AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

THE FUTURE OF TELEHEALTH: HOW COVID-19 IS CHANGING THE DELIVERY OF VIRTUAL CARE

VIRTUAL HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

MARCH 2, 2021

Serial No. 117–9

Published for the use of the Committee on Energy and Commerce

energycommerce.house.gov

THE FUTURE OF TELEHEALTH: HOW COVID-19 IS CHANGING THE DELIVERY OF VIRTUAL CARE

THE FUTURE OF TELEHEALTH: HOW COVID-19 IS CHANGING THE DELIVERY OF VIRTUAL CARE

VIRTUAL HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

MARCH 2, 2021

Serial No. 117–9

Published for the use of the Committee on Energy and Commerce

govinfo.gov/committee/house-energy

energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

45–928 PDF WASHINGTON : 2022

COMMITTEE ON ENERGY AND COMMERCE

FRANK PALLONE, JR., New Jersey
Chairman

BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
DIANA DEGETTE, Colorado
MIKE DOYLE, Pennsylvania
JAN SCHAKOWSKY, Illinois
G. K. BUTTERFIELD, North Carolina
DORIS O. MATSUI, California
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
JERRY MCNERNEY, California
PETER WELCH, Vermont
PAUL TONKO, New York
YVETTE D. CLARKE, New York
KURT SCHRADER, Oregon
TONY CÁRDENAS, California
RAUL RUIZ, California
SCOTT H. PETERS, California
DEBBIE DINGELL, Michigan
MARC A. VEASEY, Texas
ANN M. KUSTER, New Hampshire
ROBIN L. KELLY, Illinois, *Vice Chair*
NANETTE DIAZ BARRAGÁN, California
A. DONALD MCEACHIN, Virginia
LISA BLUNT ROCHESTER, Delaware
DARREN SOTO, Florida
TOM O'HALLERAN, Arizona
KATHLEEN M. RICE, New York
ANGIE CRAIG, Minnesota
KIM SCHRIER, Washington
LORI TRAHAN, Massachusetts
LIZZIE FLETCHER, Texas

CATHY MCMORRIS RODGERS, Washington
Ranking Member
FRED UPTON, Michigan
MICHAEL C. BURGESS, Texas
STEVE SCALISE, Louisiana
ROBERT E. LATTA, Ohio
BRETT GUTHRIE, Kentucky
DAVID B. MCKINLEY, West Virginia
ADAM KINZINGER, Illinois
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILL JOHNSON, Ohio
BILLY LONG, Missouri
LARRY BUCSHON, Indiana
MARKWAYNE MULLIN, Oklahoma
RICHARD HUDSON, North Carolina
TIM WALBERG, Michigan
EARL L. "BUDDY" CARTER, Georgia
JEFF DUNCAN, South Carolina
GARY J. PALMER, Alabama
NEAL P. DUNN, Florida
JOHN R. CURTIS, Utah
DEBBBIE LESKO, Arizona
GREG PENCE, Indiana
DAN CRENSHAW, Texas
JOHN JOYCE, Pennsylvania
KELLY ARMSTRONG, North Dakota

PROFESSIONAL STAFF

JEFFREY C. CARROLL, *Staff Director*
TIFFANY GUARASCIO, *Deputy Staff Director*
NATE HODSON, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

ANNA G. ESHOO, California
Chairwoman

G. K. BUTTERFIELD, North Carolina
DORIS O. MATSUI, California
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
PETER WELCH, Vermont
KURT SCHRADER, Oregon
TONY CÁRDENAS, California
RAUL RUIZ, California
DEBBIE DINGELL, Michigan
ANN M. KUSTER, New Hampshire
ROBIN L. KELLY, Illinois
NANETTE DIAZ BARRAGÁN, California
LISA BLUNT ROCHESTER, Delaware
ANGIE CRAIG, Minnesota
KIM SCHRIER, Washington
LORI TRAHAN, Massachusetts
LIZZIE FLETCHER, Texas
FRANK PALLONE, JR., New Jersey *(ex officio)*

BRETT GUTHRIE, Kentucky
Ranking Member
FRED UPTON, Michigan
MICHAEL C. BURGESS, Texas
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILLY LONG, Missouri
LARRY BUCSHON, Indiana
MARKWAYNE MULLIN, Oklahoma
RICHARD HUDSON, North Carolina
EARL L. "BUDDY" CARTER, Georgia
NEAL P. DUNN, Florida
JOHN R. CURTIS, Utah
DAN CRENSHAW, Texas
JOHN JOYCE, Pennsylvania
CATHY MCMORRIS RODGERS, Washington *(ex officio)*

C O N T E N T S

	Page
Hon. Anna G. Eshoo, a Representative in Congress from the State of California, opening statement	2
Prepared statement	3
Hon. Doris O. Matsui, a Representative in Congress from the State of California, prepared statement	4
Hon. Brett Guthrie, a Representative in Congress from the Commonwealth of Kentucky, opening statement	5
Prepared statement	6
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	7
Prepared statement	8
Hon. Cathy McMorris Rodgers, a Representative in Congress from the State of Washington, opening statement	9
Prepared statement	11

WITNESSES

Megan Mahoney, M.D., Chief of Staff, Stanford Health Care	13
Prepared statement	15
Answers to submitted questions	328
Ateev Mehrotra, M.D., Associate Professor of Health Policy and Medicine, Harvard Medical School	21
Prepared statement	23
Answers to submitted questions	330
Elizabeth Mitchell, President and Chief Executive Officer, Purchaser Business Group on Health	31
Prepared statement	33
Answers to submitted questions	333
Jack Resneck, M.D., Member, Board of Trustees, American Medical Association	44
Prepared statement	46
Answers to submitted questions	336
Frederic Riccardi, President, Medicare Rights Center	55
Prepared statement	57
Answers to submitted questions	339

SUBMITTED MATERIAL

Statement of the ERISA Industry Committee "Employers on Telehealth: Government Standing in the Way," March 2, 2021, submitted by Ms. Eshoo	134
Fact sheet of March 2021, "Expanding Access to Care Through Telehealth During COVID–19 and Beyond," BlueCross BlueShield Association, submitted by Ms. Eshoo	141
Letter of March 1, 2021, from Jeffrey A. Singer, Senior Fellow, Department of Health Policy Studies, Cato Institute, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	142
Letter of March 2, 2021, from Graham Dufault, Connected Health Initiative, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	146
Statement of the Cystic Fibrosis Foundation, February 25, 2021, submitted by Ms. Eshoo	153
Statement of the American Hospital Association, March 2, 2021, submitted by Ms. Eshoo	155
Letter of March 1, 2021, from Gary L. LeRoy, Board Chair, American Academy of Family Physicians, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	160

Page

Statement of the Association of American Medical Colleges, March 2, 2021, submitted by Ms. Eshoo 163
Letter of March 2, 2021, from Ceci Connolly, President and Chief Executive Officer, Alliance of Community Health Plans, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 168
Letter of March 1, 2021, from Meghan Woltman, Interim Chief Government Affairs Officer, Advocate Aurora Health, to Ms. Eshoo and Mr. Guthrie, with letter of December 28, 2020, from Denise Keefe, President, Post-Acute Division, Advocate Aurora Health, to Seema Verma, Administrator, Centers for Medicare & Medicaid Services, submitted by Ms. Eshoo 172
Memorandum of March 2, 2021, from Charlie Katebi, Health Policy Analyst, Americans for Prosperity, submitted by Ms. Eshoo 182
Summary, "AHRQ portfolio on chronic pain and/or telehealth 2021," Agency for Healthcare Research and Quality, submitted by Ms. Eshoo 185
Letter of March 3, 2020, from Krista Drobac, Executive Director, Alliance for Connected Care, to Ms. Eshoo, et al., submitted by Ms. Eshoo 187
Statement of The ALS Association by Neil Thakur, Chief Mission Officer, March 2, 2021, submitted by Ms. Eshoo 194
Statement of the Alzheimer's Association and Alzheimer's Impact Movement, March 2, 2021, submitted by Ms. Eshoo 197
Statement of the American Nurses Association, March 2, 2021, submitted by Ms. Eshoo 200
Letter of February 26, 2021, from Sharon L. Dunn, President, American Physical Therapy Association, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 202
Letter of February 4, 2021, from Kyle Zebley, Public Policy Director, American Telemedicine Association, to Hon. Charles E. Schumer, Majority Leader, United States Senate, submitted by Ms. Eshoo 208
Letter of March 2, 2021, from Alliance of Community Health Plans, et al., to Hon. Catherine Cortez Masto, United States Senate, et al., submitted by Mr. Bilirakis 212
Statement of the Children's National Medical Center–Rare Disease Institute by Dr. Marshall Summar, Division Chief, Genetics and Metabolism, submitted by Ms. Eshoo 214
Statement of CommonSpirit Health, March 2, 2021, submitted by Ms. Eshoo .. 217
Statement of the American College of Physicians, March 2, 2021, submitted by Ms. Eshoo 219
Statement of the American Psychological Association, March 2, 2021, submitted by Ms. Eshoo 227
Article of February 17, 2021, "Health Experts Misjudged EHR Clinician Burnout at HITECH Act Passage," by Christopher Jason, EHR Intelligence, submitted by Mr. Burgess 230
Statement of the Heart Failure Society of America, March 2, 2021, submitted by Ms. Eshoo 232
Technical Assistance, "Telehealth: Potential Program Integrity Issues," February 2021, Office of Inspector General, Department of Health and Human Services, submitted by Mr. Guthrie 235
Letter of March 1, 2021, from Mary R. Grealy, President, Healthcare Leadership Council, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 239
Letter of March 2, 2021, from Jody L. Dietel, Senior Vice President, Advocacy and Government Affairs, HealthEquity, Inc., to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 241
Summary, "COVID–19 & Rural Health Equity in Northern New England," by Elizabeth Carpenter-Song and Anne N. Sosin, Center for Global Health Equity, Geisel School of Medicine, Dartmouth College, submitted by Ms. Kuster 243
Letter of March 2, 2021, from Bobby Patrick VI, Vice President, Strategic Growth and Policy, Medical Alley Association, to Ms. Craig, submitted by Ms. Eshoo 247
Letter of March 2, 2021, from Piper Nieters Su, Division Chair, External Relations, Mayo Clinic, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 250
Letter of March 1, 2021, from Anders Silberg, Senior Vice President, Government Affairs, Medical Group Management Association, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 253
Letter of March 1, 2021, from the Mental Health Liaison Group to Mr. Pallone, et al., submitted by Ms. Eshoo 256

Page

Article, "Amyotrophic lateral sclerosis care and research in the United States during the COVID–19 pandemic: Challenges and opportunities" by James D. Berry, et al., Muscle & Nerve. 2020;62:182-186, submitted by Ms. Eshoo 262
Statement of the National Safety Council, March 2, 2021, submitted by Ms. Eshoo 267
Letter of March 1, 2021, from Will Crump, Director of Public Health Policy, Ochsner Health, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 270
Statement of the Oncology Nursing Society, March 2, 2021, submitted by Ms. Eshoo 281
Statement of the Partnership for Employer-Sponsored Coverage, March 2, 2021, submitted by Ms. Eshoo 283
Statement of the Physician Assistant Education Association, March 2, 2021, submitted by Ms. Eshoo 285
Letter, undated, from Courtney M. Joslin, Resident Fellow, R Street Institute, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo 288
Statement of America's Health Insurance Plans, March 2, 2021, submitted by Ms. Eshoo 291
Statement of Johns Hopkins Medicine by Brian Hasselfield, Medical Director, Digital Health and Telemedicine, March 2, 2021, submitted by Ms. Eshoo ... 297
Statement of the American Pharmacists Association, March 2, 2021, submitted by Ms. Eshoo 305
Fact sheet, "Telehealth: Addressing the Growing Demand for Behavioral Health Services During COVID and Beyond," Centerstone, submitted by Ms. Eshoo 309
Letter of February 22, 2021, from the Mental Health Liaison Group to Hon. Patty Murray, Chairwoman, Senate Committee on Health, Education, Labor, and Pensions, et al., submitted by Ms. Eshoo 310
Memorandum of February 26, 2021, from Andrew Schwab, Director of Policy, Federal Affairs & Partnerships, United States of Care, submitted by Ms. Eshoo 314
Statement of the California Hospital Association, March 2, 2021, submitted by Ms. Eshoo 317
Summary, COVID–19 Telehealth Grants, submitted by Ms. Eshoo 319
Statement of the National Association of Free and Charitable Clinics by Nicole Lamoureux, President and Chief Executive Officer, submitted by Ms. Eshoo 322
Statement of the Society for Women's Health Research by Kathryn G. Schubert, President and Chief Executive Officer, submitted by Ms. Eshoo 324

THE FUTURE OF TELEHEALTH: HOW COVID–19 IS CHANGING THE DELIVERY OF VIRTUAL CARE

TUESDAY, MARCH 2, 2021

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m. via Cisco Webex online video conferencing, Hon. Anna G. Eshoo (chairwoman of the subcommittee), presiding.

Members present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Welch, Schrader, Cárdenas, Ruiz, Dingell, Kuster, Kelly, Barragán, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio), Guthrie (subcommittee ranking member), Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Also present: Representatives O'Halleran, Latta, Johnson, and Pence.

Staff present: Jeffrey C. Carroll, Staff Director; Waverly Gordon, General Counsel; Tiffany Guarascio, Deputy Staff Director; Perry Hamilton, Deputy Chief Clerk; Mackenzie Kuhl, Digital Assistant; Una Lee, Chief Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Policy Analyst; Juan Negrete, Junior Professional Staff Member; Kaitlyn Peel, Digital Director; Chloe Rodriguez, Deputy Chief Clerk; Samantha Satchell, Professional Staff Member; C.J. Young, Deputy Communications Director; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Grace Graham, Minority Chief Counsel, Health; Caleb Graff, Minority Deputy Chief Counsel, Health; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

Ms. ESHOO. The Subcommittee on Health will now come to order. Due to COVID–19, today's hearing is being held remotely. And all Members and witnesses will be participating via teleconferencing—video conferencing.

