Partnership to Advance Virtual Care

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January 30, 2023

The Honorable Brian Schatz
U.S. Senate
722 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Mike Thompson
U.S. House of Representatives
268 Cannon House Office Building
Washington, D.C. 20515

Re: CONNECT for Health Act; Request for Feedback

Dear Senator Schatz and Representative Thompson:

On behalf of the Partnership to Advance Virtual Care (PAVC), we thank you for your on-going efforts to advance telehealth policy. Per your request, and as you will see from our comments below, we have recommendations around some of existing provisions in the CONNECT for Health Act of 2021 (S. 1512/H.R. 2903 in the 117th Congress). We also identified other policies for your consideration as you continue to comprehensively address expanding access to telehealth.

PAVC is a coalition of health systems, health IT vendors, innovators, chronic care specialists, and primary care stakeholders committed to providing and facilitating access to innovative, patient-centered care across the country. Our members are leaders working together to promote policies to preserve and advance access to virtual care services for patients and consumers. We appreciate the opportunity to provide feedback on how to update telehealth policy to meet the needs of patients and providers today and in the future.

Medicare Telehealth Policy Recommendations

Changes to Current Statutory Limitations. As you know, the Consolidated Appropriations Act, 2023, extended some Medicare telehealth flexibilities, originally provided in response to the COVID-19 public health emergency (PHE), through December 31, 2024. PAVC was pleased this two-year policy was enacted, as it provides some length of certainty for patients and providers. However, permanency remains a priority. To that end, PAVC has identified the following legislative barriers that would severely restrict patient access to care through telehealth if not permanently changed:

- *Geographic and originating site restrictions.* Before the pandemic, Medicare required that the patient be located in a rural or certain health professional shortage area and use telehealth in an approved originating site, such as a hospital or physician office. Together, these restrictions functionally prevent beneficiaries from accessing telehealth from a variety of appropriate and more accessible locations, including their home. Only about two 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)

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will not be allowed to serve as distant site telehealth providers. This would prevent low-income and geographically isolated individuals from utilizing telehealth visits to maintain continuity of care with their existing provider or connect with clinicians best equipped to meet their needs, creating barriers to affordable treatment for the populations who often need it most.

- *Qualifying providers.* Under current policy, the Centers for Medicare & Medicaid Services (CMS) would have to revert back to policies that restrict the types of providers that can deliver reimbursable care virtually 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.

PAVC appreciates provisions that will permanently address the barriers we have identified. Specifically, we are strongly supportive of the permanent elimination of originating and geographic site restrictions to secure beneficiary access to telehealth wherever the patient is located, including a patient's home. We also appreciate providing flexibility for CMS to permanently expand telehealth-eligible providers. Together, these policies can help patients manage their care more affordably and more consistently, reducing the need for emergency department (ED) visits and lowering the overall cost of care. Studies have estimated that even just a one percent conversion of ED visits to telehealth visits could result in an annual savings of more than $100 million.[1]

PAVC also supports ensuring telehealth reaches traditionally underserved areas and chronically and terminally ill populations. Allowing FQHCs and RHCs to permanently offer telehealth services maximizes provider resources, expands the reach of specialty care, and provides critical infrastructure in lower-income and geographically isolated areas. Furthermore, provisions focused specifically on allowing assessment for initial dialysis and hospice care visits via virtual care can help reduce overutilization and allow patients to manage advanced disease sooner.

Continued Access to Behavioral and Mental Health Services. The COVID-19 PHE has vastly accelerated the revolution in telehealth care delivery. During the pandemic, enhanced flexibilities and access to telehealth services, including behavioral health care services, served as a lifeline to patients across the country. The pandemic and the resulting economic recession have negatively affected many Americans' mental health, and created new barriers for those already suffering from mental illness and substance use disorders.

About four in 10 U.S. adults reported symptoms of anxiety or depressive disorder during the pandemic, compared to one in 10 adults who reported these symptoms in 2019.[2] This increased mental distress is occurring against the backdrop of already high rates of mental illness and

[1] Telemedicine, the current COVID-19 pandemic and the future: a narrative review and perspectives moving forward in the USA, Family Medicine and Community Health, August 2020.

[2] The Kaiser Family Foundation, The Implications of COVID-19 for Mental Health and Substance Use (Feb. 10, 2021).

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substance use that existed prior to the PHE.[3] Patients living with chronic conditions have unique mental and behavioral health care needs. As an example, dialysis patients suffer from high rates of depression and anxiety.[4] Maintaining access to high-quality telehealth services can vastly improve care for vulnerable populations.

According to the Health Resources and Services Administration (HRSA), roughly 37 percent of the U.S. population lives in a mental health professional shortage area.[5] As America's mental health continues to deteriorate, there are simply not enough mental health professionals to address increasing behavioral health needs. It is critical that we make behavioral health care services more available and accessible, and that we make the advances in behavioral telehealth care delivery a permanent part of our health care system.

To that end, the COVID-19 pandemic has had a particularly devastating impact on the mental wellbeing of America's seniors and those living with disabilities.[6] Enhanced access to mental telehealth services during the pandemic improved the lives of many Medicare patients across the country. To protect and improve the mental health of Medicare beneficiaries, we encourage you to consider repealing the "in-person requirement" for telehealth treatment of certain mental health conditions.

There is no compelling clinical reason to legislatively mandate an in-person visit for all Medicare patients for the expanded range of eligible mental health services. Whether a patient requires an in-person visit prior to commencing their mental telehealth treatment should be left to the clinical judgment of her health care provider. The nature of mental and behavioral health care services does not require in-person assessments with legislated frequency. In cases where an in-person visit would be warranted, providers can exercise their clinical judgment.

