American Hospital Association™
Advancing Health in America

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March 4, 2022

The Honorable Mariannette Miller-Meeks
U.S. House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

The Honorable Mike Kelly
U.S. House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
U.S. House of Representatives
House Office Building
Washington, DC 20515

Dear Representatives Miller-Meeks, Kelly and Griffith:

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 comments to the Modernization Subcommittee of the Healthy Future Task Force.

Throughout the COVID-19 pandemic, telehealth has provided a critical way for patients to continue accessing needed care. The increased use of telehealth since the start of the public health emergency (PHE) is producing high-quality outcomes for patients, as well as closing longstanding workforce gaps and those that arose as a result of an overwhelmed, hardworking provider workforce. We urge Congress to consider how to ensure these flexibilities could remain in place for patients and health care providers beyond the PHE.

FLEXIBILITIES TO MAKE PERMANENT

We greatly appreciate the flexibilities implemented during the PHE, as they have allowed hospitals and health systems to care for patients in the safety of their own homes. To ensure a seamless transition going forward, AHA has identified several waivers that require legislation to remain in place, and we urge Congress to make these permanent. These include:

- Eliminate the telehealth originating and geographic site restrictions for all telehealth services.

- Allow rural health clinics and federally qualified health centers to continue to serve as distant sites for all telehealth services beyond mental health services.
- Expand eligibility to deliver telehealth services to certain practitioners, such as respiratory therapists, physical therapists, occupational therapists and speech language therapists.
- Allow professionals who provide hospice and home health services to do so via telehealth and grant these professionals the ability to meet face-to-face requirements via virtual visits, including audio-only visits.
- Allow hospital outpatient departments (HOPDs) and critical access hospitals to bill for telehealth services; or, alternatively, clarify the Health and Human Services Secretary's authority to enable hospitals to bill for outpatient psychiatry programs and other outpatient therapy services delivered through remote connection in order to provide increased access to those individuals in need of these services.
- Allow hospitals to bill the originating site fee when hospital-based clinicians provide telehealth services to patients at home who would normally receive services at an HOPD.
- Grant an exception for practitioners in states that have medical licensing reciprocity requirements to file separate Drug Enforcement Agency registration in any state a provider practices to ensure appropriate prescribing for patients through telehealth services.

AHA-Supported Telehealth Legislation

Without making waivers permanent and updating current law, much of the progress that has been made over the past two years to significantly increase patient access to care could disappear. Prior to the pandemic, Medicare reimbursement for telehealth was limited to rural areas of the country and required patients to be at certain types of facilities to receive care. The PHE clearly demonstrated the ability to provide access to telehealth in all areas and communities, including in the safety of patients' homes. While telehealth has great potential to increase access to care, any expansion of telehealth should be implemented with supporting policies, such as access to broadband and end-user devices, to reach underserved populations.

The AHA has supported several bills that make permanent many of the current telehealth flexibilities. We urge consideration for these bills, as well as others that would address the telehealth waivers.

- The **Telehealth Modernization Act (S.368/H.R. 1332)** would improve access for patients by removing originating and geographic site restrictions. This would allow patients to access telehealth from their homes and for patients in both rural and urban areas to receive needed services. This legislation also would make

permanent the ability of federally qualified health centers and rural health clinics to provide telehealth services.

- The **CONNECT for Health Act (S.1512/H.R. 2903)**, would permanently remove all geographic restrictions on Medicare telehealth services and expand originating sites to include home and other sites. The bill also would expand telehealth for emergency medical care and allow rural health clinics and federally qualified health centers to serve as distant sites, among other provisions.

- The **Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S.168 and H.R. 708) would allow for the temporary reciprocity for treatment by medical professionals licensed in one state to patients in other states.** State licensure laws for physicians and other health care professionals can be major obstacles for those facilities wanting to provide telehealth services to patients in other states because of the current lack of portability of health professional licenses. This legislation would provide flexibility for health care workers to cross state lines physically and virtually to provide care during the COVID-19 pandemic.

- The **Protecting Rural Telehealth Access Act (S.1988/H.R. 5425)** would make permanent several telehealth flexibilities provided under the current PHE, including allowing patients to access telehealth services from their homes, removing restrictions on store and forward technologies that are currently only allowed in Alaska and Hawaii, 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, and authorizing audio-only services and paying for them at rates equal to payment for audio/visual services.

BENEFITS OF TELEHEALTH

One of the most salient benefits of telehealth is the access to care it creates for broad patient populations. Telecommunications technology connects patients to vital health care services through videoconferencing, remote monitoring, electronic consults and wireless communications. It increases patients' access to physicians, therapists and other practitioners. This is especially important in areas of the country where recruiting and retaining providers is challenging, such as in rural areas, and in areas where vulnerable populations often lack an entrance point to the health care system.

During the pandemic, hospitals and health systems have used critical flexibilities that the Centers for Medicare & Medicaid Services (CMS) established under waiver authority enacted by Congress to allow telehealth services to reach even more patients. Several of the benefits include:

- **Increased Access to Specialists:** One example of the impact made by these flexibilities comes from a hospital that reported a 10-fold increase in access to specialists while reaching 39% more ZIP codes in their state using telehealth. They also received extremely high patient satisfaction ratings; one such patient, a farmer, relayed how he conducted a visit with his physician via his smartphone while on his tractor, a process that would normally take three hours if in person.

