April 18, 2022

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Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: ATA and ATA Action Response to CMS Medicaid and CHIP Reform Request for Information
Submitted via CMS RFI portal

The American Telemedicine Association (ATA), the only organization exclusively devoted to advancing telehealth, and ATA Action, the ATA's affiliated trade organization focused on advocacy, appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on Medicaid and CHIP Reforms around Eligibility, Enrollment and Access. During the COVID-19 pandemic, millions of Americans utilized telehealth in order to continue to receive critical healthcare services. According to a recent GAO study, Medicaid data from five states showed an exponential increase in utilization of telehealth services from March 2020 to February 2021, 32.5 million services were delivered via telehealth versus 2.1 million services the prior year.[1] Telehealth has become an integral component to our healthcare system, and we must ensure current and future policies allow all patients to continue to receive care where and when they need it. The ATA and ATA Action would like to respond to a few specific questions under objective 3 within the RFI.

Objective 3

Question 1: What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

Telehealth services can and should play a role in strategies to address health disparities and inequities in the U.S. Now, as CMS looks to better integrate telehealth into benefit design and further enhance provider networks, we encourage you to consider policies that afford flexibility and incentivize additional investment in technologies that allow plans and providers to deliver high-quality access to general medical and specialty care.

- **Harmonize Commercial and Medicaid Telehealth Coverage Requirements:** Despite the widespread adoption and acceptance of telehealth, gaps remain between coverage requirements for commercially insured Americans and those on Medicaid. While we understand that states are largely left on their own to determine what services are covered by Medicaid, there are many states arbitrarily disadvantaging individuals enrolled in Medicaid from having equal access to services as compared to those insured by their employer or a commercial health plan.

[1] https://www.gao.gov/products/gao-22-104700

For example, some states have in-person requirements ahead of or following a telehealth encounter in order to be covered, which serves as an access limitation especially in behavioral and mental health services. This is true for virtual care services delivered both by providers with existing in-person relationships with patients and those building new patient-provider relationships without an in-person component. The ATA and ATA Action are opposed in-person requirements. These arbitrary and antiquated requirements significantly restrict patient access to high-quality care. We believe that so long as the licensed provider obtains the patient's consent for the use of telehealth services, verifies the patient's identity, and discloses his or her own identity and credentials, the provider should be able to use any telehealth modality – synchronous or asynchronous with a new or established patient.

Many Americans have experienced a new clinician relationship, particularly in behavioral health, during the pandemic that has been virtual only with that provider. This has expanded access to care for those who may never have sought or received it before. We cannot go backward and remove that option, nor can we expect brick-and-mortar practices alone to absorb all of the need in the community.

Other states have restricted access to audio-only services only for Medicaid beneficiaries which have proven to be a lifeline for many underserved populations. According to data from Assistant Secretary for Planning and Evaluation (ASPE), "There were significant disparities among subgroups in terms of audio versus video telehealth use. Among telehealth users, the highest share of visits that utilized video services occurred among young adults ages 18 to 24 (72.5%), those earning at least $100,000 (68.8%), those with private insurance (65.9%), and White individuals (61.9%). Video telehealth rates were lowest among those without a high school diploma (38.1%), adults ages 65 and older (43.5%), and Latino (50.7%), Asian (51.3%) and Black individuals (53.6%)." Audio only services are imperative for those who do not have access to broadband or certain devices, such as laptops, within their homes. All telehealth modalities should be covered, and it should be left up to the provider's discretion as to which modality is best for the visit so long as it meets the patients' needs and the standard of care.

We encourage CMS to leverage the Toolkit and other national correspondence to demonstrate the value of telehealth and encourage states to implement policies and regulations that provide coverage for all modalities specifically for those on Medicaid.

Question 5: What are the specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP? (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

- **Make Permanent the Medicare Part B Telehealth Flexibilities:** The ATA and ATA Action's top priority is to ensure the Medicare Part B telehealth flexibilities implemented during the Public Health Emergency are made permanent. We encourage CMS to work closely with Congress to make these flexibilities permanent as state Medicaid agencies and private insurers typically follow the federal governments lead and implement similar policies. Permanency will lead to certainty, creating a telehealth friendly environment and increasing the number of providers willing to offer telehealth services.

- **Incentivize States to Implement Reciprocal Licensure Models:** Each state has different requirements, making multistate licensure applications a cumbersome and often costly process for physicians, nurses, and other healthcare professionals. During the pandemic, many states waived certain licensure requirements, allowing more clinicians to deliver telehealth services across state lines than ever before. Unfortunately, many state public health declarations have ended or are about to end, resulting again in another barrier to care.