As part of our hearing today, microphones will be set on mute to eliminate background noise. And Members and witnesses, you need to unmute your microphone each time you wish to speak.

Documents for the record should be sent to Meghan Mullon at the email address that we have provided to the staff. And all documents will be entered into the record at the conclusion of the hearing.

The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

As the chairwoman of this subcommittee and a senior member of the Communications and Technology Subcommittee, I have been highlighting the importance of telehealth for years, and I am not the only one. This has been a longstanding bipartisan issue for many Members on this subcommittee, including Representatives Welch, Matsui, and Johnson, who are all leads on the CONNECT for Health Act, and Representative Kelly, who leads the Evaluating Disparities and Outcomes of Telehealth Act.

I think it is time to make Medicare reimbursement for telehealth service permanent. Over the last several months, I have talked to many healthcare professionals and providers in my district, and I think the members of the subcommittee have, as well, including Dr. Mahoney of Stanford Health, who I am so pleased to have on our expert panel today. I have heard how the wide adoption of telehealth has been a bright spot during a very dark time in our country.

One reason is that HHS waived many outdated rules and payment policies surrounding telehealth coverage in traditional Medicare during the public health emergency. A nonpartisan HHS report found that, from mid-March through early July of last year, more than 10.1 million traditional Medicare beneficiaries used telehealth, thanks to those waivers. It is also the first time we have had substantive data on the quality and the use of telehealth at scale.

We are quickly learning how telehealth can be used to address specialty shortages. For example, 70 percent of U.S. counties do not have a child psychiatrist. Telehealth could help close that gap. Telehealth can also address racial disparities in health outcomes. Our subcommittee has studied racial bias in doctors and how it impacts maternal mortality. A new landmark study by the University of Minnesota School of Public Health recently showed that the mortality rate for Black babies is cut in half when Black doctors care for them. That is highly instructive. Telehealth could make it easier for patients of color to find a doctor of the same race or who speaks the same language.

I know that telehealth isn't the silver bullet for the deeper problems that exist in our healthcare system, but it has demonstrated great promise for high-quality, innovative care if we intentionally create legislation that fits our Nation's needs. Now that Medicare beneficiaries and Americans are receiving this important benefit,

we need to find a way to continue affordable telehealth access for seniors and other Americans.

So, from today's hearing, we will learn from providers, payers, and patients about their experiences with telehealth and be better able to chart a legislative path forward to deliver on the promise of telehealth.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

As the chairwoman of the Health Subcommittee and a senior member of the Communications and Technology Subcommittee, I've been highlighting the importance of telehealth for years.

And I'm not the only one. This has been a longstanding, bipartisan issue for many Members on this subcommittee, including Representatives Peter Welch, Doris Matsui, and Bill Johnson, who are all leads on the CONNECT for Health Act, and Robin Kelly, who leads the Evaluating Disparities and Outcomes of Telehealth Act.

It's time to make Medicare reimbursement for telehealth service permanent.

Over the last several months, I've talked to healthcare professionals and providers in my district, including Dr. Mahoney of Stanford Health, who I'm so pleased to have on our expert panel today. I've heard how the wide adoption of telehealth has been a bright spot during a very dark time.

One reason is that HHS waived many outdated rules and payment policies surrounding telehealth coverage in traditional Medicare during the public health emergency.

A nonpartisan HHS report found that, from mid-March through early July 2020, more than 10.1 million traditional Medicare beneficiaries used telehealth thanks to those waivers.

It's also the first time we've had substantive data on the quality and use of telehealth at scale.

We're quickly learning how telehealth can be used to address specialty shortages. For example, 70% of U.S. counties have no child psychiatrist. Telehealth could help close that gap.

Telehealth can also address racial disparities in health outcomes. Our subcommittee has studied racial bias in doctors and how it impacts maternal mortality. A new landmark study by the University of Minnesota School of Public Health recently showed that the mortality rate for Black babies is cut in half when Black doctors care for them. Telehealth could make it easier for patients of color to find a doctor of their same race or who speaks the same language.

I know telehealth isn't the silver bullet for the deeper problems that exist in our healthcare system, but it does show promise for high-quality, innovative care if we intentionally create legislation that fits our Nation's needs.

Now that Medicare beneficiaries and Americans are receiving this important benefit, we need to find a way to continue affordable telehealth access for seniors and other Americans.

From today's hearing we will learn from providers, payers, and patients about their experiences with telehealth and be better able to chart a legislative path forward to deliver on the promise of telehealth.

Ms. ESHOO. I now yield the rest of my time to the gentlewoman from California, Congresswoman Matsui.

Ms. MATSUI. Thank you very much, Madam Chair, for calling this very important hearing, and thank you for the witnesses for being here today.

Telehealth has been, without a doubt, critical to preserving access to care during the public health emergency. We are seeing virtual care being embraced like never before, largely due to providers quickly scaling and adopting technology at the start of the pandemic. For years we have been working on policy to incentivize this adoption. But it was the CMS waivers issued early in the pandemic that were key to jump starting the widespread telehealth investment.

What is striking to me is that many of the changes made by CMS to waive geographic and site requirements and increase flexibility for telehealth under Medicare were not new ideas. They are the same policy changes we have been fighting for in Congress for years, commonsense solutions that broaden where services can be provided, and you can provide them breaking down longstanding, inequitable barriers to digital care.

I am proud to colead several efforts that would give our providers more certainty about how care will be delivered in the future, such as the comprehensive CONNECT for Health Act, aimed to remove the most onerous roadblocks in telehealth, to ensure its extension beyond this public health emergency.

Modernizing telehealth policy to meet the moment is one of the most important responsibilities of this Health Subcommittee. I look forward to hearing from witnesses today and working with my colleagues on solutions that promote safe and equitable access to health telehealth for years to come.

Thank you very much, Madam Chair, and I yield back.

[The prepared statement of Ms. Matsui follows:]

PREPARED STATEMENT OF HON. DORIS O. MATSUI

Thank you, Madam Chair for calling this important hearing and thank you to our witnesses for being here today.

Telehealth has been critical to preserving access to care during the public health emergency.

We are seeing virtual care being embraced like never before. largely due to providers quickly scaling and adopting technology at the start of the pandemic.

For years we have been working on policy to incentivize this adoption. but it was the CMS waivers issued early in the pandemic that were key to jump starting the widespread telehealth investment.

What is striking to me is that many of the changes made by CMS.to waive geographic and site requirements and increase flexibility for telehealth under Medicare.were not new ideas.

They are the same policy changes we have been fighting for in Congress for years, common sense solutions that broaden where services can be provided and who can provide them, breaking down long-standing, inequitable barriers to digital care.

I am proud to colead several efforts that will give our providers more certainty about how care will be delivered in the future. Both the Protecting Access to Post-COVID–19 Telehealth Act and the comprehensive CONNECT for Health Act would remove the most onerous roadblocks in telehealth ensuring its continued use beyond the public health emergency.

Modernizing telehealth policy to meet the moment is one of the most important responsibilities of this Health Subcommittee in the near term.

I look forward to hearing from our witnesses today and working with my colleagues on solutions that promote safe and equitable access to telehealth for years to come.

Ms. ESHOO. Thank you, Congresswoman Matsui. The Chair now recognizes Mr. Brett Guthrie, the ranking member of the subcommittee, for 5 minutes for his opening statement.

And remember to unmute.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you. Thank you, Madam Chair, I appreciate it. I am sorry I was a few minutes late getting on. I was doing typos or something, trying to get on to the website. So thank you for holding this important hearing.

Almost a year ago today the public health emergency began. All of our lives changed, and we all had to adapt. Telehealth was rarely used prior to the public health emergency for many Americans but has since increased substantially due to COVID–19.

I have heard from mental health providers that have seen a huge growth in telehealth services. One mental health provider group has seen telehealth services grow from 5 percent to more than 80 percent. I have also heard from a Kentucky provider who expressed how helpful their telehealth has been—over 600 telehealth visits—has been to stay connected with medically fragile patients during COVID–19, especially pediatric patients. These patients are very vulnerable to infections and must limit any contact in order to prevent exposure to COVID–19.

I am grateful for the providers who stepped up and worked hard to provide telehealth services to their patients.

I was very pleased that the Centers for Medicare and Medicaid Services, CMS, the Trump administration, and Congress worked together to make sure telehealth was accessible and available during the public health emergency. Swift action last year provided flexibilities for telehealth usage to grow. More recently, in the December COVID–19 relief package, Congress allowed Medicare to permanently waive the originating site requirement for mental health services. I was very supportive of these measures that are key to adapting to a COVID–19 world.

I have said before the genie is out of the bottle concerning telehealth flexibilities and expansion, and I continue to believe this. We have seen good development and progress so far. However, not every medical condition is appropriate to receive medical care through telehealth, or some patients can't access telehealth due to their specific needs, such as disorders—

Additionally, in my district, broadband continues to be a limiting factor. In five COVID–19 relief packages that were signed into law, Congress has worked to help resolve this issue. But our work is not done. I am committed to working with my colleagues on ways to address infrastructure limitations for telehealth access.

Additionally, we must examine appropriate guardrails for telehealth services to combat bad actors who are taking advantage of this terrible circumstance. Criminals have gotten very creative with telehealth scams, including cold calling Medicare beneficiaries and using fraudulent overseas providers to bill for services, to name a few.

I look forward to hearing from our witnesses and examining solutions today on ways to prevent fraud and abuse, as well as ensure Americans have access to valuable telehealth services.

HHS is currently conducting reports on telehealth during the pandemic. They are focusing on three—the OIG are focusing on three key areas of telehealth, including quality of care and patient safety; verification of services and patient consent; and infrastructure. While more is to come from OIG's research, I believe we should fully examine these issues now and also revisit once OIG investigations are complete.

We need to examine ways to continue to allow telehealth. But there are several factors we need to consider and improve on as we move forward. Telehealth can't replace all in-person business, and

we need to ensure quality of care is still given by the provider no matter the setting. Additionally, we need to make sure telehealth isn't being used for fraud and abuse.

I look forward to hearing from our witnesses in examining solutions today in order to ensure Americans have access to valuable telehealth services.

I yield back.

[The prepared statement of Mr. Guthrie follows:]

PREPARED STATEMENT OF HON. BRETT GUTHRIE

Thank you, Chair Eshoo, for holding this important hearing about telehealth.

Almost a year ago today, the public health emergency began, our lives changed, and we all had to adapt. Telehealth was rarely used prior to the public health emergency for many Americans but has since increased substantially due to COVID–19. I have also heard from mental health providers who have seen a huge growth in telehealth services. One mental health provider group has seen telehealth services grow from 5% to more than 80%. I also heard from a Kentucky provider, who expressed how helpful their over 600 telehealth visits have been to stay connected with medically fragile patients during COVID–19, especially pediatric patients. These patients are very vulnerable to infections and must continue having care they need to be protected from COVID–19. I am grateful for the providers who stepped up and worked hard to provide telehealth access to their patients.

I was very pleased that the Centers for Medicare and Medicaid Services (CMS), the Trump administration and Congress worked together to make sure telehealth was accessible and available during the pandemic. Quick action last year allowed for Medicare to waive many telehealth requirements including the originating site requirement for the duration of the public health emergency. Most recently, I was very supportive of the recent measure Congress took to waive originating site requirement for mental health services in the December COVID–19 relief package. These flexibilities are key to adapting to a COVID–19 world.

I've said before the "genie is out of the bottle" concerning telehealth flexibilities and expansion, and I continue to believe this. We have seen good development and progress so far; however, not everyone is a good candidate for telehealth or can access telehealth due to their disease or condition. In my district, broadband continues to be a limiting factor. In the five COVID–19 relief packages that were signed into law, Congress has worked to help resolve this issue, but our work is not done. I am committed to working with my colleagues on ways to address infrastructures limitations for telehealth access. Additionally, we must examine appropriate guardrails for telehealth services to combat bad actors who are taking advantage of this terrible circumstance. Criminals have gotten very creative with telehealth scams including cold calling Medicare beneficiaries, and using fraudulent overseas providers to bill for services, to name a few. I look forward to hearing from our witnesses and examining solutions today on ways to prevent fraud and abuse as well as ensure Americans have access to valuable telehealth services.

HHS OIG is currently conducting reports on telehealth during the pandemic. They are focusing on three key areas of telehealth, including quality of care and patient safety, verification of services and patient consent, and infrastructure. While more is to come from OIG's research, I believe we should fully examine these issues now and also revisit once the OIG investigations are complete. We examine ways to continue to allow telehealth, but there are several factors we need to consider and improve as we move forward. Telehealth can't replace all in-person visits, and we need to ensure quality of care is still given by the provider, no matter the setting. Additionally, we need to make sure telehealth isn't being used for fraud and abuse.

I look forward to hearing from our witnesses and examining solutions today on ways to prevent fraud and abuse as well as ensure Americans have access to valuable telehealth services. I yield back.

Ms. ESHOO. I just want to add that we are all really delighted that you are the ranking member of this subcommittee. I believe—I don't remember what Congress it was, but colleagues—our ranking member was voted the nicest Member of Congress. So we are blessed to have him aboard.

The Chair now recognizes Mr. Pallone, the chairman of the full committee, for his 5 minutes for an opening statement.

Good morning.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Good morning. Thank you, Chairwoman Eshoo.

Over the course of this pandemic, millions of Americans have used telehealth, some perhaps for the first time, to stay connected to their healthcare providers without increasing their risk of exposure to COVID–19. When the pandemic was beginning to take hold, we moved quickly to significantly expand access to telehealth for Medicare beneficiaries, and this was critically important because Medicare beneficiaries are some of the most vulnerable to COVID–19. And since then, Medicare has waived its originating site and rural requirements for the duration of the public health emergency.

Medicare is also now covering an expanded list of telehealth services that beneficiaries across the country can access without ever leaving their homes. Most private insurers have also acted to expand coverage of telehealth benefits by allowing coverage of more services, and reducing cost sharing for those telehealth services.

