American Hospital Association™
Advancing Health in America

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January 30, 2023

The Honorable Mike Thompson
United States House of Representatives
268 Cannon House Office Building
Washington, DC 20515

The Honorable Dave Schweikert
United States House of Representatives
460 Cannon House Office Building
Washington, DC 20515

The Honorable Bill Johnson
United States House of Representatives
2082 Rayburn House Office Building
Washington, DC 20515

Re: Feedback on the CONNECT for Health Act

Dear Representatives Thompson, Johnson and Schweikert:

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 provide feedback on the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) Act, and to support Congress' continued efforts to transform health care through permanent telehealth reform.

At the outset of the COVID-19 pandemic, the federal government moved quickly to ensure hospitals and health systems were able to respond efficiently and effectively to a wave of unprecedented need. These actions included the Centers for Medicare & Medicaid Services (CMS) waiving certain regulatory requirements and Congress providing significant legislative support to ensure hospitals and health systems could manage the numerous challenges facing them, including by an increased ability to administer virtual care. These swift actions provided hospitals and health systems with critical flexibilities to care for patients during what has been a prolonged and unpredictable pandemic.

Spurred in large part by these waivers and legislative support, virtual care and telehealth services have increased dramatically over the course of the pandemic. A report from the Department of Health and Human Services found that in 2020,

telehealth services increased by over 51 million encounters, representing a 63-fold increase from 2019.[1] There is a growing body of evidence to suggest that for the vast majority of specialties, telehealth services provided during the pandemic were not duplicative of in-person services. For example, most recently, a study of over 35 million records by Epic found that for most telehealth visits across 33 specialties, there was not a need for an in-person follow-up visit within 90 days of the telehealth visit.[2] In many cases, telehealth served as an effective substitute for in-person care and did not result in duplicative care.

Expansion of virtual care has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients. Given some of the current health care challenges, such as major clinician shortages, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. **We applaud efforts by Congress to reduce barriers to care delivery by extending many telehealth flexibilities through the end of 2024 as a part of the Consolidated Appropriations Act that passed in December 2022. Indeed, AHA continues to urge that certain of these telehealth waiver provisions be made permanent.**

Since the CONNECT Act was first introduced in 2015, the landscape has changed significantly. For example, providers and patients have learned first-hand about application and benefits of technology in care delivery, and use of virtual care modalities is seen now as an expectation for many beneficiaries. **As updated telehealth legislation is being drafted, we encourage sponsors to consider the lessons learned from the pandemic and additional provisions that have supported expansion of access to care via telemedicine during the state of emergency.**

Specifically, we encourage the following.

Permanently Eliminating the Originating and Geographic Site Restrictions

Prior to the pandemic, patients had to be located in a rural designated area or health provider shortage area, and had to be physically located in a designated facility (like a physician's office or skilled nursing facility) to participate in a telemedicine visit. These requirements are waived during the COVID-19 Public Health Emergency (PHE). One lesson learned during this time has been that patients across geographies and settings, including both rural and urban areas, have benefited from the increased access and improved convenience provided by telehealth services. For example, patients with

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[1] https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic
[2] Telehealth Visits Unlikely to Require In-Person Follow-Up Within 90 Days (epicresearch.org)

chronic disease and mobility issues have experienced similar benefits in using telehealth for follow-up appointments regardless of their geography since they could receive care from their home. In fact, data from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) showed that the majority of patients using telehealth in 2020 (92%) received telehealth from their home.[3] Data from CMS' telehealth snapshot shows that from 2020 to 2021, there were more than 28 million unique telemedicine users, and 55% were from urban areas.[4] **While previous CONNECT Act language adds the home as an eligible originating site location, it may be more efficient to simply eliminate originating and geographic site restrictions altogether. Doing so would ensure that *all* Medicare beneficiaries can access services regardless of where they and their providers are physically located.**

