May 1, 2024

The Honorable Elizabeth Warren
U.S. Senate
Washington, DC 20510

The Honorable Ed Markey
U.S. Senate
Washington, DC 20510

The Honorable Richard Neal
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McGovern
U.S. House of Representatives
Washington, DC 20515

The Honorable Lori Trahan
U.S. House of Representatives
Washington, DC 20515

The Honorable Jake Auchincloss
U.S. House of Representatives
Washington, DC 20515

The Honorable Katherine Clark
U.S. House of Representatives
Washington, DC 20515

The Honorable Seth Moulton
U.S. House of Representatives
Washington, DC 20515

The Honorable Ayanna Pressley
U.S. House of Representatives
Washington, DC 20515

The Honorable Stephen Lynch
U.S. House of Representatives
Washington, DC 20515

The Honorable William Keating
U.S. House of Representatives
Washington, DC 20515

Dear Members of the Massachusetts Congressional Delegation:

On behalf of the Massachusetts Telemedicine Coalition (*t*MED), representing more than fifty healthcare provider organizations, consumer advocates, technology organizations and telecommunication associations, thank you for your ongoing leadership in ensuring access to health care delivered virtually, and for your commitment to considering permanent telehealth policies. We write today to urge Congress to make permanent important telehealth flexibilities as soon as possible prior to the statutory expiration of flexibilities on December 31, 2024. By acting as soon as possible, this will provide much needed certainty, and safeguard against this important policy getting left behind among competing priorities at the end of the year.

Telehealth policy flexibilities granted during the pandemic, and subsequently extended in 2022, have supported telehealth access nationwide, including more than thirty million Americans in Medicare. 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. The Centers for Medicare & Medicaid Services (CMS) waived certain regulatory requirements and Congress provided significant legislative support to ensure hospitals and health systems could manage the numerous challenges facing them, including by increased virtual care options. These swift actions provided hospitals and health systems with critical flexibilities to care for patients during what has been a prolonged and unpredictable pandemic.

Clinicians need telehealth to expand access to care and support strong patient relationships, and they value the flexibility created by the option for remote care when clinically appropriate. Important safety net providers like community health centers and rural health clinics have depended on these flexibilities, as have clinicians such as physical therapists, speech therapists and occupational therapists to extend access to patients. Current telehealth flexibilities have played a critical role in promoting access to vital health care services including advanced specialists (e.g., oncologists) and mental health services without a previous in-person appointment. This is particularly true for patients in rural and underserved areas,
those with mobility issues, and patients with transportation or other limitations that prevent them from accessing in-person care in a timely manner.

Predictability in telehealth policy now, in advance of the end of year deadline would:

• Create certainty for Medicare beneficiaries (and the Medicare program), who will otherwise wonder if they will have continued access to clinicians and services they are using virtually;

• Strengthen our national health care workforce by enabling greater number of clinicians to provide telehealth services and allowing for investment in flexible virtual staffing models that address current workforce shortages while maintaining high quality health care;

• Ensure continued investment in the technology tools and infrastructure to offer telehealth services, particularly for smaller providers serving the rural and underserved – who cannot afford to invest in these tools without a reimbursement pathway.

Without clear guidance from Congress on a long-term approach for telehealth flexibilities, health care delivery systems will not be able to invest sufficient resources to allow maximal access to patients. We believe that policymakers now have more than enough evidence to see the benefits of telehealth and consider a permanent pathway to ensure that telehealth continues to be available and accessible.

We appreciate Congress' focus on this critical issue and urge you to make these key telehealth flexibilities permanent before they expire on Dec. 31, 2024:

Removing geographic restrictions and expanding originating sites to include any site at which the patient is located, including the patient's home. Patients across geographies and settings, including both rural and urban areas, have benefited from increased access and improved convenience provided by telehealth services. We support permanently removing geographic restrictions that currently limit where patients can access telehealth services. Removing these unnecessary barriers would ensure all Medicare beneficiaries can access services regardless of where they and their providers are physically located.

Extending the Hospital at Home (H@H) Waiver beyond December 31, 2024. The hospital-at-home model — where patients receive acute level care in their homes, rather than in a hospital — has emerged as an innovative and promising approach to provide high quality care to patients in the comfort of their home. To allow providers to continue to take steps to transform care delivery in a way that improves patient experience, the AHA strongly supports the continuation of this program. CMS provided this flexibility that eased several Medicare restrictions and requirements to allow hospitals and health systems to respond to the COVID-19 pandemic effectively and efficiently. Hospitals continue to see H@H programs as a safe and innovative way to care for patients in the comfort of their homes. A growing body of research shows that H@H is an effective strategy that improves all three components of the value equation — improve outcomes, enhance the patient experience, and reduce cost. A meta-analysis of 61 studies found that patients that have received hospital-at-home care have a 20% reduction in mortality while another randomized control trial found that acutely ill patients admitted to H@H through the ED were three times less likely to be re-admitted to the hospital within 30 days than usual inpatient care patients.

