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March 4, 2022

The Honorable Mariannette Miller-Meeks, MD
1716 Longworth House Office Building
Washington, DC 20515

The Honorable Mike Kelly
1707 Longworth House Office Building
Washington, DC 20515

The Honorable H. Morgan Griffith
2202 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Miller-Meeks, Kelly, and Griffith:

Thank you for your leadership of the Modernization Subcommittee of the Healthy Future Task Force. EHI commends you on your recognition of digital health tools as a key factor in modernizing our health care system.

Telemedicine Expansion

Which flexibilities created under the COVID-19 public health emergency should be made permanent?

EHI would like to highlight four priorities as you consider legislation to permanently allow telehealth reimbursement in the Medicare program:

1. Remove Geographic & Originating Site Restrictions

In order to ensure all Medicare beneficiaries can access high-quality care when and where they need it, Congress must act to permanently remove restrictions in Section 1834(m) of the Social Security Act that dictate where a patient must be located in order to receive telehealth services. Once the COVID-19 PHE ends, the geographic and originating site restrictions in Section 1834(m) dictate that a Medicare beneficiary must be located in a provider office (or other health care facility) in a federally defined rural area in order to be able to utilize telehealth to be treated by a provider at a distant site. Congress should permanently remove these restrictions and allow beneficiaries across the country to receive virtual care in their homes, or the location of their choosing, where clinically appropriate and with appropriate beneficiary protections and guardrails in place.

2. Enhance HHS Authority to Determine Appropriate Providers and Modalities

Additionally, Section 1834(m) has a specific set of clinicians that are considered "telehealth eligible providers" and thus able to bill Medicare for telehealth services. While the law allows the Center for Medicare and Medicaid Services (CMS) the authority to add telehealth eligible services through an annual process, it does not allow the same flexibility to add telehealth eligible providers. For example, under 1834(m) physical, speech-language, and occupational therapists are not telehealth eligible providers. Congress should allow CMS the flexibility to add telehealth eligible providers, as supported by data and clinically appropriate. Additionally, Congress should direct CMS to consider how telehealth services could be delivered using all modalities, including audio-only. Audio-only telehealth services are critical to ensuring that those with limited access to high-speed, affordable broadband are still able to connect to their providers when and where they need.

3. Ensure Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics Can Furnish Telehealth Services

Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and Rural Health Clinics (RHCs) are critical safety net providers on the frontlines of providing care to those in rural and underserved areas. Prior to the COVID-19 PHE, in many cases FQHCs, CAHs, and RHCs could only serve as an originating site – meaning patients could be located in one such facility and use telehealth to connect to a provider in a distant location. However, FQHCs, CAHs, and RHCs have made substantial investments in their telehealth capabilities and are now reaching their own patients in their homes (or another remote location) via telehealth. Congress must ensure safety net providers can continue to provide telehealth services at an appropriate reimbursement level after the COVID-19 PHE.

4. Remove Telemental Health Access Barriers

Without Congressional action, those who wish to access mental or behavioral health care via telehealth after the COVID-19 PHE will be required to first have an in-person visit. The pandemic has led to a growth in the need for mental and behavioral health care, yet many still lack access to providers. Approximately 32% of American adults report symptoms of anxiety and/or depressive disorder—an increase of 11% since 2019.[1] Telehealth has proven a critical tool in meeting this increased need – in 2020, mental, behavioral, and neurodevelopmental disorders accounted for 25% of allowed Medicare charges for telehealth.[2] While the need has grown during the pandemic, its effects will be long lasting and requiring an in-person visit prior to a telehealth visit will be a barrier to accessing these much-needed services.

Employers and plans are often faced with provider shortages in certain geographic areas. Increased use of telemedicine may help alleviate these shortages, but barriers still exist that keep providers from practicing across state lines. Should Congress allow for healthcare providers who hold a valid license in good standing in at least one state to practice via telemedicine in all other states? Why or why not?

[1] https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/
[2] https://www.medpac.gov/wp-content/uploads/2021/09/Telehealth-MedPAC-Nov-2021.pdf

For more than 200 years, the practice of medicine has been, for the most part, regulated at the state level. State boards of medicine (and other provider boards) regulate the practice of medicine within their own state. This system was a sensible approach to ensuring patient safety for the last 200 years; however, with the advent of the digital age and digital health tools such as telehealth, it is time to consider reform in order to ensure patients can safely access quality care when and where they need it.