Permanently Eliminating In-person Visit Requirement for Behavioral Telehealth

Behavioral health is one specialty area that has seen sustained growth in telehealth utilization. In fact, prior to the pandemic, telehealth visits accounted for less than 1% of behavioral health visits. During the pandemic, they peaked at about 40% of all behavioral health visits and have been sustained at around 36%.[5] Issues like increased demand for behavioral health services and shortages of behavioral health providers have contributed to this trend and underscore the continued need for virtual access. In addition more than 30% of the U.S. adult population has reported symptoms of anxiety and depression since the start of the pandemic (compared to 11% prior),[6] and provider shortages in areas like psychiatry are only expected to grow (estimates for 2024 indicate a shortfall of between 14,280 and 31,091 psychiatrists nationally).[7]

The Consolidated Appropriations Act of 2021 requires that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment and also must have an in-person visit annually thereafter. However, this requirement may, in fact, adversely impact access, quality and cost for behavioral health services. From an access perspective, requiring an in-person visit six months before and annually after may serve as a barrier to accessing services, particularly considering the majority of patients utilizing behavioral telehealth during the pandemic were in rural areas (55%).[8] This can in part be attributed to the fact that over 158 million people live in

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[3] medicare-telehealth-report.pdf (hhs.gov)
[4] Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic | KFF
[5] Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic | KFF
[6] Mental Health and Substance Use State Fact Sheets | KFF
[7] Projected Workforce of Psychiatrists in the United States: A Population Analysis - PubMed (nih.gov)
[8] Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic | KFF

mental health provider shortage areas as defined by the Health Resources & Services Administration (HRSA).[9] These patients are not able to readily see an in-person provider given the shortages in their geographic area.

From a quality perspective, ASPE has highlighted that part of what makes behavioral health a great use case for telehealth is the fact that in person and physical exams may not be required as frequently.[10] Finally, from a cost perspective, an analysis by Epic of over 4.3 million behavioral telehealth visits found that only 15% needed an in-person visit within three months.[11] Data from the pandemic suggest that behavioral telehealth visits were generally substitutes for in-person care, as opposed to overutilization of services. Therefore, while some patients may benefit from a periodic in-person evaluation, it should be left to clinical judgment, rather than an arbitrary general requirement. Indeed, adding a requirement for an in-person visit at specific cadences may unintentionally lead to scheduling of additional appointments that otherwise are not clinically necessary. **Therefore, in the interest of supporting increased access, improved quality and reduced costs, we recommend repealing the in-person visit requirements for behavioral telehealth services.**

Removing Distant Site Restrictions on Federally Qualified Health Centers and Rural Health Clinics

Historically, restrictions have been made on allowed distant sites (the locations where providers administering telehealth could be located). Again, since part of the benefit of telehealth is the ability to connect patient demand with provider capacity, restricting the sites for providers to administer services can negatively impact access and, in some cases, reduce patients' abilities to connect with their own providers. **Therefore, AHA supports allowing rural health clinics (RHCs) and federally qualified health centers (FQHCs) to serve as distant sites, so that these facilities may use the providers at their own sites to offer care to patients, ensuring patients remain connected to their primary providers. Furthermore, we support reimbursement at face-to-face rates and allocation of costs associated with administration of telehealth services to be considered allowable under FQHC prospective payment system and RHC All Inclusive Rate calculations.** These sites are important partners to hospitals, particularly in rural and underserved areas. The AHA supports allowing critical access hospitals the same ability to offer and bill for telehealth services.