Expanding eligible practitioners to furnish telehealth services to include occupational therapists, physical therapists, speech-language pathologists, and audiologists. All healthcare professionals who are eligible to bill Medicare for their professional services, including respiratory therapists, physical therapists, occupational therapists, speech language pathologists, and others have been permitted to deliver and bill for services provided via telehealth. However, Section 1834(m)(4)(E) limits payment for telehealth services to physicians and a limited set of non-physician practitioners under the Medicare physician fee schedule. Fortunately, CMS used its authority under the CARES Act (and subsequently Congress extended through legislation) to waive this limitation to expand the types of health care professionals that can furnish distant site telehealth services. A change in legislation is necessary to permanently allow this expanded list of providers to deliver and bill for telehealth services as they have been doing for the past 4 years.

Extending the ability for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to furnish telehealth services by allowing rural health clinics and federally qualified health centers 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. Additionally, the *t*MED Coalition recommends that **critical access hospitals (CAHs) should have the same ability to offer and bill for telehealth services by including language to include CAHs as eligible distant sites.**

Removing the six-month in-person requirement for mental health services furnished through telehealth, including the in-person requirements for FQHCs and RHCs. Behavioral health is one specialty area that has seen sustained growth in telehealth utilization. Geographically dispersed patients have benefited from increased access to behavioral health services provided through telehealth, especially in areas that may have provider shortages and in-person visits are not possible. As a result, we support the proposed removal of the requirements that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment and must have an in-person visit annually thereafter.

Extending coverage and payment for audio-only telehealth services. Virtual care represents a spectrum of 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. 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. Especially if the Affordable Connectivity Program is <u>not</u> reauthorized, we would encourage the explicit addition of Medicare coverage and payment for audio-only services in statute.

Extending the ability to use telehealth services to meet the face-to-face recertification requirement for hospice care. Section 3706 of The CARES Act allowed for face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit can now be conducted via telehealth (i.e., two-way audio-video telecommunications technology that allows for real-time interaction between the hospice physician/hospice nurse practitioner and the patient). This has been a useful tool for the recertifying hospice care, and it should be extended beyond the December 31, 2024, deadline.

Additionally, we would be remiss if we did not urge your support for three additional federal telehealth priorities moving forward:

Extension of the Affordable Connectivity Program (ACP) which was enacted under President Biden's Bipartisan Infrastructure Law as the largest internet affordability program in our nation's history.

This program has now helped twenty-three million households – 1 in 6 households across America – save $30-$75 each on their monthly internet bills and receive discounts for equipment. In Massachusetts alone, more than 366,728 households across every Congressional District in Massachusetts have benefitted from the ACP – that is 1 in 8 households in the state are saving $10.6 million in costs for broadband services each month. In the 21st century, affordable, reliable high-speed internet is critical to access healthcare and the lack of high-speed broadband services in low-income communities creates access and health disparities – a digital divide – leading to poorer health outcomes for patients.

Urge CMS to allow healthcare providers to continue to render telehealth services as needed from locations other than their primary practice setting *without* having to add their home address to their Medicare enrollment form.

During the PHE, CMS did not require providers to list their home address on the 1500 claim form when services were provided virtually. Instead, providers have been allowed to list the address of the facility with which they are associated. Within CMS guidance, it has been noted that this flexibility will be continued through CY2024. Maintaining the confidentiality and security of the provider's address is imperative to supporting the continued use of telehealth for our patients. Concerns for privacy and safety are not new, but escalating trends in violence towards physicians and other health care providers demonstrate that these professionals have never been at a greater risk of injury due to workplace violence. According to the U.S. Bureau of Labor Statistics, the rate of injuries from violent attacks against medical professionals grew by 63 percent from 2011 to 2018, and hospital safety leaders indicated that aggression against staff escalated as the COVID-19 pandemic intensified in 2020.[1] Healthcare violence and provider safety is a significant issue for Massachusetts healthcare providers. According to the Massachusetts Health & Hospital Association, every 38 minutes in a Massachusetts healthcare facility, someone – most likely a clinician or employee – is either physically assaulted, endures verbal abuse, or is threatened.[2] Given these realities, we must stress that any effort towards preserving the privacy and safety of a health care professional must be a top priority for CMS. Providers need to have the assurance that they are safe and can provide care without any fear that patients can have access to their home address. And should CMS decide to allow the flexibility to utilize their primary practice location to expire, CMS should inform healthcare providers as soon as possible to allow providers who may have their home address listed on these forms sufficient time to provide an alternate address or have their home address suppressed if they desire.

