Congress of the United States
Washington, DC 20515

July 12, 2021

The Honorable Xavier Becerra
Secretary
US Department of Health and Human Services
200 Independence, Ave. SW
Washington, D.C. 20201

Dear Secretary Becerra,

We write today to encourage the Department of Health and Human Services to work with Congress in developing a comprehensive telehealth strategy that ensures Medicare beneficiaries can continue accessing critical virtual care services following the expiration of the COVID-19 Public Health Emergency (PHE). We are especially interested in identifying any gaps in your regulatory authority where the agency and Congress can work together in a bipartisan fashion to permanently expand and improve the accessibility of telehealth services.

We appreciate the actions taken by the Centers for Medicare and Medicaid Services (CMS) during the COVID-19 pandemic that have facilitated a surge in telehealth innovation. To continue this momentum, we ask that CMS use its rulemaking authority in the upcoming CY 2022 Medicare Physician Fee Schedule Proposed Rule to consider providing permanent coverage of certain telehealth services added during the PHE, including services listed under the newly established Category 3 of codes, which are likely to provide clinical benefit when furnished via telehealth. Patients should have access on a permanent basis to virtual care where clinical evidence clearly demonstrates that the service, when furnished via telehealth, is appropriate for delivering high-quality care.

The beginning of the COVID-19 pandemic prompted millions of U.S. adults to defer primary and preventative routine medical care to slow the spread of the novel coronavirus. Providers quickly turned to telehealth to meet patients' needs and alleviate delays in care. As the pandemic continued, the expansion of telehealth proved to be particularly helpful in facilitating access to care to some of Medicare's more disadvantaged populations. A recent report from the Medicare Payment Advisory Council (MedPAC) further demonstrates the popularity of telehealth among older adults, with ninety-one percent of those surveyed indicating they were satisfied with the telehealth care they received during the pandemic.[1]

To fully leverage the opportunities of virtual care and strengthen our health care system beyond the COVID-19 pandemic, we must evaluate the impacts that the increased utilization of telehealth services has on the quality and accessibility of care. We also must focus on establishing a framework for determining permanent reimbursement for certain telehealth services that will enable patients to reliably receive appropriate virtual care following the end of the COVID-19 PHE. For the 140 additional telehealth services added by Medicare during the PHE, permanent coverage decisions should be informed by data supporting the clinical appropriateness of a telehealth service, as well as the potential for virtual care to create additional access points for patients. In the interim, to avoid creating a telehealth 'cliff effect' following the pandemic, we look to CMS to work with Congress in considering continuing coverage on a temporary basis for certain telehealth services added during the PHE.

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[1] http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf?sfvrsn=0

As such, please respond to the following inquiries:

1. What criteria will CMS use to determine the clinical appropriateness of a telehealth service?

2. Please explain the process in place and the anticipated timeline for CMS to collect, analyze and share telehealth utilization data from the Public Health Emergency. How will this data be considered in the CY22 Physician Fee Schedule rulemaking process as it relates to expanding the Medicare List of Telehealth Services?

3. When evaluating data to accurately estimate the impact of telehealth on access and quality, how will CMS determine if provider payment rates are aligned with the costs of delivering telehealth? We are particularly interested in the need for fair payment for services deemed to be clinically appropriate for telehealth and delivered at the same high-value standard, whether in-person, via video or audio-only telehealth.

4. As you continue to look at the use of telehealth services in Medicare during the COVID-19 PHE, what are the demographic characteristics [sex, age, race, income, location (urban vs rural), education level and region of the U.S.] of beneficiaries who are utilizing audio-only telephone services? From CMS's expanded list of services that may be performed via telehealth, what are the top ten services most frequently delivered via audio-only communication during the PHE?

5. What clinical data would be most useful to CMS to determine which of the telehealth services added to the Medicare Telehealth List during the PHE should be granted Medicare coverage on permanent basis?

6. How do you believe telehealth should be integrated into Medicare's value-based payment programs and the types of care that should be reimbursed in the traditional fee-for-service model of care?

Thank you for your attention to this important matter. We look forward to hearing your response.

Sincerely,

John Curtis
Member of Congress

Doris Matsui
Member of Congress

Peter Welch
Member of Congress

Michael C. Burgess, M.D.
Member of Congress