American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

"Enhancing Access to Care at Home in Rural and Underserved Communities"

March 12, 2024

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 comment on how telehealth flexibilities, the hospital-at-home (H@H) program and home health agencies have expanded access to care for patients in their homes and the need for these programs to continue.

TELEHEALTH COVID-19 FLEXIBILITIES HAVE IMPROVED ACCESS TO CARE

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.

We greatly appreciate the committee's focus on this critical issue and urge Congress 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.
- Expanding eligible practitioners to furnish telehealth services to include occupational therapists, physical therapists, speech-language pathologists and audiologists.
- Extending the ability for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to furnish telehealth services.
- Delaying the six-month in-person requirement for mental health services furnished through telehealth, including the in-person requirements for FQHCs and RHCs.
- Extending coverage and payment for audio-only telehealth services.
- Extending the ability to use telehealth services to meet the face-to-face recertification requirement for hospice care.

CONNECT for Health Act

The AHA supports the CONNECT for Health Act of 2023 (H.R. 4189/S. 2016), comprehensive legislation which addresses many of these waivers. 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.

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.

Additionally, the AHA supports 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. The AHA also supports allowing critical access hospitals (CAHs) the same ability to offer and bill for telehealth services and would encourage consideration of adding language to include CAHs as eligible distant sites.

We also appreciate the ability to waive restrictions on the use of telehealth during national and public health emergencies (PHE) and support improving Medicare's

process for coverage of telehealth services given the positive impact of improving patient's access to care.

Continuing Payment and Coverage for Audio-only Telehealth Services

We urge the committee to consider support for audio-only telehealth services payment and coverage. 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. Therefore, we would encourage the explicit addition of Medicare coverage and payment for audio-only services in statute.

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. 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.[1] Hospitals, health systems, providers and patients have seen the benefits and potential for telehealth to increase access and transform care delivery. We appreciate your leadership on this important issue and look forward to working together to ensure telehealth permanency.

HOSPITAL AT HOME PROGRAMS HAVE TRANSFORMED HEALTH CARE DELIVERY

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.

[1] Telemedicine and Medical Licensure — Potential Paths for Reform | NEJM

To allow hospitals and health systems the ability to respond to the COVID-19 pandemic effectively and efficiently, CMS provided a number of waivers and flexibilities that eased several Medicare restrictions and requirements to allow hospitals and health systems to effectively and efficiently respond to the COVID-19 pandemic.

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 admitted to the hospital within 30 days than usual inpatient care patients.[2,3]

HOME HEALTH AGENCIES CONTINUE TO FACE CHALLENGES

Home health agencies (HHAs) play a critical role in the care continuum, including for Medicare beneficiaries following a hospitalization. These providers allow patients to return home safely and continue their recovery while receiving needed nursing, therapy and other care. Hospitals around the country partner with HHAs to ensure the best outcomes for their patients. However, recent reductions in Medicare reimbursement for HHAs are jeopardizing access for these needed services. Specifically, CMS has cut base payments for these providers due to the switch to the new patient-driven grouping model by more than 10% in the last several years and plans to cut billions of dollars more in payment in the near future. These reductions directly impact not only HHAs and their patients, but also hospital operations as hospitals have face increased difficulties with placing patients in HHA care. This, in turn, requires hospitals to care for these patients while awaiting placement, driving up lengths of stay and costs for the entire Medicare program, and hampering the continued recovery of beneficiaries.

CONCLUSION

We look forward to working with Congress to permanently adopt telehealth waivers, extend the H@H program, and support home health agencies. Thank you for your attention to this issue and your consideration of our comments on behalf of hospitals and health systems.

---

[2] Caplan G.A., Sulaiman N.S., Mangin D.A., et al. A meta-analysis of “hospital in the home”. Med J Aust. 2012 Nov 5;197(9):512-9. doi: 10.5694/mja12.10480. PMID: 23121588. Accessed at https://www.mja.com.au/ journal/2012/197/9/meta-analysis-hospital-home.

[3] Levine D.M., Ouchi K., Blanchfield B., et al. HospitalLevel Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77- 85. doi: 10.7326/M19-0600. Epub 2019 Dec 17. PMID: 31842232. Accessed at https://www.acpjournals.org/ doi/10.7326/ M19-0600.