- **Avoided Hospitalizations:** The COVID-19 pandemic spurred another hospital to set up a virtual hospital with significant telehealth capabilities when the pandemic first hit. The program's original objectives were to provide proactive management of COVID-19 patients across the care continuum, keep significant numbers of patients out of emergency departments (EDs) and hospitals, and preserve and increase inpatient bed capacity for those who needed it.

    - These objectives were met with great success: nearly 18,000 patients were treated in the virtual hospital as of August 2020, with only 3% requiring transfer to a brick-and-mortar site. A significant number of hospitalizations were avoided, making the program cost effective.
    - The patients who were transferred often were able to bypass busy EDs, and by the time they arrived at the facility, the hospital already had their essential information due to their prior virtual care.
    - Patients were extremely satisfied with the program. Every patient discharged from the virtual hospital was set up with a follow-up appointment with a primary care provider, the majority of which were completed virtually. For many of these patients, that primary care visit was the jumping off point to ongoing access to care they never had before. This hospital is now expanding its virtual hospital beyond COVID-19 care to assist those with chronic conditions.

- **Improved Outcomes:** Many hospitals indicated they observed greatly improved health outcomes for patients who no longer canceled or missed their appointments due to the ability to connect with their providers remotely.

Given these and the millions of other successful telehealth encounters that have occurred since COVID-19 first hit, the AHA strongly urges Congress to consider enacting legislation to make waivers permanent.

PAYMENT FOR TELEHEALTH SERVICES

For providers to be able to continue delivering high-quality patient care through telehealth and other virtual services, they need adequate reimbursement for the substantial upfront and ongoing costs of establishing and maintaining their virtual infrastructure, including secure platforms, licenses, IT support, scheduling, patient

education and clinician training. Without adequate reimbursement of these costs, providers may be forced to decrease their telehealth offerings. Adequate reimbursement for virtual services also is key to ensuring providers have the means to invest in HIPAA-compliant technologies and to deliver these services with high quality of care.

Specifically, to best support providers' ability to deliver high-quality care and improved patient outcomes, there must be a thorough and complete accounting of the costs that go into providing virtual visits and how such expenses relate to the need to maintain capacity for in-person services. There are, in fact, significantly more actions that hospital staff and providers must take to execute a virtual visit than they do for an in-person visit. For example, before the visit takes place, the hospital must first equip providers with the hardware they need, such as laptops and webcams, and acquire professional licenses for the virtual platform they choose to use. If the hospital staff is at home, hospitals also may purchase additional software to protect the privacy of personal phone numbers and redirect staff to focus exclusively on helping providers and patients execute virtual visits.

Next, other dedicated staff work to set patients up on a platform, communicate with patients before the visit to complete pre-registration, obtain patients' verbal consent to telehealth and then manually record that consent, and provide several pre-visit points of communication to ensure patients have the correct link for their telehealth visit. For in-person care, many of these functions can occur at the same time as the visit when the patient interacts with registration staff while waiting for a provider. However, via phone and video, they must be completed in advance of the visit, requiring significant staff resources. And, this process is even more complicated for a service such as group therapy, which involves more than one patient.

When the time of the visit arrives, clinical staff admit a patient from a virtual waiting room or call the patient if they do not present to the waiting room. The clinical staff person then completes an intake process and notifies the provider that he or she can enter the virtual visit. If any consent or release forms are required, the clinical staff obtain verbal authorization and note that in the patient's documentation, a two-step process that, when completed in person, requires only the single step of a patient signature. At the end of the visit, when a provider would normally send a patient to check-out to schedule any follow-up visits, providers must conduct this follow-up planning themselves because there is no way to do a warm handoff on that provider's license to a staff person, as the provider needs the license for the next patient. And, finally, once the visit is over, hospital staff must send patients their visit summaries via a patient portal or via mail for patients not on the portal; a step that, in person, consists of simply handing the patient their summary sheet.

Without funding to cover these numerous added steps, it will be difficult or impossible for hospitals and health systems to provide telehealth at the level at which patients are demanding. The goal of expanding telehealth should be integrated care across modalities to achieve the most appropriate and efficient care for patients. Therefore, we strongly urge Congress and CMS to carefully consider the costs of providing telehealth and ensure sufficient reimbursement to cover those costs.

We urge Congress to work in conjunction with CMS to ensure the ability of providers to deliver high-quality care and improved patient outcomes.

The ongoing COVID-19 pandemic has brought unprecedented demands on the nation's health care system, and it also has changed the way people receive care. For patients, the need to continue to receive care remotely from their trusted health care provider is important for healthy outcomes. We thank you for your attention to telehealth and consideration of our comments on behalf of hospitals and health systems. We look forward to working with Congress to ensure continued telehealth access to care for patients.

Sincerely,

/s/

Stacey Hughes
Executive Vice President