Expanding access to this critical tool early on helped save lives and also helped keep providers afloat during a time when patients are rightfully hesitant to receive health services in person. Early data shows that telehealth utilization has skyrocketed, not only in the Medicare program but also in Medicaid and private insurance plans. And, unlike Medicare, private insurance plans and Medicaid did not have the same statutory restrictions on telehealth services, such as the rural and originating site requirements.

And our committee has a long history of working to expand access to health—to telehealth services in Medicare. For example, the Bipartisan Budget Act of 2018 expanded access to telestroke services and provided additional flexibility for accountable care organizations to expand telehealth. The SUPPORT Act expanded access to substance use disorder services delivered via telehealth. And most recently, the Consolidated Appropriations Act in, you know, the end-of-the-year package, permanently expanded access to telemental health services in Medicare.

In each of these examples, Congress expanded access after carefully looking at the evidence and weighing tradeoffs with respect to quality of care, access, and value. And while I applaud the work that has been done so far to rapidly expand telehealth in Medicare and elsewhere during these times, I think it is important for the committee to carefully consider the impacts of the current waivers.

We must also ensure that the data being collected today informs our decisions going forward. For example, there are several key areas for our committee to consider.

The first is value. While the convenience of telehealth can help provide critical services to hard-to-reach populations, it can also lead to overutilization or low-value care. So it is important to consider how future policies can encourage the use of high-value care

while at the same time discouraging potentially low-value care and over-utilization in Medicare fee-for-service.

Second, it is important to consider ways to strengthen program integrity and prevent potential bad actors from taking advantage of the system and consumers. In recent years the Department of Health and Human Services Office of the Inspector General has warned of increased fraud connected to telehealth-related schemes. While there are significant benefits to telehealth, we should not ignore the potential for illegitimate uses of telehealth and scams that prey on consumers, especially seniors.

And third, it is critical that we ensure equitable access to telehealth. Ideally, telehealth would help those areas that are already underserved and individuals who lack access to providers or individuals who are managing serious health conditions. Utilization data should be analyzed to ensure that we are effectively reaching these populations and to help identify any barriers in reaching them. We know that many Americans lack the digital literacy, technology, or Internet access needed to use telehealth as effectively as others. These are all issues that Congress has to work to address. And in providing increased access to telehealth, we need to ensure that we are not further fragmenting care.

And these are just some of the many issues that warrant further consideration. But we have all seen various tangible benefits to telehealth, particularly during the pandemic. It is important for us to continue to investigate the impact of these changes on our healthcare system before enacting permanent policies.

So I look forward to working with members of the committee to examine the data and ultimately provide certainty to patients and providers on future telehealth policy. We have a unique opportunity to use the lessons learned from the pandemic, and translate them into legislation that ensures that these critical telehealth tools are used appropriately to advance health equity and improve quality of care for all Americans.

I know, Madam Chair, that, you know, I hear about this telehealth all the time. And, you know, we obviously want to make things permanent, but we also have to be careful about how we do it. So thank you again. This is a very important hearing. I thank the chair.

I yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Over the course of this pandemic millions of Americans have used telehealth, some perhaps for the first time, to stay connected to their healthcare providers without increasing their risk of exposure to COVID–19.

When the pandemic was beginning to take hold in America, we moved quickly to significantly expand access to telehealth for Medicare beneficiaries. This was critically important because Medicare beneficiaries are some of the most vulnerable to COVID–19. Since then, Medicare has waived its originating site and rural requirements for the duration of the public health emergency. Medicare is also now covering an expanded list of telehealth services that beneficiaries across the country can access without ever leaving their homes. Most private insurers have also acted to expand coverage of telehealth benefits by allowing coverage of more services and reducing cost-sharing for telehealth services.

Expanding access to this critical tool early on helped save lives and also helped keep providers afloat during a time when patients are rightfully hesitant to receive

healthcare services in person. Early data shows that telehealth utilization has skyrocketed not only in the Medicare program but also in Medicaid and private insurance plans. Unlike Medicare, private insurance plans and Medicaid do not have the same statutory restrictions on telehealth such as rural and originating site requirements.

Our committee has a long history of working to expand access to telehealth services in the Medicare program. For example, the Bipartisan Budget Act of 2018 expanded access to telestroke services and provided additional flexibility for Accountable Care Organizations (ACOs) to expand telehealth. The SUPPORT Act expanded access to substance use disorder services delivered via telehealth. And most recently the Consolidated Appropriations Act, 2021 permanently expanded access to telemental health services in Medicare.

In each of those examples, Congress expanded access after carefully looking at the evidence and weighing trade-offs with respect to quality of care, access, and value. While I applaud the work that has been done so far to rapidly expand telehealth in Medicare and elsewhere during these unprecedented times, I think it's important for the committee to carefully consider the impacts of the current waivers. We must also ensure that the data being collected today informs our decisions going forward.

For example, there are several key areas for our committee to consider. The first is value. While the convenience of telehealth can help provide critical services to hard-to-reach populations, it can also lead to overutilization or low-value care. It's important to consider how future policies can encourage the use of high-value care, while, at the same time, discouraging potential low-value care and overutilization in Medicare fee-for-service.

Second, it is important to consider ways to strengthen program integrity and prevent potential bad actors from taking advantage of the system and consumers. In recent years the Department of Health and Human Services' (HHS) Office of the Inspector General has warned of increased fraud connected to telehealth related schemes. While there are significant benefits to telehealth, we should not ignore the potential for illegitimate uses of telehealth and scams that prey on consumers, especially seniors.

Third, it's critical that we ensure equitable access to telehealth services. Ideally telehealth will help those areas that are already underserved and individuals who lack access to providers or individuals who are managing serious health conditions. Utilization data should be analyzed to ensure that we're effectively reaching those populations and to help identify any barriers in reaching them. We know that many Americans may lack the digital literacy, technology, or internet access needed to use telehealth as effectively as others. These are all issue Congress must work to address. And, in providing increased access through telehealth, we need to ensure that we're not further fragmenting care.

These are just some of the many issues that warrant further consideration. Though we have all seen various tangible benefits to telehealth, particularly during the pandemic, it is important for us to continue to investigate the impact of these changes on our healthcare system before enacting permanent policies.

I look forward to working with members of the committee to examine the data and ultimately provide certainty to patients and providers on future telehealth policy. We have a unique opportunity to use the lessons learned from this pandemic and translate them into legislation that ensures that these critical telehealth tools are used appropriately to advance health equity and improve quality of care for all Americans.

Ms. ESHOO. The gentleman yields back. The Chair is now pleased to recognize the ranking member of the full committee, Representative Cathy McMorris Rodgers, for 5 minutes for her opening statement.

Good morning to you.

OPENING STATEMENT OF HON. CATHY MCMORRIS RODGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mrs. RODGERS. Good morning, everyone, and thank you, Madam Chair. Thank you. A big thank you to all our witnesses for joining us today.

Telehealth is a vital way for patients to access care, especially in rural communities and during a pandemic. I am from a small town in eastern Washington, Kettle Falls, and I have lived through the challenges that people face in rural communities when it comes to accessing healthcare. I have also visited hospitals and healthcare facilities in eastern Washington.

As a leader on the Rural Healthcare Caucus, our conversations about expanding telehealth to address doctor shortages is no longer just a goal for the future. It is happening today. In response to COVID–19, Providence Health System, which has four hospitals in my district, scaled up their telehealth services from more than 7,000 visits in 2019 to more than 100,000 visits in 2020. This is more than a 1,000 percent increase in volume.

Physicians across Washington State have leverage telehealth technology to reach more patients, save lives, and improve care. They diagnosed appendicitis in a young patient, worked with a pregnant woman to help her find her baby's fetal heartbeat, and are providing care for behavioral health patients. Across America COVID–19 led to a massive expansion of telehealth when non-emergency visits were shuttered. It was the only way for people to get routine care.

The Trump administration took bold and rapid action by waiving certain requirements so technology like Facetime could be used for telehealth, requiring Medicare to pay for more services by telehealth, and reducing out-of-pocket for telehealth, removing any Federal licensing requirements, and expanding the availability of telehealth services in long-term care facilities, where people are especially vulnerable to COVID–19.

According to the CDC, the number of telehealth visits increased by 154 percent during the first quarter of 2020. HHS reported that nearly half of all Medicare primary care visits were via telehealth in April, compared to less than 1 percent in February before the start of the COVID–19 pandemic.

Now is the time for us to plan for the future of telehealth. Thanks to the groundwork we laid with 21st Century Cures, leadership by the private sector, and Operation Warp Speed, the third vaccine for COVID–19 was just authorized for emergency use. Also, this past weekend, more than 2 million shots made it into people's arms each day.

With continued work, I am hopeful we will crush this virus and restore our way of life. That includes patients returning to the doctor's office without fear of contracting COVID–19. However, the pandemic has made clear that telehealth can and should be a part of modernizing healthcare delivery in America.

It is up to Congress to make sure we understand how this dramatic expansion has helped patients get the care they need. That means examining both where telehealth may not be appropriate and when it drives better outcomes for patients. Our shared goal should be to promote solutions that help patients recover from their illnesses and manage their chronic conditions better, whether it is through a video call or in-person care.

With the rise of anxiety and suicide, I am especially interested in the advantages of telehealth to reach people who are in need of mental healthcare.

We have also seen a risk of waste, fraud, and abuse when it comes to the deployment of telehealth. And we need to take that into account.

We need to be aware of the cost to the healthcare system of changes that we make permanent. The Medicare Hospital Trust Fund is projected to go bankrupt in 2024, less than 5 years from now. We need to make sure we expand telehealth and maintain our commitment to our Nation's seniors to provide a top-notch level of care.

I am optimistic about telehealth and its ability to improve the health and wellness of America. It is bringing doctors right into the family's living room. And this is an example of how innovation can improve and save people's lives.

This hearing today is just the beginning of a discussion, and we need to talk about the future of healthcare. And Madam Chair, I appreciate you bringing us together in a bipartisan way to review the experiences of the last year and where we can further unleash lifesaving innovation and medical breakthroughs. Let's have a plan for America to lead the way on the best use of telehealth for the benefit of every patient.

Thank you, and I yield back.

[The prepared statement of Mrs. Rodgers follows:]

PREPARED STATEMENT OF HON. CATHY MCMORRIS RODGERS

EASTERN WASHINGTON

Thank you Chair...and thank you to our witnesses for participating today.

Telehealth is a vital way for patients to access care, especially in rural communities and during the pandemic.

I grew up in a small town in Kettle Falls.

. and I have lived through the challenges that people face in rural communities when it comes to accessing healthcare.

I have also visited hospitals and healthcare facilities all throughout my district in Eastern Washington too.

As a leader on the Rural Healthcare Caucus, our conversations about expanding telehealth to address doctor shortages is no longer just a goal for the future, it's happening today.

In response to COVID–19, Providence Health System—which has four hospitals in my district—scaled up their telehealth services from more than 7 thousand visits in 2019 to more than 100 thousand visits in 2020.

This is more than a 1,000% increase in volume.

Physicians across Washington State have leveraged telehealth technologies to reach more patients, save lives, and improve care.

They diagnosed appendicitis in a young patient...

...worked with a pregnant woman to help find her baby's fetal heartbeat...

..and providing care for behavioral health patients.

REPUBLICAN LEADERSHIP

Across America, COVID–19 led to a massive expansion of telehealth, when non-emergency visits where shuttered.

It was the only way for people to get routine care.

The Trump administration took bold and rapid action by...

. waiving certain requirements so technology like Facetime could be used for telehealth ...

. requiring Medicare to pay for more services by telehealth, and reducing out of pocket costs for telehealth...

. removing any Federal licensing requirements and...

. expanding the availability of telehealth services in long-term care settings, where people are particularly vulnerable to COVID–19.

According to the CDC, the number of telehealth visits increased by 154 percent during the first quarter of 2020.

HHS reported that nearly half of all Medicare primary care visits were via telehealth in April, compared with less than 1% in February before the start of the COVID–19 pandemic.

WIN THE FUTURE OF TELEHEALTH

Now, it's time to plan for the future of telehealth.

Thanks to the groundwork we laid with 21st Century Cures, leadership by the private sector, and Operation Warp Speed, the third vaccine for COVID–19 was just authorized for emergency use.

Also, this past weekend, more than 2 million shots made it into people's arms each day.

With continued work, I'm hopeful we will crush this virus and restore our way of life that includes patients returning to the doctor's office without fear of contracting COVID–19.

However, the pandemic has made clear that telehealth can and should be a part of modernizing healthcare delivery in America.

It's up to Congress to make sure we understand how this dramatic expansion has helped patients get the care they need.

That means examining both where telehealth may not be appropriate and when it drives better outcomes for patients.

Our shared goal should be to promote solutions that help patients recover from their illnesses and manage their chronic conditions better—whether it is through a video call OR in-person care.

With the rise of anxiety and suicides, I'm especially interested in the advantages of telehealth to reach people who are need of mental healthcare.

We have also seen a real risk of waste, fraud, and abuse in telehealth. We need to take that into account.

We also need to be aware of the cost to the healthcare system of changes we want to make permanent.

The Medicare Hospital Trust Fund is projected to go bankrupt in 2024—less than 5 years from now.

We need to make sure we expand telehealth and maintain our commitment to the Nation's seniors to provide a top-notch level of care.

CONCLUSION

I'm optimistic about telehealth and its ability to improve the health and wellness of Americans.

It's bringing doctors right into families' living rooms...

. and it's an example of how innovation can improve and save people's lives.

This hearing today is just the beginning of a discussion we need to have about the future of healthcare.

Let's work together in a bipartisan way to review the experiences of the last year and where we can further unleash life-saving innovation and medical breakthroughs.

Let's have a plan for America to lead the way on the best use of telehealth for the benefit of every patient.

Thank you and I yield back.

Ms. ESHOO. The gentlewoman yields back. Thank you for your kind and timely comments.

The Chair would like to remind Members that, pursuant to committee rules, all Members' written opening statements shall be made part of the record.

And now I would like to introduce our witnesses and thank them for being with us today.

First, Dr. Megan Mahoney, chief of staff of Stanford Healthcare. I am so pleased to welcome her, she is my constituent. She has dedicated her career to developing innovative, compassionate approaches to healthcare that empowers patients.