  Expanded geographic telehealth use is critical to access. Creating flexibility and regulatory modernization that reflect new technological realities that allow providers to care for patients remotely will aid in reducing barriers to accessing care. Therefore, states should be incentivized to adopt interstate licensure compacts and other related licensure portability policies to ensure that clinicians can treat patients safely across state lines.

  This will also allow pre-existing provider relationships to continue, assures care continuity, and maintains quality care. The ATA and ATA Action seek regulatory modernization that advances telehealth by maximizing access to all healthcare services while assuring quality. This modernization can be done safely for patients and there is precedent for easing multistate licensing requirements seen by:
    - Arizona made permanent the rules allowing out-of-state medical providers to practice telehealth for Arizona residents, as long as they register with the state and their home-state license is in good standing.
    - Connecticut's similar rules have now been extended until June 2023.

  The federal government can play a positive role in state licensure by encouraging state legislatures to adopt reciprocal licensure compacts and helping ensure the compacts are working as planned. Policymakers in Washington can do so under the precedent that allows for the federal government to predicate funding on state legislatures adopting certain standards.[2] For more information please see the ATA's Recommendations on Enabling Healthcare Delivery Across State Lines.

- **Expand Access to Remote Prescribing of Controlled Substances via Telehealth** – There are over 6,000 mental health professional shortage areas (HPSAs) in the U.S., accounting for more than 135 million people.[3] Living in a rural or frontier community poses unique challenges to accessing behavioral health care, including greater distances to find care, which create financial and access barriers. In addition, living in a smaller community may heighten concerns around the stigma of having a behavioral health condition, presenting additional barriers for some people seeking care and support. Telehealth has proven to be a successful tool to deliver mental and behavioral healthcare during the pandemic, but post-PHE policies must allow providers to practice and prescribe via telehealth without additional barriers, such as in-person requirements.

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[2]In South Dakota v. Dole, the United States Supreme Court held that a statute conditioning receipt of federal highway funds on state adoption of a minimum drinking age is a legitimate use of federal spending power.

[3]https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf

Prior to the COVID-19 pandemic, a Drug Enforcement Administration (DEA) registered provider was required to see a patient in-person before prescribing controlled substances as a result of the Ryan Haight Act.

During the pandemic, this in-person requirement was waived allowing DEA registered providers to prescribe controlled substances via telehealth regardless of the patient's location. We urge CMS to work with Congress to make this flexibility permanent to ensure patients can continue accessing critical and lifesaving medications without having to travel long distances to see a provider.

If this in-person requirement were to be reinstated many patients, due to many factors, would stop seeking treatment. Waiving the in-person requirement would allow patients to continue to seek treatment in the comfort of their homes while having access to more telemental health and behavioral health providers. Additionally, this would create a uniform standard for all fifty states to follow.

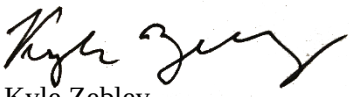
- **Ensure States Have Access to Medicaid and CHIP Telehealth Data:** For policymakers, healthcare providers and consumers, missing data often makes it challenging to adequately assess the needs of the diverse communities and recognize we need better, actionable data to assess and improve the ability to equitably support underserved and diverse populations. We encourage CMS to collect and publish telehealth data specific to Medicaid and CHIP, during and post PHE, for all policymakers to view and utilize as they implement critical telehealth policies to expand access.

- **Modernizing Medicaid Provider Enrollment to Account for Telehealth:** Medicaid provider enrollment applications include outdated requirements that fail to stay abreast of innovation in digital health care. In many states, Medicaid agencies require providers to have an in-state service address in order to be considered an in-state provider. When these conditions were established, Medicaid agencies did not anticipate the possibility of telehealth platforms that operate in multiple states or at a national scale. Consequently, telehealth platforms are blocked in many states from registering as in-state Medicaid providers if they do not have an in-state service address in each state they seek to offer services.

  This requirement is onerous and unnecessary and prevents many Medicaid beneficiaries from receiving the full scope of high-quality services and expertise. CMS should issue guidance to state Medicaid agencies, that if a provider is treating a patient in the state that they are licensed to practice medicine in, then they shall not be considered an out-of-state provider. This is a concrete step that can increase provider pools for Medicaid beneficiaries.

Again, the ATA and ATA Action thank you for the opportunity to comment on this important request for information. Please reach out to **kzebley@ataaction.org** Executive Director of ATA Action, if you have any questions.

Kind regards,



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