Ensuring Reimbursement Parity Based on Place of Service Where the Visit Would Have Been Performed In Person

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[9] Shortage Areas (hrsa.gov)
[10] medicare-telehealth-report.pdf (hhs.gov)
[11] Telehealth Visits Unlikely to Require In-Person Follow-Up Within 90 Days (epicresearch.org)

Prior to the pandemic, CMS reimbursed providers administering telehealth at a facility rate regardless of if the provider were performing the visit from a facility or non-facility setting. However, such reimbursement did not account for practice related expenses, such as support staff to virtually room patients or software licenses. This was a challenge for providers, who were performing the same level of work and quality of care as in-person visits but receiving inadequate reimbursement. During the COVID-19 PHE, CMS updated guidance to reimburse providers at the rate they would normally receive if the patient were seen in person, which provided much more adequate reimbursement and therefore facilitated patient access to care.

Physician reimbursement should compensate for work expenses, malpractice expenses and practice expense related costs; these expenses are generally the same regardless of if the encounter were in person or virtual. For example, malpractice expenses, which cover professional liability insurance premiums, are the same regardless of the method that care is delivered. In addition, for practice expense (which covers staffing, supplies and equipment), virtual encounters may reduce supply expenses (like exam gloves or paper for exam tables), but increase technology expenses (like software licenses and hardware). For providers to continue delivering high-quality patient care through telehealth and other virtual services, they need appropriate reimbursement. Indeed, Section 1834 of the Social Security Act already requires that, “The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.” **As such, we would recommend clarifying language to specify reimbursement should reflect the same rate that providers would receive if the visit were in person based on the place of service where the care would have been provided.**

Continuing Payment and Coverage for Audio-only Telehealth Services

Virtual care represents a spectrum of different ways that telecommunications technologies can be used in care delivery, from synchronous real-time video visits, to audio-only phone visits, to remote monitoring of patient vitals. Prior to the pandemic, most payers, including Medicare, required that telehealth be performed using real-time audio-visual technologies. However, COVID-19 PHE waivers allowing coverage of audio-only services provided a needed access point for patients who had bandwidth constraints, lacked data plans or devices to support video-based visits, or who otherwise were not able to participate in audio-visual encounters. Indeed, a recent report from ASPE reviewing Census Bureau data from 2021 found that there were differences in utilization of audio-visual versus audio-only visits across different demographic subgroups like age, income level, race, insurance coverage and education level. For example, the majority of surveyed respondents 65 and older used audio-only visits (56.5%) compared to video visits, partly driven by the fact that over 26% of

Medicare beneficiaries reported not having computer or smartphone access at home.[12] Continued coverage and reimbursement for audio-only services will ensure that patients without access to technology are still able to access care where clinically appropriate. **Therefore, we would encourage explicit addition of Medicare coverage and payment for audio-only services in statute.**

Permanently Expanding the Eligible Provider Types

Historically, Section 1834 of the Social Security Act limited the types of providers who were able to administer telehealth services. During the COVID-19 PHE, CMS expanded the list of providers able to deliver telehealth to include physical therapists, occupational therapists, audiologists and speech language pathologists. Indeed, recent studies from Harvard Medical School and Spaulding Rehabilitation Hospital found high levels of patient satisfaction across age, gender and these specialties of physical therapy, occupational therapy and speech language pathology. Survey respondents also reported benefits such as being able to get tailored feedback from providers on equipment that was set up in their home, more easily coordinating caregiver training for patient transitions back to their home since caregivers could be at the patient's home with the patient, and being able to support pediatric rehab in an environment that the child is familiar with (in addition to the more typical benefits of reduced drive times and added convenience).[13] **Given the improved access and high levels of satisfaction we encourage permanent expansion of eligible provider types able to perform telehealth services.**

Removing Unnecessary Barriers to Licensure

Prior to the pandemic, many states required that out-of-state providers delivering telehealth have a license in the state where the patient was located. However, COVID-19 PHE waivers allowing licensure flexibilities including abbreviated applications and reciprocity arrangements enabled provision of care across state lines more easily. In addition, licensure compacts, although established prior to the pandemic, have grown, in part to streamlined licensure, facilitate provision of care across state lines (especially for telehealth) and reduce financial burden to the extent possible. Indeed, reducing barriers to licensure can help maximize limited provider capacity, particularly in areas where there are shortages. **The AHA supports efforts to ensure that licensure processes are streamlined for providers employed by hospitals and health systems operating across state lines and encourages additional research be done on the feasibility, infrastructure, cost and secondary effects of licensure reform options.[14]**