Welcome to you, and thank you.

Dr. Ateev Mehrotra, associate professor of healthcare policy at Harvard Medical School. Thank you and welcome, Doctor.

Ms. Elizabeth Mitchell, president and CEO of the Purchaser Business Group on Health. Welcome to you and thank you.

Dr. Jack Resneck, Jr., board of trustees of the American Medical Association. We welcome you back to the subcommittee to testify today. It is always great to see you.

And Mr. Frederic Riccardi, president of the Medicare Rights Center. Welcome back to the committee to you, Mr. Riccardi, and thank you for being willing to testify.

So, Dr. Mahoney, you are recognized for 5 minutes. And please unmute.

STATEMENT OF MEGAN MAHONEY, M.D., CHIEF OF STAFF, STANFORD HEALTH CARE; ATEEV MEHROTRA, M.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND MEDICINE, HARVARD MEDICAL SCHOOL; ELIZABETH MITCHELL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PURCHASER BUSINESS GROUP ON HEALTH; JACK RESNECK, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; AND FREDERIC RICCARDI, PRESIDENT, MEDICARE RIGHTS CENTER

STATEMENT OF MEGAN MAHONEY, M.D.

Dr. MAHONEY. Thank you. Good morning, Chairwoman Eshoo, Ranking Member Guthrie, and members of the subcommittee. I am Dr. Megan Mahoney, a family physician of over 20 years, chief of staff at Stanford Healthcare, and a clinical professor in the department of medicine at Stanford University.

The COVID–19 pandemic accelerated broad adoption of telehealth, and healthcare systems across the Nation had to make significant investments to rapidly develop virtual care capabilities. Stanford Medicine enabled telehealth for 2,000 providers and 300,000 patients since the beginning of the pandemic. We have had several learnings that I would like to share with you.

We learned that virtual care is broadly adopted as a clinically effective tool, even after we return to offering in-person care across all specialties. In rheumatology, endocrinology, gastroenterology, and cancer care, well over 50 percent of our visits are now being conducted virtually. Across all Stanford clinics we have stabilized at around 30 to 40 percent of visits being conducted virtually, and we believe this is our new normal.

We learned virtual care is appropriate and broadly adopted by nonphysician practitioners such as physical therapists and speech pathologists. These vital team members are eligible to independently bill Medicare for in-person services yet are statutorily excluded from offering those same services via telehealth under section 1834(m) of the Social Security Act.

We also found that we were able to offer unique and safe specialty care via telehealth across State lines. Patients from all 50 States sought care at Stanford Medicine for subspecialties not available in their State when interstate restrictions were waived.

In many ways, telehealth hearkens back to days when the doctor would make house calls. As a family physician, it is incredibly valuable for me to see my patient's home environment. I have found that a thorough medication review can be more easily and accurately done at home, where patients can access medicine bottles and supplements.

There is a perception that telehealth may be overused and lead to increased healthcare costs, something I worry about, as a value-based care champion at my institution. Fortunately, this has not been our experience. Telehealth is a tool in our toolkit that is largely substitutive, not additive to in-person care.

Practically speaking, we find that the physician's time is still the rate-limiting factor for visits per day. We learned a tremendous amount over the past 12 months, but large-scale studies in a postpandemic environment still need to be conducted to determine telehealth's long-term quality and patient safety outcomes.

First, the restrictions of 1834(m) need to be addressed to conserve Medicare beneficiary access to telehealth. We need the ability to provide video visits to patients regardless of whether the patient is at home, at work, or any other private location of their choosing, rural or nonrural. And all provider types that are enrolled to independently bill Medicare for in-person services should also be able to provide clinically appropriate telehealth services.

Second, we need continued expansion of covered telehealth services by CMS in the annual physician fee schedule and for those services to be available to both new and established patients.

Third, we need recognition that visits provided via video require the same effort and medical decisionmaking by the provider. Reimbursements should be equivalent for clinically equivalent services.

And finally, we need a reevaluation and a national view of medical licensure that allows physicians to care for patients across State lines. We support the TREAT Act as a positive step in this direction.

Thank you for this opportunity to share our experience and recommendations with the subcommittee. Telehealth transformation would not have been possible without the rapid actions you and your colleagues in Congress took to ensure access to millions of Americans. We look forward to discussing the continued role of telehealth to realize its promise of high-quality, sustainable, and equitable care for the people of the United States.

Thank you.

[The prepared statement of Dr. Mahoney follows:]

Written Testimony before the U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health

Hearing Concerning the Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care

Megan Mahoney, MD
Chief of Staff, Stanford Health Care
March 2, 2021

Good morning Chairwoman Eshoo, Ranking Member Guthrie and members of the Subcommittee. I am Dr. Megan Mahoney, a family physician for over 20 years, the Chief of Staff at Stanford Health Care, and a Clinical Professor in the Department of Medicine at Stanford University.

Thank you for the opportunity to appear before you to discuss the impact of telehealth on our practice and patients and share recommendations to ensure we can continue to provide safe, effective, patient-centered care beyond the public health emergency (PHE).

The COVID-19 pandemic illuminated important gaps and vulnerabilities in the healthcare delivery system, most visibly the lack of existing infrastructure and preparation needed to provide care to patients remotely and limit the risk of infection. Health systems around the nation made tremendous investments to rapidly develop virtual care capabilities and are now hardwiring that change into their clinical practice. At Stanford Health Care, this system-wide transition to virtual enabled all of our 2000+ physicians with telehealth capabilities and over 225,000 of our patients to complete their first video visit. The depth and breadth of this transformation highlights the changing dynamics and fundamental expectations of our delivery system, as well as patients' receptivity to accessing care through telehealth. Over 90% of our patients **surveyed have said the likelihood they would schedule another video visit is either 'good' or 'very good'.** Patients will demand the option for virtual care going forward, and it is now our collective responsibility to make the system sustainable, efficient and accountable to patients and payors.

The transformation from in-person care to telehealth may have been catalyzed by COVID-19 and the shelter-in-place orders, but it **would not have been possible to achieve without the lifting of legislative and regulatory barriers including:**

1. The waiving of Section 1834(m) geographic, originating site and provider type restrictions
2. The ability to see both new and established patients via telehealth, without any requirement for a prior in-person visit
3. Equivalent provider reimbursement for clinically equivalent services provided via telehealth and in-person
4. State medical licensure waivers creating a path for physicians to provide video visits to patients across state lines

Based on experience and what we have learned to-date, these policy changes should be made permanent. They have dramatically improved access to patient-centered care without increasing overall healthcare utilization. Addressing the 1834(m) restrictions is of particular importance to avoid the inadvertent creation of a **donut hole for Medicare Fee for Service (FFS)** patients, who are among the most vulnerable. The existing statute puts Stanford Health Care and other providers in a position to offer telehealth to everyone *except* Medicare FFS patients because of antiquated restrictions that do not reflect the way healthcare is delivered today. The remainder of this testimony describes what we have learned through our experience with telehealth, what we still need to study, and recommendations for sustainability.

1. **Virtual Care is appropriate and broadly adopted across all clinical specialties and provider types**. 87% of all providers at Stanford Health Care have completed at least one video visit during the pandemic. This includes many non-physician healthcare practitioners that are critical to patients' well-being, including physical therapists, speech language pathologists and occupational therapists [Fig. 1]. These provider types are eligible to bill Medicare independently for all in-person services yet are statutorily excluded from offering those same services via telehealth under Section 1834(m) of the Social Security Act. At the initial peak of the pandemic (April 2020), our Stanford **ambulatory telehealth visits grew from 1% to over 70% of our total outpatient volumes**. With the phased reopening of all our clinics to in-person care, we are now **largely stabilized at 30-40% virtual visits across Stanford** and believe this will be our new normal going forward. We learned that virtual care is a clinically effective, critical tool across all specialties, not just those previously thought to be primed for telehealth such as psychiatry and low complexity urgent care [Fig. 2].

Figure 1. Virtual Uptake by Provider Type*

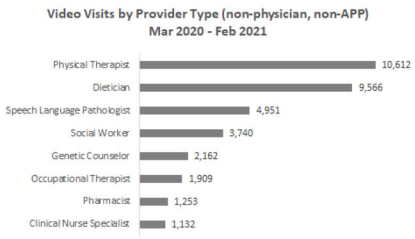
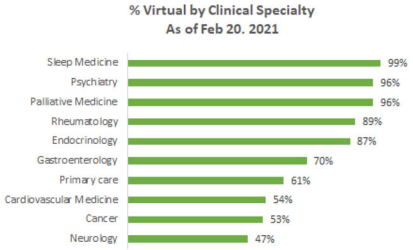


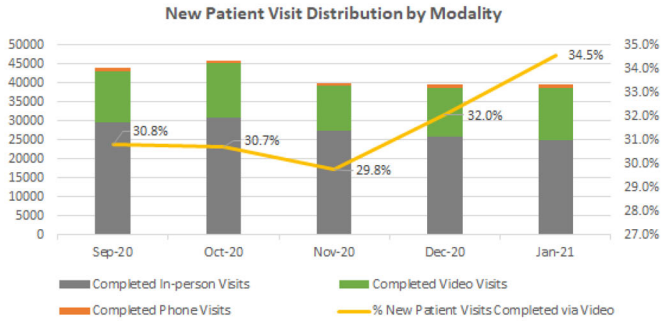
Figure 2. % Virtual by Clinical Specialty*



*Demonstrative sample, list not exhaustive

2. **Virtual care is an important healthcare access point for both new and established patients.** Patients are offered video visits based on clinical appropriateness first and are then able to choose whether they prefer to be seen remotely or in person based on their preference. Depending on the patient's clinical need, a physical exam is often not required in the first visit – in fact, over **30% of patients now initiate care with a Stanford provider via telehealth** [Fig. 3].

Figure 3. New Patient Visit Distribution by Modality



Concerns about Medicare program integrity have perpetuated the perception that requiring a patient to come in-person for an appointment before they can be seen virtually guards against fraud. Our experience in practice is that this requirement adds no clinical value and only limits access to care for patients who do not have an in-person provider. Such in-person requirements can even create safety risks – consider the elderly patient with difficulty walking who could fall unnecessarily, or the many patients receiving care from our sleep medicine clinic who are unsafe to drive. Why should we require these patients to travel to our clinic when it is not clinically necessary or safe to do so? We should do everything in our power to respect patient preference and never limit providers from delivering the most clinically appropriate care.

Additionally, these technologies can increase opportunities for personalization of care and may be particularly well-suited for patients who face barriers around transportation, inflexible work hours, and childcare needs that make it difficult to attend in-person visits. It is important to note, however, that virtual care requires reliable internet access, a smartphone or computer, digital literacy, and insurance coverage of services, which need to be considered to prevent exacerbating existing health disparities.

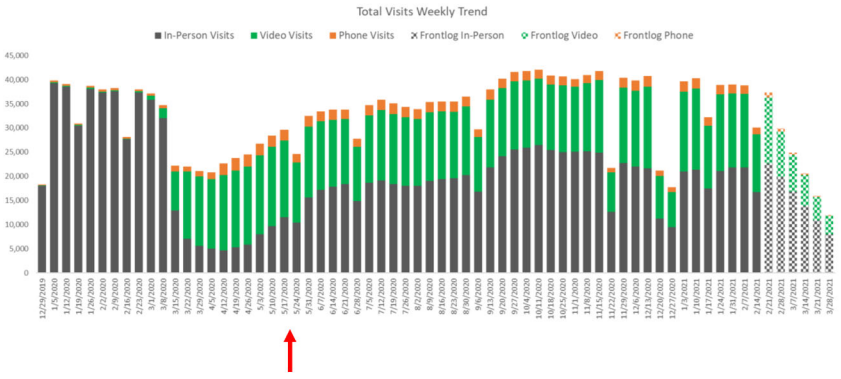
3. **Telehealth has proven clinically effective. It requires equivalent effort and medical decision making (MDM) by providers and should be reimbursed accordingly.** Remote care is one of our most effective tools for combating the spread of communicable diseases and ensuring continuity of care. Going forward, telehealth will provide critical access to care for many patients who are unable to travel, or who cannot take time off work or personal responsibilities to attend an in-person appointment. In many ways, telehealth improves the care experience harkening back to days when the doctor would make house calls – as a family physician, it has been incredibly valuable for me to see my patients' home environments. Among other use cases, we have learned we can actually complete a more valuable medication reconciliation visit with the patient at home, where they can easily access all of their medications and supplements, without having to memorize their doses or risk forgetting a prescription. From a provider billing and reimbursement perspective, the

complexity and clinical effort of the visit is already captured in the level of service coding and does not further vary whether the service was provided via video or in-person.

We encourage the application of standard quality measures for in-person and virtual care, which ensure the same yardstick is used to compare these modalities. The past twelve months have produced the first real-world dataset of scaled telehealth in the United States. Additional time and data collection are needed to complete peer reviewed research to quantify the clinical quality, cost and outcomes of telehealth as compared to in-person. To that end, the Stanford School of Medicine is collaborating with MedStar Health and Intermountain Health to develop one of the nation's largest cumulative data sets of primary care video visit longitudinal outcomes, funded through the Agency for Healthcare Research and Quality (AHRQ). In order for large scale studies like this to produce a meaningful analysis of impacts in a post-pandemic environment, telehealth access and data collection would need to continue past the end of the public health emergency (PHE).

Telehealth is substitutive, not additive to in-person care. Because telehealth at a national scale is still relatively new, there is the perception that it may be over-used and lead to increased health care costs. This has not been our experience. Even as Stanford Health Care reopened all our clinics to in-person care, we have not seen an increase in overall healthcare utilization [Fig. 4]. The past several months have provided the real-world test case for a return to regular practice providing both telehealth and in-person care. We have analyzed our own data and found that office visit utilization has remained largely flat regardless of specialty. Practically speaking, we find the physicians' time is the rate limiting factor for visits per day, and this has not changed with the transition to video. In my own clinic, I can confirm that my number of scheduled appointments per day has remained the same, with a portion of my patients simply joining their visits virtually versus in-person.