Rather than full pre-emption, EHI urges Congress to establish incentives for the creation and adoption of mutual recognition interstate licensing compacts. Interstate compacts – or a pact or agreement between two or more states - have been critical in many aspects of our nation's history – perhaps the most well-known being the Driver License Compact. They are also not new in health care – in fact, the Interstate Medical Licensure Compact (IMLC) was established in 2017 and has been adopted by 29 states, the District of Columbia, and Guam.[i] However, despite receiving more than $7 million from the Health Resources and Services Administration's (HRSA) Licensure Portability Grant Program,[ii] the IMLC does not increase licensure portability – it is a system of "expedited licensure" where physicians still must obtain individual licenses from every state in which they wish to practice.

Policymakers should ensure that all financial and policy incentives – including existing and new HRSA grants – encourage states to adopt a similar mutual recognition compact for physicians. This path forward recognizes the rights of states to regulate the practice of medicine within their borders, protects patients, and at the same time facilitates access to care across state lines.

How will artificial intelligence affect access, delivery, and cost of healthcare and the role it plays in modernization?

Artificial intelligence (AI) and machine learning (ML) are playing an increasing role in health care. Given the vast troves of health data generated today, algorithms that harness and glean insights from these data in near real-time – like those used in AI and ML – can be critical tools. This promise is especially true for combatting infectious diseases like COVID-19.

During the pandemic, AI and ML tools have been employed in three main areas to help combat the disease: research, treatment, and public health surveillance. For example, the National Institute of Biomedical Imaging and Bioengineering (NIBIB), part of the NIH, established and is leading the Medical Imaging and Data Resource Center (MIDRC).[iii] The MIDRC "goals are to lead the development and implementation of new diagnostics, including machine learning algorithms, that will allow rapid and accurate assessment of disease status and help physicians optimize patient treatment."[iv] Further, organizations have created real-time maps of the spread of COVID-19 using AI tools.[v] In order to not lose the gains we have made during this period and to continue to lead the world in cutting-edge research and development, the federal government must continue investing in AI and ML.

Though these tools hold great promise, it is critical that organizations that utilize AI and ML do so with the recognition that such usage can also lead to unintended outcomes if issues of data quality, bias, and privacy are not fully addressed. The National Institute of Standards and Technology (NIST) is currently tackling many of these issues, including bias and trustworthiness

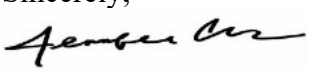
in AI. NIST must continue to collaborate with federal partners and industry in order to produce best practice and industry standards for data quality and validation for purposes of AI and ML.

In terms of reimbursement, in CMS' recent Calendar Year 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies proposed rule, CMS acknowledged that for AI and ML tools they must reexamine traditional ways of calculating reimbursement rates. EHI recognizes that technology, powered by robust and accurate data, can reduce provider burden and improve the quality of care provided to patients; however, we recognize that as it reduces burden on providers, that may affect the current PE process. EHI supports CMS' current on-going work to modernize the PE process given the impact of innovative technologies such as software algorithms and/or AI. Further, EHI believes CMS should recognize that there will be differences in practice expenses between technologies. In terms of PE costs, there is not variation between hardware and software that both perform the same function as both are, by definition, medical devices.

Conclusion

Thank you for the opportunity to provide input to the Modernization Subcommittee. We look forward to continuing to work with you and your colleagues on these important issues.

Sincerely,



Chief Executive Officer

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[i] Interstate Medical Licensure Compact. (n.d.). A Faster Pathway to Physician Licensure. Retrieved August 26, 2020, from https://www.imlcc.org/a-faster-pathway-to-physician-licensure/

[ii] Tracking Accountability in Government Grants System. (2020, August 26). TAGGS. Retrieved August 26, 2020, from https://taggs.hhs.gov/Detail/RecipDetail?arg_RecipId=DsBsFWwbQiTGXpot5NcQJQ

[iii] NIH. (2020, August 05). NIH harnesses AI for COVID-19 diagnosis, treatment, and monitoring. Retrieved August 26, 2020, from https://www.nih.gov/news-events/news-releases/nih-harnesses-ai-covid-19-diagnosis-treatment-monitoring

[iv] Ibid

[v] McCormick, J. (2020, March 05). Online Map Tracks Coronavirus Outbreak in Real Time. Retrieved August 26, 2020, from https://www.wsj.com/articles/online-map-tracks-coronavirus-outbreak-in-real-time-11583354911