Urge the Drug Enforcement Agency (DEA) to expedite the release of a revised proposed rule to permit and regulate the prescribing of controlled substances through telehealth.

During the COVID-19 public health emergency (PHE), the DEA granted flexibilities for prescribing controlled substances via telehealth and waived a requirement, as mandated by the 2008 Ryan Haight Act, that an in-person visit occur prior to prescribing controlled substances via telehealth. In February of 2023, the DEA issued proposed rules that pulled back on those flexibilities and reinstated strict limitations on the viral prescribing of controlled substances. The *t*MED Coalition was one of more than 38,000 comments submitted to the DEA raising concerns with these proposed regulations. Subsequently, the DEA has allowed the flexibilities that have been in place to continue until the end of 2024. However, it is imperative that healthcare providers have sufficient time to adapt to any final regulations regarding the telehealth prescribing of controlled substances that are forthcoming from the DEA and the current anticipated timeframe that such regulations will be released by fall of 2024 will not allow sufficient time for providers to adapt new operational practices to comply with these regulations. Healthcare providers in Massachusetts have utilized telehealth to prescribe controlled substances successfully throughout the PHE and have utilized their clinical judgement to determine when a patient needs to be evaluated in-person before a prescription for

[1] U.S. Bureau of Labor Statistics, "*Injuries, Illnesses, and Fatalities: Fact Sheet, Workplace Violence in Healthcare*," 2018, https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm; see also AAMC News, "*Threats against health care workers are rising. Here's how hospitals are protecting their staffs,"* Aug. 18, 2022

[2] https://mhalink.informz.net/mhalink/data/images/A%20Call%20to%20Action%20-%20MHA%20Workplace%20Violence%20Report.pdf

a controlled substance is written. The *t*MED Coalition supports the continued ability for DEA-registered prescribers to have the autonomy to utilize their expertise to make decisions on the safe prescribing of controlled substances via telehealth with the appropriate safeguards in place. Our most significant concern is that the proposed rule may go beyond the implementation of reasonable safeguards and may, in fact, unnecessarily restrict access to medically necessary medications.

Thank you for your time and your consideration of this matter. Should you have questions or concerns regarding this program, please do not hesitate to contact Adam Delmolino, Senior Director of Virtual Care & Clinical Affairs at the Massachusetts Health & Hospital Association (MHA) (adelmolino@mhalink.org).

Sincerely,

*t*MED – The Massachusetts Telemedicine Coalition

- Massachusetts Health & Hospital Association
- Massachusetts Medical Society
- Massachusetts League of Community Health Centers
- Conference of Boston Teaching Hospitals
- Massachusetts Council of Community Hospitals
- Hospice & Palliative Care Federation of Massachusetts
- American College of Physicians – Massachusetts Chapter
- Highland Healthcare Associates IPA
- Health Care For All
- Organization of Nurse Leaders
- HealthPoint Plus Foundation
- Massachusetts Association of Behavioral Health Systems
- Massachusetts Academy of Family Physicians
- Seven Hills Foundation & Affiliates
- Case Management Society of New England
- Massachusetts Association for Occupational Therapy
- Atrius Health
- New England Connectivity & Telecommunications Association
- Association for Behavioral Healthcare
- National Association of Social Workers – Massachusetts Chapter
- Massachusetts Psychiatric Society
- Massachusetts Early Intervention Consortium
- Digital Diagnostics
- American College of Cardiology – Massachusetts Chapter
- The ALS Association

- Zipnosis
- Perspectives Health Services
- Bayada Pediatrics
- Planned Parenthood League of Massachusetts
- Mass. Family Planning Association
- BL Healthcare
- Phillips
- Maven Project
- Upstream USA
- Cambridge Health Alliance
- Heywood Healthcare
- Franciscan Children's Hospital
- American Physical Therapy Association – Massachusetts
- Community Care Cooperative
- Fertility Within Reach
- Virtudent
- Resolve New England
- Massachusetts Association of Mental Health
- AMD Global Telemedicine
- hims | hers
- Asian Women for Health
- Massachusetts Society of Clinical Oncologists
- Reproductive Equity Now
- Recovery Centers of America
- Massachusetts Chapter, American Academy of Pediatrics
- Massachusetts Speech and Hearing Association
- Southcoast Health
- Massachusetts Orthopedic Association
- Transhealth
- Massachusetts Academy of Nutrition & Dietetics