Figure 4. Office Visit Volumes by Modality



Clinics reopen to in-person care broadly across Stanford Health Care

4. **Telehealth improves access to care. Patients from all 50 states have sought care at Stanford Medicine** during the pandemic because we provide subspecialty services that simply do not exist elsewhere. This is a unique feature of AMCs. Under the existing federated medical licensure system, physicians are required to be licensed in the state where the patient is physically located at the time of the visit. This structure has worked well and served its purpose. A strong, thorough and transparent physician licensure system is paramount to patient care and accountability but needs to be re-evaluated with the emergence of telehealth. We support the TREAT Act and are also looking beyond the end of the current pandemic to contemplate this new paradigm of care. The medical licensure system must take in to account unintended and undue administrative burdens to facilitate nationwide access to specialty care. For example, tertiary and quaternary care centers like Stanford receive patient requests from all over the country for specific subspecialists, but it would be nearly impossible for the specialist to predict the patient's location far enough in advance to pursue licensure in that state. Nor would it make practical sense to do so -- the licensure process is labor intensive and requires upkeep, including individual applications, background checks, fingerprinting, and continuing medical education (CME) requirements that differ in every state. The provider community will have strong opinions on this, but let us consider the patient perspective, such as this letter from a patient's daughter,

"My father has recently been diagnosed with an aggressive form of cancer, and both his local physicians and the consulting... physician strongly recommend a referral to Stanford in particular, for additional input on his urgently needed therapy. Unfortunately, ***he is too ill to travel to the consulting facility at Stanford****, and in addition to his fragile state making travel extremely risky, he would be at extraordinary high risk of developing severe disease if he were to acquire COVID-19 during the trip.* ***The safest and most logical course would be a video or telephone visit with the Stanford team, though it appears this approach would be prohibited under... [state] law."***

We receive letters like this every day from patients who cannot travel to us, and yet regulatory barriers prevent us from bringing the care to them. Our faculty at Stanford Children's receive many requests for consultation into Nevada because there is no pediatric rheumatologist in the entire state. This example is not unique, these access challenges existed before the pandemic and will persist after, disproportionately impacting those who do not have the resources to travel across state lines for specialty care. For the first time, telehealth creates an opportunity to open access to patients who historically have been geographically isolated in states with little to no specialty or subspecialty providers.

It is critical to the health, safety and equitable access of our patients to ensure we can continue to provide telehealth services after the end of the public health emergency. In order to do so, providers and patients will need:

1. The antiquated restrictions of 1834(m) to be addressed to conserve Medicare beneficiary access to telehealth:
    - The ability to provide video visits to patients **regardless of location** – non-rural and rural settings, and whether the patient is at home, work, or another private location of their choosing.
    - The ability for **all provider types** that are enrolled to independently bill Medicare for in-person services, to also provide clinically appropriate telehealth services – including occupational therapists, physical therapists, and speech language pathologists.
2. Continued expansion of covered telehealth services by CMS in the annual Physician Fee Schedule (PFS).
3. Recognition that the visit provided via video and in-person should be reimbursed equally as it is clinically equivalent and **requires the same effort and medical decision-making by the provider**. The complexity and clinical effort of the visit is already captured in the level of service coding and does not further vary whether the service was provided via video or in-person.
4. A national view of medical licensure that allows physicians to **care for patients across state lines**.

Thank you for this opportunity to share our experience and learnings with the Subcommittee. We deeply appreciate the rapid actions you and your colleagues in Congress took at the start of the pandemic to open access to virtual care for millions of Americans. We look forward to discussing the continued role of telehealth in providing high quality, sustainable, equitable access to care for the people of the United States.

Ms. ESHOO. Thank you, Dr. Mahoney, for your very important testimony.

And now I would like to recognize Dr. Mehrotra for your 5 minutes of testimony, and welcome, and thank you again for being with us.

STATEMENT OF ATEEV MEHROTRA, M.D.

Dr. MEHROTRA. Well, thank you, Chairwoman Eshoo and Ranking Member Guthrie, and the other distinguished members of the subcommittee. I am really honored to speak before you on a topic of such importance for Americans and their health.

My name is Ateev Mehrotra. I am a physician and in practice at the Beth Israel Deaconess Medical Center. I am an associate professor at Harvard Medical School, where my research focuses on telemedicine.

Today I was hoping to emphasize several points from my written testimony that the committee members might consider as they shape the future of telemedicine policy.

I want to start with—a key question is why do we even need telemedicine-specific policies? We don't have similar regulations or guardrails for in-person visits. And I think the key point here is that telemedicine's ability to make care more accessible, why it has so much enormous potential to improve the health of Americans, may also be its Achilles' heel: It can be too convenient in some circumstances, and that convenience translates into more care and increased healthcare spending. And that puts private insurers and government payers in a very difficult situation.

How do we build upon this enormous success that we have had during the pandemic in improving and maintaining access for Americans, but also not leading to unsustainable increases in healthcare spending? The likely path forward, I believe, is to compromise, to expand telemedicine coverage beyond what we had prior to the pandemic, but not maintain the full access that we currently have.

How do we meet that compromise? How do we judge current policies? I have emphasized that the lens by which we should judge telemedicine policies is value. Value simply means how much improvement in outcomes or access is observed, and at what cost. High value and low value are kind of abstract ideas. What does that really mean, concretely, when it comes to telemedicine?

A high-value use of telemedicine could be a patient in a rural community with poorly controlled depression who now can finally access a provider to help him with his depression, or a person with diabetes who struggles to get to doctor's appointments, who can now go to their primary care provider and check in and improve their blood glucoses.

But what do low-value applications look like? A person with well-controlled depression who has weekly check-in visits with their provider. It is so easy. He doesn't have to worry about the inconvenience of travel. Or a person who thinks they probably have a cold but decides to have a video visit because it is so much easier to get an appointment.

The point to emphasize is that neither of these low-value applications is malicious, but in aggregate they may greatly increase the

amount of care that Americans receive without substantially improving their health. In my written testimony I emphasize a number of ways to encourage high-value uses of telemedicine.

I want to touch upon two particularly thorny issues: Should audio-only telemedicine services be covered, and should the payment for telemedicine visits be the same as in-person visits?

Audio-only telemedicine visits are a fancy name for a phone call. It is key to recognize that, in many communities, in particular rural areas as well as poorer communities, many Americans do not have access to a video visit because they lack the technology, or they don't have high-speed Internet. And for those Americans, the only way they can have a telemedicine visit is by a phone call.

However, as emphasized before, there is concern that a telephone call is insufficient to address many clinical issues and that phone calls are more prone to fraud and abuse. And I am also concerned that we create a two-tiered system in the United States, where the wealthy get video calls and the poor have phone calls. And so I believe the longer-term solution is to—as many of the committee members have already pushed—to try to ensure that all Americans have access to video visits.

So I have advocated for a temporary period, 1 to 2 years, where we cover for phone calls in the hope that that time will be used to accelerate efforts to expand access to the necessary technology.

I have also advocated that we pay for telemedicine visits at a lower rate than in-person visits. Critics argue that lower payment rates means that no providers will use telemedicine. I disagree. While I recognize that implementing telemedicine requires some short-term investment, I think in the longer term telemedicine visits have a lower overhead per visit, and those payments should reflect those lower costs. Lower payment rates would also, hopefully, spur more competition through new, more efficient providers.

Thank you again for this opportunity to speak today on this really critical topic, and I look forward to the questions.

[The prepared statement of Dr. Mehrotra follows:]

Telemedicine: What Should the Regulatory and Payment Landscape Look Like Post-Pandemic?

Statement by
Ateev Mehrotra MD
Associate Professor of Health Policy and Medicine
Harvard Medical School

Before the Committee on Energy and Commerce Subcommittee on Health
United States House of Representatives
March 2, 2021

Thank you Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the subcommittee; I am honored to have been invited to testify before you on a topic of such importance to Americans and their health.

My name is Dr. Ateev Mehrotra. I am a physician at the Beth Israel Deaconess Medical Center and an Associate Professor at Harvard Medical School. My research focuses on the impact of telemedicine. Has telemedicine improved people's ability to access care, in particular in rural communities? Has it improved the quality of care they receive? And what impact is telemedicine having on health care spending? In my research I have studied a wide range of clinical applications of telemedicine including mental illness, substance use disorders, stroke, contraception, and acute respiratory illness. I do this research because I hope telemedicine can help address the common complaint I hear as a physician, and what I am sure you hear from your constituents: that people across this nation often have difficulty accessing care in a timely manner.

WHY DO WE NEED TELEMEDICINE POLICIES? [i]

The COVID-19 pandemic has driven a dramatic uptake of telemedicine. After decades of telemedicine being touted as the future of medicine, it has suddenly become commonplace. This growth has been in part facilitated by sweeping changes to regulations and payment from across health care- Medicare, Medicaid, private insurers, and states. Telemedicine groups,[1] employer coalitions,[2] physicians,[3] as well as policymakers[4,5] have lauded these changes and called for some or all of them to be made permanent.[6] Should they be?

Before the pandemic there was a confusing labyrinth of payment and regulations for telemedicine. A provider who wanted to use telemedicine had to consider: (1) Medicare payment policy as well as numerous federal agency regulations; (2) state policy such as telemedicine parity laws, licensing board regulations, and state-specific Medicaid rules; and (3) private insurance rules and regulations. Despite this confusing landscape, the number of telemedicine video visits was steadily growing by roughly 30 to 50 percent per year.[7] In some rural communities, telemedicine was commonly used by people to receive care for mental illness.[8] Still, outside rural areas, telemedicine visits made up a small fraction of the one billion office visits in the U.S. each year.

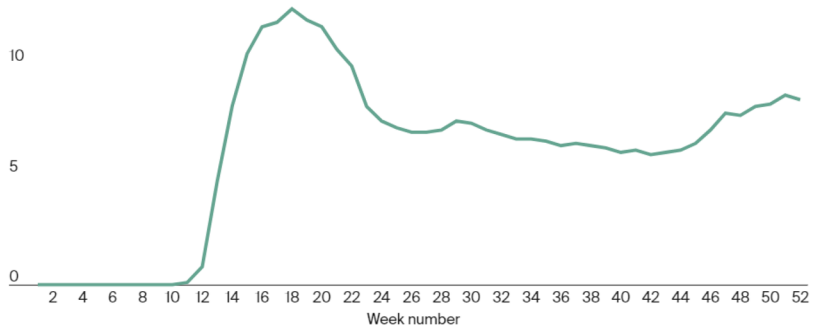
Then came COVID-19. Telemedicine is ideally suited to address some of the fundamental challenges posed by COVID-19.[9] For patients with COVID-19 or concerned that they have the virus, telemedicine can be used by providers to safely answer questions and make triage decisions. For patients without COVID-19, telemedicine can be used to treat chronic illness or other non-virus related care without putting the patient at risk. Without telemedicine, some patients may defer

[i] Much of the content in this testimony is adapted from a Commonwealth Fund Issue Brief I wrote with colleagues Bill Wang and Gregory Snyder. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/telemedicine-post-pandemic-regulation

necessary care due to fear of acquiring the virus at the clinic. Because these benefits were widely recognized, Medicare, states, and private insurers made numerous changes to encourage use of telemedicine.[10]

There was an immediate response by providers. In mid-March 2020 there was a sudden and sharp rise in the use of telemedicine (Exhibit 1). The pace of telemedicine adoption was dizzying; changes that might have taken decades occurred within weeks. Since the start of the pandemic, telemedicine has been key for maintaining American's access to their providers.[11]

Exhibit 1: Number of telemedicine visits per week in 2020 as a fraction of the number of visits seen per week at baseline



SOURCE: Data come from Phreesia, a health information technology company, which works with 1,600 provider organizations representing more than 50,000 providers across all 50 states. Percentage represent the number of telemedicine visits in a given week divided by the number of all visits (telemedicine and in-person) in the baseline week of March 1st. More details are available here.[12]

Speaking about the changes to telemedicine policy, former CMS Administrator Seema Verma said, 'I can't imagine going back.'[13] This idea has been echoed by Health and Human Services Secretary-designate Xavier Becerra who recently noted, "[I] wholeheartedly believe that we're going to be doing an expansion of telehealth…Covid has taught us so much … If we don't learn from Covid how telehealth can help save lives, then we're in trouble."[14]

The question is how to prudently permanently expand telemedicine coverage and what temporary changes should be made permanent and which should lapse.

Though the pandemic may still be with us for months to years, the decision on long-term post-pandemic plans is urgent. After the initial surge of uptake, many physicians have moved away from telemedicine and returned to in-person visits — driven in part by uncertainty over telemedicine's long-term sustainability.[15] (Exhibit 1) Initially, medical practices, out of desperation, made short-term adaptations to use video visits or phone calls. To implement video telemedicine effectively in the long term, however, medical practices need to buy the right technology, invest in staff training, change clinical schedules, and help their patients obtain and navigate the necessary technology. Practices will only make this investment of time and money if they can recoup the investment over many years.

Given there are few regulations and payment policies specific to in-person visits, why do we even need telemedicine-specific policies? The concern is that in some circumstances telemedicine is *too convenient* and may encourage excessive use of care. For example, after an in-person visit, a physician could easily add a quick follow-up telemedicine visit that increases costs without any substantial improvement in health (discussed more below). This logic underlies why the Congressional Budget Office and others believe that broad telemedicine expansions will substantially increase health care

spending.[16] In other words, telemedicine's ability to make care convenient and more accessible — the key to its enormous potential to improve the health of many patients — may also be its Achilles' heel.

TWO OVERARCHING PRINCIPLES

What are the key principles in telemedicine policy? The first is that we should not try and formulate a single policy that covers all forms of telemedicine and patients — just as there can be no single policy of coverage all prescription drugs. In the same way different drugs yield different outcomes, telemedicine may provide health benefits for *certain* clinical uses. For example, telestroke could save lives. On the other hand, telemedicine visits for the common cold have little clinical benefit.

