January 22, 2021

Michael E. Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

RE: MedPAC Recommendations to Congress on Telehealth Policy

Dear Dr. Chernew,

On behalf of the American Telemedicine Association (ATA), thank you for your commitment to thoughtfully considering commonsense Medicare telehealth policy and for the recent opportunity to engage with MedPAC on ATA policy priorities as well as member experiences. In response to our December 2020 meeting with MedPAC staff, the ATA is glad to provide some additional information to help inform your ultimate policy recommendations to Congress.

As the only organization exclusively devoted to expanding access to care through telehealth, the ATA appreciates the opportunity to share with MedPAC our federal policy priorities for 2021. During the COVID-19 Public Health Emergency (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 recommendations to Congress on how they should address this looming telehealth cliff, we request that you review ATA's Permanent Policy Recommendations as well as ATA's Federal Legislative Priorities.

At minimum, the ATA urges MedPAC to provide policymakers with recommendations to remove existing statutory barriers that limit access to care and not to recommend adding more restrictions to statute. 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 healthcare. Providers, patients, and possibly CMS clinical experts are best suited to determine clinical appropriateness of medical services, not Congress. 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. The ATA recommends MedPAC take this into consideration when offering policies to Congress. Further, the ATA urges MedPAC 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 will unnecessarily stifle innovation and tie the hands of regulators, providers, and patients.

During the PHE, America's health care system has heavily depended on telehealth technology, and ATA members have been proud to help ensure the continuity of care for American patients. As you consider utilization and telehealth data during the PHE, we urge you to recognize the unique circumstances during which this care was provided. As such, we caution you from making recommendations that will continue to restrict care based on utilization during the pandemic. Rather, we encourage you to ensure your recommendations reflect beneficiaries' and providers' growing interest in having telehealth as a choice when accessing care.

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 adds to complexities in the health-care system. In summary, the ATA has prioritized the following policies for consideration in the 117th Congress:

- 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 urges MedPAC to consider these policy priorities and to actively engage with telehealth stakeholders, including telehealth providers, health systems, and patient advocacy organizations. As such, we thank MedPAC for the thoughtful discussion in December of 2020 and are glad to provide additional details in response to specific questions raised during the meeting.

Direct to Consumer Care Model used in Medicare

Some ATA members that offer direct-to-consumer (DTC) services have partnered with Medicare Advantage plans for years before the PHE to deliver telehealth services to Medicare beneficiaries. At least one ATA member company has shared they are in the process of enrolling via the appropriate MACs to participate in Medicare fee for service but are not currently furnishing services to beneficiaries or billing Medicare for telehealth services.

Service Offerings through Direct to Consumer Model of Care

Examples of some DTC services ATA members provide include but are not limited to:

- **General Medical Care:** Connecting patients with care providers across a number of specialties who diagnose & treat healthcare needs—anytime, anywhere.
- **Primary Care:** From the annual exam and everyday health needs to managing chronic conditions and more complex challenges, members build an ongoing virtual care relationship with their primary care team.
- **Mental Health:** Convenient, stigma-free access to high-quality mental healthcare specialists
- **Chronic Care:** Address comorbid conditions and work with virtual care coaches to improve health outcomes
- **Complex Conditions:** Access expert specialists to make informed healthcare decisions with confidence
- **Partnering with Health Systems**: Help hospitals and health systems stand up their own virtual care programs with services ranging from telestroke to teleICU, to teleNICU.

We understand MedPAC may be concerned that expanded access to direct-to-consumer telehealth services could lead to fragmented care. Concerns about fragmented care were long used at the state level to justify restricting telehealth under state practice acts. Over the past decade, the telehealth community has worked with legislators and regulators in each state on requirements to prevent fragmentation. For example, a patient has full access to their medical records on many telehealth platforms and can use the platform to have records sent to their existing primary care provider or other physician. The efforts already underway at CMS and ONC to advance interoperability will begin to ease the burden on patients who find it challenging to share records between providers. However, the notion that our existing healthcare system is not already fragmented is a myth. Most health systems and providers struggle sharing basic patient data and robust technology driven care coordination is rare.

Modality Specific Policies

When making recommendations to Congress, MedPAC should remain modality and service agnostic as specifying specific technology or modalities in statute will only unnecessarily tie the hands of regulators, providers, and patients. On the issue of audio-only, federal law should not specify that one type of technology is superior to another. The COVID-19 pandemic has exposed a troubling fact that Americans are not living equitably with equal access to basic necessities, including reliable broadband connectivity.[1] Federal law and regulations should not unnecessarily and categorically exclude populations who may actually have the highest need for telehealth services, Medicare beneficiaries living with limited or no access to high-speed internet.

Currently the large majority of states allow a provider to establish a patient-provider relationship via interactive audio so long as the standard of care is upheld. As Congress and HHS work to expand access to telehealth, efforts to harmonize federal and state requirements must be a priority to prevent the further fracturing of an already complex patchwork regulatory landscape that has long hindered the uptake and adoption of virtual care.

Code G2012 Use

From the data we've seen it appears that nearly half of all claims for G2012 came from Short Term Acute Care Hospitals, the majority of which are in rural areas. The ATA has heard anecdotally from some providers that their institutions do not bill G2012 because they were not aware, or it was too much work within their respective EMR to document and submit bill for the ~$15 return. In concept, the code can be very effective, but in reality, the reimbursement rate is far too low to cover the practitioner's time and associated overhead with claims submission. Unless the payment rate is increased, there will be insufficient incentive for practitioners to seriously consider G2012 as an offered service.

[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488

CMS Engagement with Stakeholders

In terms of fraud, waste, and abuse concerns, the ATA recommends that CMS should identify what they see as the primary mechanism by which bad actors can use telehealth to abuse and/or defraud Medicare. We are confident providers and technology vendors can come together on solutions, but we first need to understand the true nature of the problem as these bad actors are not legitimate telehealth providers. We suspect the forces driving these telefraud arrangements are traditional illegal kickback referral schemes with cold-calls, routine waivers of patient co-pays, and no freedom of choice. We don't believe these schemes are driven by the use of telehealth technology itself.

The ATA believes policymakers' focus should be on developing fraud detection models, systems, and audit mechanisms to catch illegal prescribing and billing. Further, OIG should be staffed appropriately to enforce the current laws that are intended to prevent FWA, including through existing mechanisms like the Health Care Fraud and Abuse Control Program. The ATA urges MedPAC to avoid recommendations to Congress that would instead codify so-called "guardrails" like in-person requirements and other service-specific restrictions that do nothing to actually combat fraud but instead directly limit beneficiaries' access to care.

Thank you again for your thoughtful deliberation on how the federal government, and specifically federal statute, should 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 which all support the goal promoting a healthcare system where people have access to safe, effective, and appropriate care when and where they need it. We hope the recommendations and insights we've provided will be beneficial to you as you consider the anticipated recommendations for congressional action. Should you have any additional questions, please know the ATA is honored to continue to be a resource for you, the commissioners, and the MedPAC staff. We are always happy, too, to connect you directly with ATA members and experts

to answer specific questions related to how telehealth is really working for Medicare beneficiaries. If you have any questions or would like to further discuss the telehealth industry's perspective, please contact kzebley@americantelemed.org.

Kind regards,

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