Additional (non-Medicare) Policies to Consider for Inclusion

Streamline Medicaid Provider Enrollment Process to Improve Access to Behavioral Health Services. We also respectfully encourage you to modernize the Medicaid provider enrollment process by amending Section 5005 of the original 21st Century Cures Act, to allow auto-enrollment of providers into Medicaid if they are already credentialed by a participating Medicaid Managed Care Organization.

Under Section 5005, all Medicaid providers must be enrolled directly with the state Medicaid agency. Unfortunately, this requirement did not consider the role that advances in virtual care plays in improving access to critical health care services such as behavioral health. In addition, it places an administrative burden and discourages Medicaid participation from providers operating in

[3] *Id.*
[4] See Mark Unruh, Renal and Urology News, Chronic Kidney Disease: Depression in Chronic Kidney Disease.
[5] USAFacts, Over one-third of Americans live in areas lacking mental health professionals (updated July 14, 2021).
[6] The Kaiser Family Foundation, One in Four Older Adults Report Anxiety or Depression Amid the COVID-19 Pandemic (Oct. 2020).

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multiple states, as Medicaid provider enrollment requirements, processes, and timelines vary by state. Further, some state Medicaid programs require providers to be physically located in the state, in addition to holding an appropriate license, to provide services to Medicaid beneficiaries. We support further Medicaid provider enrollment modernization, and request that you prohibit Medicaid programs from requiring a physical in-state presence or address for the purposes of provider enrollment.

Access to Telehealth for Beneficiaries with Employment-Based Coverage. PAVC supports a permanent extension the safe harbor created under the Coronavirus Aid, Relief and Economic Security (CARES) Act of 2020 to allow high deductible health plan (HDHP) participants to have coverage for telehealth services on a pre-deductible basis, allowing them to continue to make contributions to health savings accounts (HSA).

Section 3701 of the CARES Act created a safe harbor that allowed individuals with HSA-eligible HDHPs to have telehealth covered on a first-dollar basis without having to first meet their deductible. Roughly 51 percent of workers in the U.S. have an HDHP. As a result, millions of workers have been able to access quality care conveniently, remotely and affordably, mitigating the spread of COVID-19 and ensuring continued access to routine health care. For many individuals, this was not only a vital tool for staying safe, but also one that helped them access care that many employers waived fair market value charges on. PAVC was pleased this safe harbor was extended through December 31, 2024 as part of the CAA 2023. This policy should be made permanent.

In addition to providing temporary increased access to those HDHP beneficiaries, on June 23, 2020, the Labor, HHS and Treasury Departments 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.[7] Specifically, it stated that the agencies would take a non-enforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan. Therefore, unless and until legislation is enacted, the treatment of telehealth services as an excepted benefit is temporary and will expire once the PHE ends. Uncertainty has driven employer hesitancy to offer telehealth benefits that will have to be taken away a short time later. We encourage you to consider including language from the Telehealth Benefit Expansion for Workers Act of 2022 (H.R. 7353 in the 117th Congress) to permanently address this issue.

Assessing Equity – Language Barriers. PAVC believes more attention is needed to encourage comprehensive, interagency efforts to study and address methods for assessing whether agency policies and actions create or exacerbate barriers to full and equal participation by all eligible individuals. These efforts include the assessment of equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability.

[7] https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf

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While "disability" includes individuals who are deaf or hard of hearing, the category is broader than that. Many people who were born deaf would argue, in fact, that they do not have a disability at all, but rather, just speak a different language. Further, language access does not fit squarely in the disability category any more than it does in the categories related to race, income, or geography, though people in all of these groups can lack meaningful access to health care services due to a language barrier.

In order to more accurately assess and address health equity, PAVC recommends you take English language ability—or lack thereof—into account when updating telehealth policies. Efforts should be made to measure language ability through Census data, or other relevant data sources, and take steps to incorporate this data into health equity efforts.

Access to Accurate and Updated Provider Directory Information. Patients deserve access to accurate and up-to-date information when trying to appropriately identify a provider. There are a myriad of provider directories with varying levels of accuracy and sometimes very limited accessible information. CMS is considering feedback on a "national directory of healthcare providers and services" generated by a Request for Information in October 2022. We appreciate the discussion around what is appropriate for such a tool. In the meantime, existing provider directories, particularly in the private insurance market, could be more robust. PAVC encourages you to consider policies that would enhance provider director standards for all insurance providers. Patients should be able to know if providers have telehealth services as an option or if new patients are being accepted, for example.

Urgency Needed in Finalizing the DEA Telemedicine Special Registration. Responsible prescribing patterns must be a priority for all providers, regardless of whether they are seeing patients in-person or virtually. Importantly, the Drug Enforcement Administration (DEA) has waived requirements relating to an in-person visit prior to the prescription of medically necessary controlled substances during the COVID-19 PHE; however, the agency still needs to promulgate and finalize the telemedicine special registration rule allowed under the Ryan Haight Act to ensure providers can continue to treat and prescribe controlled substances via telehealth to patients post-pandemic. This needs to occur prior to the end of the COVID-19 PHE in order to prevent access disruptions, and the DEA has yet to issue an interim final rule.

We encourage you to ensure that the DEA promulgates the special registration rule and establishes clear rules of the road, which would allow DEA-registered practitioners to prescribe controlled substances, such as certain kinds of medication-assisted treatment, without an in-person medical evaluation.

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We appreciate the opportunity to submit these comments and are available to discuss further, at your convenience.