The second principle is that policymakers should formulate their telemedicine policy decisions through the lens of value. In the case of telemedicine, value is the dollars per improvement in care outcomes and access. Improvements in access could decrease travel time, disruption to lives, and the need for childcare. Under the value framework, the questions are: What are the high-value applications of telemedicine? And how can policies encourage higher-value applications of telemedicine and discourage lower-value applications of telemedicine?

Value is dictated not only by the condition treated (for example, common cold vs. stroke), but also by the patient who is receiving care. Consider two patients with depression who can participate in a telemedicine visit. One lives in rural Alaska with no access to local providers and with substantial transportation barriers. Telemedicine could be the only way he can access care and improve his condition. The second patient lives in Anchorage, her depression is well controlled, she sees her psychiatrist every month, and she is on the right medications. There is minimal value in an additional telemedicine visit every two weeks for her depression. As described below, many telemedicine policies try and target the patient populations most likely to benefit from improved access.

Components of Value

In the context of telemedicine, value encompasses quality, costs, and access. I highlight important factors in each of these domains that payers and policymakers should consider.

Quality. To date, most telemedicine research has focused on the equivalency of in-person visits and telemedicine visits. In general, randomized trials have supported the idea that telemedicine is of equal quality. For example, one trial compared telemedicine to in-person care and found they are equivalent using validated scales of depression severity.[17] In some cases increasing access to telemedicine can improve care. In an article we published just yesterday we found that across over 600 hospitals, many in smaller or rural communities, the introduction of telemedicine for the treatment of stroke improved quality and saved lives.[18]

However, our concern is that this research has been used to support the idea that *all* forms of telemedicine are safe and therefore should be reimbursed. Telemedicine video visits are limited by the inability to complete a full physical exam and obtain ancillary testing.[19] It is impossible to reliably diagnose an infant with an ear infection without looking at her ear drum; not surprisingly, telemedicine visits for ear infection result in overuse of antibiotics.[20] There are also concerns that telemedicine makes fraud easier to commit.[21,22]

Quality of telemedicine also depends on having equipment available to the patient. To be most effective, telemedicine often requires the addition of devices such as home oxygen monitors, EKGs, and stethoscopes. For example, a video of a child's ear drum obtained by the parent via a video-enabled otoscope may allow a physician to accurately diagnose an ear infection. In "hospital-at-home" programs, telemedicine enhanced with home monitoring equipment is essential to enabling physicians to manage serious conditions such as pneumonia and heart failure within the home.[23]

Spending. Three factors drive telemedicine's impact on spending from the perspective of an insurance plan or Medicare.[24] The first is the proportion of telehealth encounters that are substitutive versus additive. Spending is reduced if lower-cost telemedicine visits substitute for costlier in-person ones. However, the convenience of telemedicine may induce new use. In previous work, we estimated that for telemedicine for treatment of low-acuity conditions, such as sinusitis, roughly 90 percent of visits are additive and only 10 percent are substitutive; in net, telemedicine for these conditions increased spending.[25]

The balance of substitution versus additive care will be driven primarily by the clinical condition. Conditions such as rashes and common colds are common, and most patients with these conditions do not get care. These are the conditions most prone to additive care. In contrast, acute conditions such as stroke, for which most already receive treatment, are less prone to increased utilization. Another driver of the balance between substitutive versus additive is how is telemedicine being used. Visits are more likely to be additive if telemedicine is used as a triage tool and if most patients still get a follow-up in-person visit — or if providers begin billing for follow-up phone visits, which previously they did not bill for.

The second consideration is the relative cost difference between a telemedicine visit and an equivalent in-person visit. If telehealth is reimbursed at a much lower rate than an equivalent in-person visit, increased use of care may not contribute to an overall increase in spending. This relative cost difference is particularly relevant given that even before the pandemic, Medicare paid the same amount for a video visit.[ii] Moreover, many states have passed laws mandating that telemedicine visits be paid at the same level as equivalent in-person visits. Although payment parity may spur more providers to adopt telemedicine, parity will lead to increased spending.

The third factor is downstream care. Telemedicine may decrease spending if it is deployed in settings where there is a costly and preventable downstream event, such as an emergency room visit, inpatient admission, or specialty referral. In these areas, telemedicine may reduce spending even if upfront use increases. For example, among older, sicker nursing home residents, after-hours telehealth coverage may generate substantial savings by deterring costly emergency department transfers and inpatient admissions.[26]

Access. One erroneous belief is that if telemedicine is offered to the full population, it will be used most by patients with difficulty accessing care. In fact, it may be the opposite. For example, when a company offered telemedicine to all its employees, those who used telemedicine for lower-acuity conditions tended to be younger than the rest of the population and live in an urban community with an ample supply of providers[27]. Older adults, the poor, communities of color, and patients who visit a community health center are all less likely to have the technology necessary to conduct a video visit.[28] Indeed, in some settings telemedicine may actually increase disparities in care.

A second access consideration is the *form* of telemedicine being used. Video-based telemedicine visits were relatively uncommon before the pandemic. In contrast, other telemedicine models that are not reimbursed, including patient portals or email, were common. Though not typically reimbursed, telephone calls, now called audio-only telemedicine visits, were also a common way patient received advice. "Virtual endocrinology" providers have introduced models in which patients are continuously monitored using internet-connected continuous glucose monitors and smart phone apps. Communication with patients on the adjustment of insulin occurs through a variety of means, from automated feedback on apps to glucometers and text messages. These other forms of telemedicine complicate the conversation about payment and regulations. While it seems feasible for an insurer to pay for a video visit or phone call, it is hard to envision paying a provider for each text message, portal exchange, or use of a smart phone app. These forms of telehealth are better suited to alternative payment models than fee-for-service payments.

[ii] It could be argued that Medicare pays more for a video visit because there are often two payments for a video visit. The payment to the provider who delivers the care and an additional payment to the provider hosting the patient. However, a complicating component is that for outpatient hospital practices, a video visit will result in lower reimbursement because there is no associated facility fee.

Policies Available to Encourage High-Value and Discourage Low-Value Uses of Telemedicine

Policymakers face a difficult challenge in designing an optimal payment and regulatory policy for telemedicine. I outline the different polices or the "tool kit" available.

One strategy is to move away from fee-for-service to alternative payment models such as full or partial capitation and bundled payments. These payment models put providers at financial risk if spending is too high. The assumption is that providers will only use telemedicine when it is cost-effective and therefore will adopt higher-value telemedicine applications. This assumption has driven Medicare's policy to allow accountable care organizations more freedom in using telemedicine.

A second strategy is to leverage benefit design. Out-of-pocket costs in the form of copayments or coinsurance may deter low-value care. Introducing "time costs," or inconvenience, can also deter low-value care. For example, prior to the pandemic, Medicare required telemedicine visits to be hosted at a local clinic or other hosting provider, which places a time constraint on patients.

A third strategy is to limit coverage to certain types of care. Coverage decisions can be made based on the type of provider (primary care vs. specialist), the medical condition treated, or the patient population (rural patients, people with a disability, or those with a compromised immune system). Before the pandemic, there were coverage limitations across all these dimensions. Medicare has allowed physicians, typically primary care providers, to use telemedicine for care transitions.[29] The SUPPORT Act, FAST Act, and the Consolidated Appropriations Act of 2020, meanwhile, explicitly expanded use of telemedicine for treatment of substance use disorder, acute strokes, and behavioral health conditions respectively. And Medicare has typically paid only for telemedicine visits in rural communities. Underlying these coverage choices is the hope that the resulting telemedicine visits will be of higher value than in-person visits.

A fourth strategy lies in setting payment rates for a telemedicine visit relative to an in-person visit. Telemedicine payment rates have been set below, equivalent to, and substantially above those for in-person visits. There are concerns that if payment rates for telemedicine visits are lower that an in-person visit then providers will abandon telemedicine.[30] However, I believe a provider's choice is driven by the relative margin (payment rate minus costs of delivering a visit) and how this differs between in-person versus telemedicine visits. Using this framework, telephone visits should be paid substantively less because phone visits are less costly to deliver.

A fifth strategy category is regulation. For example, there may be a policy that patients and providers have an initial in-person visit before offering telemedicine. In the Consolidated Appropriations Act of 2020, the Congress required an in-person visit before a provider could provide a telemedicine visit for a behavioral visit. This could, in theory, deter fraud and encourage greater continuity of care. However, the concern is that this will limit access for patients as they will not be able to access specialty care from providers outside their community. Other telemedicine regulations include limiting the number of telemedicine visits during a given time period; requiring providers to obtain informed consent or have a provider ("telepresenter") with the patient during the visit; limiting software to those that are HIPAA compliant; and requiring providers to have special telemedicine training. Possibly the most important regulation has been licensure and the requirement that all telemedicine providers (physicians, nurse practitioners, social workers) be licensed in the patient's state.

RECOMMENDATIONS

How can we balance the goals of encouraging high-value telemedicine and addressing concerns about low-value telemedicine use and spending? I recommend the following:

1. Increase use of alternative payment models. Such payment models give providers the flexibility to use a package of telemedicine tools (portal message, video visit, phone call, telemonitoring) and in-person visits that are best suited for an individual patient and clinical scenario. Paying for just video visits may deter more innovative models such as the

virtual endocrinology providers described above. Insurers do not have to address the complexity of how much each such encounter should be paid, and it can spur efficiency in care. Medicare has allowed telemedicine to be used under most of its alternative models, but the keys are to expand how many providers are paid under such a model and ensure the rules for alternative payment models facilitate telemedicine use. I am particularly enthusiastic about such payment models for primary care providers.

2. Make permanent nearly all regulatory waivers introduced during the pandemic, including requirements that providers: a) have an in-person visit before a telemedicine visit; b) host telemedicine visits at a clinical facility; c) obtain informed consent; and d) obtain special training. The prior regulatory framework across federal, state, and individual plans added tremendous complexity. Despite the laudable reasons underlying these regulations, I believe they are both relatively blunt and ineffective. I have also called for physician licensure reciprocity such that a physician licensed in any state can provide care to a Medicare enrollee.[31]
3. Cover *all forms* of telemedicine for high-risk patient populations where access is likely difficult. Coverage can be expanded beyond rural communities to patients who are cared for in federally qualified health centers, community mental health centers, nursing homes, and for people who have substantial physical or mental disability.
4. For the rest of the population, cover telemedicine only where there is evidence of value or there is compelling need. Such selective coverage decisions could be either by condition or by provider. For example, I agree with the recent decision to permanently expand access to behavioral health in the Medicare program. In an effort to encourage continuity and financially support primary care, Medicare could implement policies by which a designated primary care provider will be paid for any form of telemedicine visit.
5. Pay for telemedicine visits at a lower rate than for in-person visits and therefore avoid telemedicine parity. While I recognize that implementing telemedicine does require significant investment in the short term, in the longer term a providers' marginal costs for telemedicine visits should be lower than for in-person visits, and reimbursement should reflect those lower costs. Lower payment rates could also spur more competition through new, more-efficient providers and may deter low-value uses of telemedicine.
6. Pay for telephone calls (audio-only telemedicine visits) for only a time-limited period such as two years. While I recognize telephone calls may increase access for disadvantaged populations, I am concerned about a future with a two-tiered system where the poor and disadvantaged have phone calls and the wealthy have video visits. My hope would be that limiting payment for a short period will spur investment in broadband, technology, and training so that all Americans can have the capacity to have a video visit.
7. Encourage consistency across insurers. If Medicare covers telemedicine for opioid-use disorder but private insurers or Medicaid do not, then substance use providers will be less likely to embrace telemedicine. For example, CMS can require Medicare Advantage plans to echo some of its coverage decisions in the fee-for-service program.

There is obviously no single optimal policy for telemedicine. And I acknowledge that the coverage decisions and payment choices recommended are by no means perfect. They will deter some effective forms of telemedicine and do add administrative burden. However, I believe they represent the best way to encourage high-value applications of telemedicine and encourage a necessary transformation of our health care system.

Again, let me thank Chairwoman Eshoo, Ranking Member Guthrie, and members of the subcommittee for allowing me to appear before you today to discuss this important issue. I would be happy to take your questions.

