked with protecting federal health programs—and ultimately beneficiaries and taxpayers—must be appropriately equipped to maximize and leverage currently available technologies and strategies to audit claims and enhance fraud investigations.

HHS OIG and CMS must continue to invest in innovative strategies, appropriate private sector best practices, and leverage artificial intelligence and predictive analytics rather than rely on policies that would restrict access to virtual care.

Recommendation 7.1: HHS OIG and CMS have extensive program integrity policies and procedures in place to address fraud, waste, abuse, and improper payments. Congress should ensure HHS and CMS have the necessary tools to combat bad actors and provide robust funding for critical antifraud programs. Teladoc Health believes that the existing public-private partnership codified under Sec. 124, Public-Private Partnership for Health Care Waste, Fraud, and Abuse Detection, H.R. 133, Consolidated Appropriations Act, 2021 can significantly advance efforts to mitigate and prevent telehealth from being utilized as an avenue for fraud and abuse. We recommend strengthening the public private partnership by ensuring experts with experience in virtual care are included and represented on the executive board.

Recommendation 7.2: States should maintain responsibility for regulating the practice of medicine to ensure the full resources of the state are available for the protection of any patients that receive services that fall short of the standard of care. Federal policy should support and incentivize the adoption of interstate licensure compacts and other related licensure portability policies to ensure that clinicians can treat patients safely across state lines.

Infuse Innovation into Federal Health-care Programs

More than seven million federal employees have access to Teladoc Health solutions through their Federal Employees Health Benefit Program. There is great potential to empower those in federal service through contracting opportunities with entities like the Department of Veterans Affairs, the Department of Defense and the Indian Health Service. Supporting and caring for federal health beneficiaries with chronic conditions is a complex process that draws on many clinical and financial resources from across the federal government. From devices and supplies to care management, nutrition, clinic visits, and specialist consults, the points of contact for a beneficiary, and the associated agency cost/payment flows, are numerous.

Modern digital disease management solutions offer the potential to make things easier and meet federal health beneficiaries where and when they need support the most. Connected data can be combined with intelligent support and empathetic coaching that is available all day every day. Unfortunately, most federal beneficiaries with chronic conditions have little access to management tools such as this. Depending on their disability status, federal beneficiaries receive various levels of care from appointments to medications and testing. Across Medicare/Medicaid, VA, and IHS, beneficiaries are now receiving video visits via telehealth, as well as a small number receiving home-based remote monitoring. This piecemeal approach does not allow for scale or comprehensive cost analysis and is complicated for both beneficiary and federal agency alike.

---

[9] Howard, David H, and Ian McCarthy. "Deterrence Effects of Antifraud and Abuse Enforcement in Healthcare." Working Paper. Working Paper Series. National Bureau of Economic Research, October 2020, *https://www.nber.org/papers/w27900.*

Recommendation 8.1: Congress must continue to invest and ensure that federal health-care program beneficiaries through the Office of Personnel Management (OPM), the Department of Veterans Affairs (VA), the Department of Defense (DoD) and the Indian Health Services (IHS) have access to telehealth and other innovative virtual care offerings to manage their health and wellness.

Recommendation 8.2: As hospital systems, health plans, and employers, are seizing on modern virtual care methods to support their patients and beneficiaries with chronic conditions, VA, DOD, and IHS should create pathways to pursue Alternative Payment Models (APMs) for chronic conditions and diabetes management.