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[12] telehealth-hps-ib.pdf (hhs.gov)
[13] Outpatient Physical, Occupational, and Speech Therapy Synchronous Telemedicine: A Survey Study of Patient Satisfaction with Virtual Visits During the COVID-19 Pandemic - PMC (nih.gov)
[14] Telemedicine and Medical Licensure — Potential Paths for Reform | NEJM

Establishing DEA Special Registration Process for Telemedicine for Administration of Controlled Substances

Historically, the Ryan-Haight Act established statutory requirements for administration of controlled substances virtually. Specifically, this legislation prohibited the prescribing of controlled substances via online forms and required that it be done via an in-person visit. This in-person requirement could be waived during PHEs (as was done during the COVID-19 state of emergency) or through a special registration process to be administered by DEA. However, the requirement that the agencies issue a regulation outlining such a special registration process for telemedicine was first established nearly 14 years ago and was re-enforced over three years ago in the SUPPORT Act. Indeed, the SUPPORT Act established a deadline of Oct. 24, 2019, for regulations to be developed. However, the DEA still has yet to publish such requirements.

There is growing concern that the pending expiration of the COVID-19 PHE and its associated waivers, combined with the lack of a special registration regulation, will leave providers in a position where they will need to cut services, leaving patients without access to necessary treatment. We have urged the DEA to release proposed rules as soon as possible to ensure an appropriate feedback period, time for hospitals and health systems to comply with requirements, and time for them to enable an interim plan to support continuity of care for the period between the expiration of the COVID-19 PHE and the effectiveness of the special registration process, if there is a gap.[15] **Given the potential that this Special Registration process has to provide guardrails for safe prescribing of controlled substances, we encourage Congress to continue to require proposed and final rulemaking from agencies for the Special Registration for Telemedicine regulation, and to also require agencies to provide a proposed interim plan if there is a gap between expiration of the COVID-19 PHE and publication of the regulation.**

Expanding Cross-agency Collaboration on Digital Infrastructure and Literacy Initiatives

One barrier to expanding telehealth to underserved populations has been lack of access to enabling technologies (like broadband, reliable Wi-Fi or smartphones), as well as education to support digital literacy. Grant funding from organizations like the Federal Communications Commission and Health Resources and Services Administration has helped bolster infrastructure investment to provide connected care services for underserved communities during the pandemic. However, significant work remains to bridge the gap. Indeed, the Federal Communications Commission reports that over 22%

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[15] AHA Letter to DEA Regarding Request for Release of Special Registration for Telemedicine Regulation | AHA

of Americans in rural areas lack access to appropriate broadband (fixed terrestrial 25/3 Mbps) compared to 1.5% of urban areas.[16] The issue of the "digital divide" and disparities in technology access and literacy extends beyond health care. Indeed, some of the same communities that had challenges with accessing telehealth services due to technology and broadband constraints were also disproportionately impacted when schools and workforces went remote.[17] **As such, we encourage cross-agency collaboration to develop training and infrastructure investment, including among agencies like the Department of Health and Human Services, Federal Communications Commission, Department of Commerce, Department of Agriculture and Department of Education.**

Hospitals, health systems, providers and patients have seen firsthand the benefits and potential that telehealth has in increasing access and transforming care delivery. We appreciate your leadership on this important issue and look forward to working with you to ensure legislation reflects the post-pandemic lessons learned, permanently adopts waivers that have improved access to care, and establishes a sustainable framework for the future of telehealth and care delivery as a whole.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President

[16] 2020 Broadband Deployment Report | Federal Communications Commission (fcc.gov)
[17] How to Close the Digital Divide in the U.S. (hbr.org)