[1] Bart M. Demaerschalk, Jill Berg, Brian W. Chong, Hartmut Gross, Karin Nystrom, Opeolu Adeoye, Lee Schwamm, Lawrence Wechsler, and Sallie Whitchurch, "American Telemedicine Association Telestroke Guidelines," *Telemedicine and E-Health* 23, no. 5 (May 1, 2017), https://doi-org.ezp-prod1.hul.harvard.edu/10.1089/tmj.2017.0006.
[2] "Employers on Telehealth: Government Standing in the Way" (The Erisa Industry Committee, June 17, 2020), https://www.eric.org/wp-content/uploads/2020/06/06-17-20-ERIC-Statement-for-HELP-Telehealth-Hearing-Final.pdf.
[3] "Issue Brief: COVID-19 and Telehealth Changes" (American Society of Health-System Pharmacists, April 9, 2020), https://www.ashp.org/Advocacy-and-Issues/Key-Issues/Other-Issues/Issue-Brief-COVID-19?loginreturnUrl=SSOCheckOnly.
[4] United States Senate, "Letter to Leadership," June 15, 2020, https://www.schatz.senate.gov/imo/media/doc/Letter%20to%20leadership_CONNECT%20for%20Health%20Act_06.12.20.pdf; "Alexander: Make the Two Most Important COVID-19 Telehealth Policy Changes Permanent," U.S. Senate Committee on Health, Education, Labor & Pensions, June 17, 2020, https://www.help.senate.gov/chair/newsroom/press/alexander-make-the-two-most-important-covid-19-telehealth-policy-changes-permanent.
[5] HHS secretary nominee pledges support for permanent telemedicine expansion: 4 details. https://www.beckershospitalreview.com/telehealth/hhs-secretary-nominee-pledges-support-for-permanent-telemedicine-expansion-4-details.html
[6] Alicia Ault, "APA, Others Lobby to Make COVID-19 Telehealth Waivers Permanent," Medscape, May 29, 2020, https://www.medscape.com/viewarticle/931370; Seema Verma, College of Healthcare Information Mangement Executives, n.d., https://chimecentral.org/wp-content/uploads/2020/05/CHIME-Letter-to-CMS-on-COVID-19-Interim-Final-Rules.pdf.
[7] Ateev Mehrotra, et al., "Utilization of Telemedicine among Rural Medicare Beneficiaries," *JAMA* 315, no. 18 (2016): 2015–16; Michael L. Barnett, et al., "Trends in Telemedicine Use in a Large Commercially Insured Population, 2005-2017," *JAMA* 320, no. 20 (2018): 2147–49.
[8] Patel, Sadiq Y., Haiden A. Huskamp, Alisa B. Busch, and Ateev Mehrotra. "Telemental Health and US Rural–Urban Differences in Specialty Mental Health Use, 2010–2017." *American Journal of Public Health* 110, no. 9 (2020): 1308-1314.
[9] Judd E. Hollander, and Brendan G. Carr., "Virtually Perfect? Telemedicine for COVID-19," *New England Journal of Medicine* 382, no. 18 (2020): 1679–81; Anthony C. Smith, et al., "Telehealth for Global Emergencies: Implications for Coronavirus Disease 2019 (COVID-19)," *Journal of Telemedicine and Telecare*, 2020, https://doi.org/10.1177/1357633X20916567.
//[10] Verma.
[11] Patel, Sadiq Y., Ateev Mehrotra, Haiden A. Huskamp, Lori Uscher-Pines, Ishani Ganguli, and Michael Lawrence Barnett. "Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States: Study examines variation in total US outpatient visits and telemedicine use across patient demographics, specialties, and conditions during the COVID-19 pandemic." Health Affairs 40, no. 2 (2021): 349-358. and Huskamp, Haiden A., Alisa B. Busch, Lori Uscher-Pines, Michael L. Barnett, Lauren Riedel, and Ateev Mehrotra. "Treatment of Opioid Use Disorder Among Commercially Insured Patients in the Context of the COVID-19 Pandemic." JAMA 324, no. 23 (2020): 2440-2442.
[12] Ateev Mehrotra et al., The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/bvhf-e411
[13] "Speech: Medicare Remarks by CMS Administrator Seema Verma at the Commonwealth Club of California," Centers for Medicare & Medicaid Services, June 25, 2018, https://www.cms.gov/newsroom/press-releases/speech-medicare-remarks-cms-administrator-seema-verma-commonwealth-club-california.
[14] Adriel Bettlheim, Can Biden go Bigger? Politico, February 24, 2021. https://www.politico.com/newsletters/future-pulse/2021/02/24/can-biden-go-bigger-793559
[15] Ateev Mehrotra, David Linetsky, and Hilary Hatch, "This Is Supposed to Be Telemedicine's Time to Shine. Why Are Doctors Abandoning It?," STAT News, June 25, 2020, https://www.statnews.com/2020/06/25/telemedicine-time-to-shine-doctors-abandoning-it/.
[16] Lori Housman, Zoe Williams, and Philip Ellis, "Telemedicine," Congressional Budget Office, July 29, 2015, https://www.cbo.gov/publication/50680.
[17] Richard O'Reilly, et al., "Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results from a Randomized Controlled Equivalence Trial.," *Psychiatric Services* 58, no. 6 (2007): 836–43.
[18] Wilcock, Andrew D., Lee H. Schwamm, Jose R. Zubizarreta, Kori S. Zachrison, Lori Uscher-Pines, Jessica V. Richard, and Ateev Mehrotra. " Reperfusion Treatment and Stroke Outcomes in Hospitals With Telestroke Capacity." JAMA Neurology, Published Online, March 1, 2021.
[19] Lori Uscher-Pines, et al., "Access and Quality of Care in Direct-to-Consumer Telemedicine," *Telemedicine and E-Health* 22, no. 4 (2016): 282–87.
[20] Kristin N. Ray, et al., "Antibiotic Prescribing during Pediatric Direct-to-Consumer Telemedicine Visits," *Pediatrics* 143, no. 5 (2019), https://doi.org/10.1542/peds.2018-2491.
[21] Fred Schulte, "Coronavirus Fuels Explosive Growth In Telehealth — And Concern About Fraud," Kaiser Health News, April 22, 2020, https://khn.org/news/coronavirus-fuels-explosive-growth-in-telehealth-%E2%80%95-and-concern-about-fraud/.
[22] Alicia Diaz, Federal watchdog raises concerns about increasing telehealth fraud during pandemic. *STAT*, Feb. 22, 2021. https://www.statnews.com/2021/02/22/federal-watchdog-raises-concerns-about-increasing-telehealth-fraud-during-pandemic/

[23] David M. Levine, et al., "Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial," *Annals of Internal Medicine* 172, no. 2 (2020): 77–85.
[24] Adam M. Licurse, and Ateev Mehrotra, "The Effect of Telehealth on Spending: Thinking through the Numbers," *Annals of Internal Medicine*, 2018, https://doi.org/10.7326/M17-3070.
[25] Scott J. Ashwood, et al., "Direct-to-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending," *Health Affairs* 36, no. 3 (2017): 485–91.
[26] David C. Grabowski, A. James O'Malley, "Use Of Telemedicine Can Reduce Hospitalizations Of Nursing Home Residents And Generate Savings For Medicare," *Health Affairs* 33, no. 2 (2014), https://doi.org/10.1377/hlthaff.2013.0922.
[27] Lori Uscher-Pines, et al., "Access and Quality of Care in Direct-to-Consumer Telemedicine."
[28] June-Ho Kim, Eesha Desai, Megan B. Cole, "How The Rapid Shift To Telehealth Leaves Many Community Health Centers Behind During The COVID-19 Pandemic," *Health Affairs*, June 2, 2020, https://doi.org/10.1377/hblog20200529.449762; Cyrus K. Yamin, et al., "The Digital Divide in Adoption and Use of a Personal Health Record," *JAMA Internal Medicine* 171, no. 6 (2011): 568–74, https://doi.org/doi:10.1001/archinternmed.2011.34.
[29] "FAQ on Transitional Care Management," American Academy of Family Physicians, accessed July 8, 2020, https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/tcm/tcmfaq.html.
[30] Mehrotra, Ateev, R. Sacha Bhatia, and Centaine L. Snoswell. "Paying for Telemedicine After the Pandemic." JAMA 325, no. 5 (2021): 431-432.
[31] Ateev Mehrotra, Alok Nimgaonkar, Barak Richman. Telemedicine and Medical Licensure — Potential Paths for Reform. N Engl J Med 2021; 384:687-690

Ms. ESHOO. Thank you, Dr. Mehrotra. That was fascinating testimony.

Ms. Mitchell, thank you for being with us and testifying today. You have 5 minutes. And please unmute.

STATEMENT OF ELIZABETH MITCHELL

Ms. MITCHELL. Thank you, Chairwoman Eshoo, Congressman Guthrie, and members of the subcommittee. And thank you particularly for inviting the perspective of purchasers and large employers.

The Purchaser Business Group on Health, who I am representing, represents over 40 jumbo private employers and public entities across the U.S. Together we pay for healthcare for more than 15 million Americans and spend more than 100 billion a year on healthcare services. So we are truly invested in improving the U.S. healthcare system.

I want to start by saying that we strongly support patient-centered innovation and digital modernization in healthcare. There are few industries that still rely on fax machines, and leveraging new technology is long overdue. The U.S. healthcare system needs urgent reforms in care delivery, including more effective use of technology. But in our view, simply adding a new service or technology to an already dysfunctional system without consideration for quality outcomes, patient experience, and total cost is not the right approach.

However, we see enormous promise for telehealth. By making care more accessible, telehealth can function as a highly useful tool in providing care to underserved areas, like we have heard today, particularly in rural communities, and expanding care to sectors like behavioral health, which is a top priority for my employer members.

Not only can telehealth improve access and outcomes, telehealth can be cost effective, which is a rare trifecta in healthcare, and why my employer members are so supportive. By reducing overhead costs and enabling healthcare providers to efficiently treat more patients, several studies have concluded that broader availability of telehealth could bring significant cost savings to the healthcare system.

One of our member companies, eBay, has calculated that, if they were to enable appropriate adoption of telehealth among their U.S.-based employees, the company could reduce its self-insured medical and pharmacy costs by roughly 8 percent annually, without sacrificing quality and improving the patient experience. That type of savings is very significant, and that investment can go back into core business and wages.

Another of my members, a manufacturer, just shared yesterday that they see huge promise for telehealth for improving access for their employees to primary care. We see these as truly necessary and important innovations.

But even better news is that people like it. We recently completed research among California-based HMOs and Medicare, and nearly 9 in 10 people report that they would recommend telehealth, and nearly three-quarters wished to continue using it. So, from a patient perspective, this is a positive change.

In addition, physicians and other healthcare providers also tell us that they are satisfied with providing care via telehealth. So this really has the potential to be a win and win.

So why hasn't telehealth been broadly adopted? Telehealth is not even a new technology, it has been with us for over 2 decades. As we have heard already today, the primary barrier is payment. Payment for U.S. healthcare is irrational.

We need to change the payment system to a value-based payment system that actually rewards telehealth and other innovative, cost-effective services appropriately. We need to change how we pay for healthcare generally to reduce physician burden, reduce inequity, and get better outcomes for patients and better value for the employers and governments who are paying the bills.

We need to rapidly expand the effective use of telehealth or, as we heard this morning, do it with intentionality as part of a broader shift to a long-overdue transition to value-based care. And the key to getting this right is to adopt payment models and hold healthcare systems accountable for quality, patient experience, equity, and total cost of care. We believe in a system where accountability for outcomes and total cost is present, you will see rapid adoption of these patient-centered innovations.

And, as you have also heard today, we believe this is a huge opportunity to address equity. We know that too often low-income communities, rural communities, communities of color do not have the same access to needed care. We believe that telehealth provides a unique opportunity to address those disparities and improve outcomes for low-income communities.

We will be expanding our research on patient experience with telehealth to include Medicaid. We believe there is much to be learned and meaningful improvements to be had in care for all populations through telehealth. However, there is too little data. We need more research. We need more experience with quality and cost measurement. But we believe, collectively, there is an enormous opportunity here to improve care and improve value in the U.S. healthcare system. We thank you for your time and attention, and we look forward to talking with you further.

[The prepared statement of Ms. Mitchell follows:]

275 Battery Street, Suite 480
San Francisco, CA 94111
(415) 281-8660

pbgh.org

Testimony of Elizabeth Mitchell
President and CEO
Purchaser Business Group on Health

Hearing of the Committee on Energy and Commerce
Health Subcommittee

THE FUTURE OF TELEHEALTH:
HOW COVID-19 IS CHANGING THE DELIVERY OF VIRTUAL CARE

March 2, 2021

Chairwoman Eshoo, Congressman Guthrie, and members of the Subcommittee on Health: Thank you for the opportunity to address the subcommittee today on this critical issue. I am Elizabeth Mitchell, President and CEO of the Purchaser Business Group on Health (PBGH). PBGH is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend $100 billion annually purchasing health care services for more than 15 million Americans and their families. Our members work with us to identify needed system reforms to achieve and pay for optimal quality and outcomes and affordable care.

As you know, the novel coronavirus (COVID-19) pandemic has challenged the country's public health, health care payment and delivery systems more than any other event in living memory. Among the numerous challenges, millions of people have been unable to receive needed medical care from their usual medical providers due to travel restrictions, office closures and concerns about viral spread. The result has been a significant decline in needed care including childhood vaccinations, mental and behavioral health care, and deferred care for chronic conditions.[1]

COVID-19 As Catalyst for Telehealth – Opportunities and Concerns

The U.S. health care system needs urgent reforms in care delivery including more effective use of technology. But simply adding a new service or technology to an already dysfunctional system without consideration for quality outcomes, patient experience and total cost is not the right approach. My testimony today will focus on ways policymakers can harness the promise of telehealth and its rapid adoption during the pandemic -- and if managed properly -- to help millions of people in the United States access high quality, affordable health care. By making care more accessible, telehealth can function as a highly useful tool in providing care to underserved areas and populations and in expanding care in under-resourced sectors, such as behavioral health.

Academic studies suggest telehealth is popular with many patients and is often preferred compared to in-person care.[2] Many physicians and other providers are finding that telehealth suits their needs as well.[3] **Recently completed research by PBGH found that among 1,500 patients in California covered by commercial HMO and Medicare Advantage insurance plans, no difference was reported in satisfaction between virtual and in-person care.** In addition, 87% of respondents reported that they would recommend telehealth and 73% wish to continue its use. Telehealth adoption is an overdue improvement to enhance access and patient experience.

But rapid adoption of telehealth has the potential to be a double-edged sword: without proper oversight by policymakers and purchasers, greater use of telehealth could lead to increased fragmentation, duplicative and unnecessary spending,

higher rates of fraud and ultimately higher overall costs and worse outcomes for patients. This is why your hearing today is so timely and critically important. Congress has an opportunity to get this right the first time, rather than having to go back and fix unintended consequences later. In our view, this is not unlike the early days of electronic health records (EHRs) that had the potential to greatly improve care coordination and patient safety and outcomes. Very significant federal and private investment went into electronic data sharing and tools but ten years later we find ourselves with a massive industry that does not effectively share data, does not prioritize quality and safety, adds to the burden of physicians and care teams and has become entrenched in business interests that do not always align with patient needs or public interest. We hope to avoid that same fate for telehealth by setting clear standards and objectives for its use and adoption.

From the purchaser perspective, I offer the following principles for expanded use of telehealth in the years ahead. My testimony dives deeper into each of these principles and offers specific policy recommendations:

- ***Clinically appropriate and high quality:*** *Expanded use of telehealth services must be clinically appropriate and provide high-quality care, with outcomes commensurate with or better than in-person care.*
- ***Cost effective:*** *Telehealth should be cost effective for purchasers and patients and its use should reduce the total cost of care by reducing low-value care.*
- ***Coordinated:*** *Telehealth should enhance care coordination, rather than duplicate services and add to an already fragmented system.*
- ***Meets Patients where they Are***: *State licensure requirements should not be a barrier to access to care.*
- ***Equitable:*** *Expanded use of telehealth should reduce disparities in health care, not exacerbate existing inequities.*
- ***Used in population-focused, total-cost-of-care models:*** *Finally, telehealth is most effective when deployed in a payment model where providers are accountable for quality, patient experience, equity and the total cost of care.*

Clinically Appropriate and High Quality

There is relatively little academic research regarding the clinical appropriateness of telehealth as an alternative to traditional in-person care. **Certain services, such as behavioral health care, may be best delivered via telehealth for many populations.**[4] Yet, with current technology and regulations, many treatments and services cannot be reasonably provided outside of an in-person setting.[5] Further, certain patients may be better suited to telehealth than others. Those with poor

cognitive function, for instance, may face challenges receiving care through telehealth.[6]

There is limited research on differential quality outcomes between in-person and telehealth-based care.[7] **In addition to clinical outcomes, one critical area of quality is patient experience, where PBGH research shows promising results for telehealth. For 20 years, PBGH has led the largest statewide patient experience program, collecting data from over 40,000 patients each year, and producing performance ratings for roughly 180 provider organizations in California.** Included in our research are questions regarding patient experience with telehealth. Among the high-level results:

- Patients are roughly equally satisfied with virtual and in-person care.
- Overall, telehealth is popular: 87% of respondents say they recommend telehealth, and 73%want to continue using telehealth in the future.
- Video visits are favored over audio-only by most patients.
- The audio-visual / audio experience does not appear to negatively impact provider communication, which is rated highly among patients.

Despite these promising findings, PBGH research has been, to date, limited to commercial populations in the state of California. Further research on patient experience and clinical outcomes should be conducted nationwide with more diverse populations, including Medicaid beneficiaries, racial and ethnic minorities and those with limited English proficiency. **PBGH will have preliminary results from a survey with a sample of patients with Medi-Cal coverage in spring 2021 and seeks to expand this measurement nationwide.**

PBGH recommends that policymakers:

- *Develop clinical guidelines for which treatments and services can be appropriately provided through telehealth.*
- *Require measurement of patient experience and outcomes through telehealth*
- *Invest in nationwide research on the differential impacts of telehealth versus in-person care on quality outcomes and patient experience.*
- *Avoid mandates or other permanent policy changes regarding telehealth coverage requirements for specific services until there is clear evidence on clinical appropriateness.*

Cost-Effective

Telehealth can provide a cost-effective health care solution for many patients. By reducing overhead costs and enabling health care providers to efficiently treat more patients, **several studies have concluded that broader availability of telehealth could bring significant cost savings to the health care system**.[8] One of our member companies, eBay, has calculated that if they were to enable appropriate adoption of telehealth among its U.S.-based employees, the company could reduce its self-insured medical and pharmacy costs by roughly 8% annually without sacrificing quality and improving the patient experience.

Yet despite the inherent efficiency of telehealth as an alternative to in-person care, some stakeholders have urged policymakers to mandate that telehealth services be compensated at the same rate as in-person care, including circumstances in which care is provided via telephone rather than video link. **While so called "payment parity" may be useful in certain circumstances – for instance, during the COVID-19 pandemic, when patients had no choice but to use telehealth for needed care – we believe that parity should neither be the goal, nor the yardstick by which policymakers measure telehealth payment. Payment parity within a flawed payment system should not be the goal. Payment parity assumes several facts with which we disagree.**

- First, payment parity assumes similar input cost basis. Medicare, for instance, pays physicians according to Relative Value Units (RVUs). RVUs are derived, in part, from an assessment of the time and intensity it takes for a physician to provide a certain service, and the "practice expense" – overhead costs – of operating as a health care provider.[9] Evidence suggests that the overhead costs of telehealth can be lower than in-person care, and that physicians are able to provide service to more patients in less time than traditional in-person care.[10]
- Second, as noted above, there remains limited evidence regarding the quality of health care outcomes for telehealth versus in-person care for many sets of services. Measurement of care and more federal research funding is needed.
- Finally, pay parity could disadvantage in-person providers of similar services who lack the resources to aggressively pursue telehealth but are subject to higher overhead costs. And more importantly, we must avoid the potential for telehealth to exacerbate health disparities among rural communities or lower income communities without needed technology or broadband to benefit.

Instead of focusing on payment parity, we urge policymakers to consider telehealth payment adequacy and efficiency in the context of value-based payment. A successful telehealth payment system should be focused on improving access to

needed care while maintaining quality and reducing the **total cost of care**, rather than simply matching current payment levels.

Several studies have found that even if telehealth services are cost-effective, they can increase duplication of care, ultimately costing purchasers and patients even more than standard in-person care in the long run.[11]

Further, the Department of Health and Human Services' Office of Inspector General has found that **expanded telehealth flexibility created to respond to COVID-19 has led to a dramatic increase in telehealth-related fraud** in Medicare.[12] The cost of telehealth-related fraud can be significant. In September 2020, the Department of Justice charged more than 85 people in an alleged telehealth fraud schemes that cost purchasers $4.5 billion.[13]

PBGH recommends that policymakers:

- *Refrain from making permanent any payment parity requirements for Medicare, and other payers. Instead, policymakers should focus on a telehealth value-based payment system that ensures improved access to care, maintains quality and reduces the* ***total cost of care.***
- *Develop and implement mechanisms to minimize telehealth-related fraud.*
- *Study the extent to which telehealth services increase duplication of care, adjusting payment rates accordingly.*
- *Given that a large percentage of people are covered by high-deductible health plans (HDHP's) we recommend making the CARES Act provisions permanent and allow pre-deductible treatment of telehealth services for HDHP's.*

Coordinated

Poor care coordination is a leading cause of poor health care outcomes and leads to billions of dollars in unnecessary, wasteful spending.[14] Employers and purchasers strongly support efforts to enhance care coordination and integration as an essential factor in improving quality and reducing the costs of care. While telehealth can be integrated into a patient's regular source of care, the rise of independent "point-solution" telehealth providers raises several concerns for purchasers. More telehealth vendors are being acquired by health plans and leveraged as competitive plan-specific products, which may inhibit data-sharing and coordination.

Unless those point-solution providers are required to coordinate care with a patient's regular care provider or are paid as part of a population-focused total cost-of-care model, **we believe the proliferation of independent telehealth providers is likely to *increase* care fragmentation,** raising costs for purchasers and patients and resulting in poorer health care outcomes.

PBGH recommends that policymakers:

- *Require independent telehealth physicians and providers to directly provide all care information to their patients' primary care physician or medical home, or to an interoperable electronic medical record that the patient and his or her physician can readily and freely access.*
- *Provide purchasers the flexibility to require coordination of care between freestanding telehealth providers and primary care physicians in contracting negotiations.*

Available Across State Lines

Many researchers have identified state medical and nursing licensure requirements as significant barriers to broader use of telehealth.[15] Such requirements substantially limit the ability of patients to find appropriate telehealth providers, particularly in lower-population states and for some sub-specialties.[16] **By limiting competition to providers within states, these licensure requirements drive up health care prices without improvement in quality.[17]**

The same barriers are present for mental health care as well. For example, about one-fifth (19%) of metropolitan counties lack even a single psychologist, compared with almost half (47%) of non-metropolitan counties. And whereas about two-fifths (42%) of metropolitan counties lack even a single psychiatric nurse practitioner, this proportion nearly doubled to 81% in non-metropolitan counties.[18]

Recognizing these barriers to access, most states have taken steps to waive or reduce state licensure requirements during the COVID-19 pandemic.[19] Researchers and policymakers have identified several changes that could ease barriers and improve cross-state access to telehealth. Among the policies under consideration are:

- ***Interstate compacts:*** Some states have engaged with neighboring states to offer licensing reciprocity or make it easier for physicians and other health care providers to hold licenses in multiple states. Such compacts exist for physicians, nurses, psychologists, emergency medical services personnel and others.[20]
- ***Changing "site-of-service":*** Under current federal law, the practice of medicine occurs at the location of the patient, not the health care provider. Hence, a health care provider must be *licensed in the state where the patient is located* to be allowed to provide and bill for services. Federal legislation has been introduced in previous Congresses to reverse

this distinction, establishing the *location of the provider* as the site-of-services. Thus, a provider licensed and physically located in one state would be able to provide services to patients located in any other state based on their own location.

- ***Creation of a national medical license:*** The most radical change suggested, and one that has received more attention due to COVID-19, is to do away with state medical licensure altogether, at least for telehealth services. Instead, the federal government would license medical professionals, who could then practice anywhere in the country.[21]

To make telehealth services more affordable and accessible for patients across the country, PBGH recommends that policymakers:

- *Accelerate state-level solutions by mandating interstate compacts for telehealth services for both physical and mental health providers.*
- *Closely consider and then enact federal solutions, which may include changing site-of-service rules or establish a national framework for telehealth provider licensure for physical and mental health providers.*
- *While policymakers consider longer-term solutions, Congress should enact the TREAT Act or other legislation to ease licensing restrictions during the pandemic.*

Equitable

In recent years, policymakers have begun to focus on not only improving access to and quality of health care across the system but also to tackling persistent inequities in care particularly affecting racial and ethnic minorities and underserved areas and populations. **Telehealth provides a golden opportunity to accelerate the path toward health equity by making care less expensive and more accessible for many people experiencing disparities.**[22] For years, telehealth has been found to be particularly useful for people in underserved rural areas, where physical barriers to access are greatest.[23] Research suggests that health disparities may be reduced when people from marginalized groups receive care from people who look like them or share some key identities and experiences.[24] In conjunction with changes to state licensure requirements, telehealth can significantly expand the number of diverse physicians and other providers who can provide culturally competent, compassionate care.

Like a double-edged sword, however, telehealth has the capacity to aggravate or even further entrench disparities. Profit-motivated health care providers and intermediaries will naturally direct their energy and resources toward serving profitable commercial populations, and low-income patients may lack access to necessary technologies to receive telehealth services in their own homes.[25] In

addition, the most vulnerable populations may also be the least comfortable with receiving care through telehealth, including low-income seniors and young children.[26] Finally, health care providers that serve low-income populations may lack the financial resources to effectively pivot to telehealth for their patient population. **To better understand these potential challenges, PBGH is working to expand its patient experience research to include Medicaid beneficiaries, with ability to stratify findings by race, ethnicity, education, income and primary language.**

PBGH recommends policymakers:

- *Proactively investigate and seek to mitigate disparities in access to telehealth.*
- *Invest in broadband infrastructure to improve access in rural areas.*
- *Provide financial support to build telehealth capacity for health care providers that disproportionately care for low-income populations, including community health centers and independent primary care practices in underserved areas.*

Population-Focused, Total-Cost-of-Care Models

The rapid adoption of telehealth catalyzed by the COVID-19 pandemic provides a golden opportunity to improve access to affordable, high-quality health care, but it comes with significant potential risks, including care fragmentation, duplication, and susceptibility to fraud. **Like other health care delivery innovations, telehealth is best implemented in a payment system in which providers are held accountable for clinical outcomes, patient experience, equity and, critically, the total cost of care.** In these environments, telehealth's benefits – greater efficiency and enhanced access – can be magnified, and its risks can be minimized. By aligning incentives between providers, purchasers and patients, telehealth can be used when clinically appropriate and cost-effective and avoided when not.

To that end, PBGH recommends policymakers:

- *Rapidly accelerate movement away from fee-for-service payment models in Medicare, Medicaid and other public payers, driving volume toward population-focused models accounting for total-cost-of-care, clinical quality and patient experience in upside and downside risk sharing arrangements.*
- *Drive multi-payer alignment across Medicare and commercial payers through multi-payer programs to ensure minimal burden and waste for providers and patients.*

Conclusion

As I hope my testimony makes clear, PBGH firmly believes that Congress has a golden opportunity to establish a durable framework for sustainable, high-quality telehealth – ideally, by making telehealth a centerpiece of payment models focused on quality, equity and the total cost of care. If you miss this opportunity, I fear that telehealth will become just another profit silo that the health care industry and its private equity investors use to continue to drive up costs while ignoring quality and patient experience.

I appreciate the opportunity to provide the perspective of employers and health care purchasers in this critical debate and I look forward to your questions.

Endnotes

[1] Centers for Disease Control, 2020: https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm
[2] Medical Economics, 2020: https://www.medicaleconomics.com/view/survey-telehealth-rise-popular-patients
[3] Healthcare Dive, 2019: https://www.healthcaredive.com/news/uptake-remains-low-but-doctors-of-all-ages-interested-in-telemedicine/558776/
[4] The Commonwealth Fund, 2020: https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis
[5] New England Journal of Medicine, 2020: https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0564
[6] ibid.
[7] New England Journal of Medicine, 2017: https://www.nejm.org/doi/full/10.1056/nejmsr1503323
[8] University of Miami, 2009: https://pdfs.semanticscholar.org/924f/a27614d2bac7b9a79711475a470fb7583ad7.pdf
[9] National Health Policy Forum, 2015: https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf
[10] Red Quill Consulting, 2014: http://connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf
[11] Kaiser Family Foundation, 2017: https://khn.org/news/are-virtual-doctor-visits-really-cost-effective-not-so-much-study-says/
[12] STAT, 2021: https://www.statnews.com/2021/02/22/federal-watchdog-raises-concerns-about-increasing-telehealth-fraud-during-pandemic/
[13] Department of Justice, 2020: https://www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants
[14] American Journal of Managed Care, 2015: https://pubmed.ncbi.nlm.nih.gov/26167702/
[15] Journal for Nurse Practitioners, 2021: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7577680/
[16] National Organization of State Offices of Rural Health, 2016: https://nosorh.org/wp-content/uploads/2016/11/NOSORH-Telehealth-Policy-Barriers-Fact-Sheet-FINAL.pdf
[17] mHEALTH Intelligence, 2018: https://mhealthintelligence.com/news/debating-the-pros-and-cons-of-licensure-compacts-for-telehealth
[18] American Journal of Preventive Medicine. 2018: https://www.ajpmonline.org/article/S0749-3797(18)30005-9/

[19] Federation of State Medical Boards, 2020: https://www.fsmb.org/advocacy/covid-19/
[20] Center for Connected Health Policy, 2021: https://www.cchpca.org/telehealth-policy/cross-state-licensing
[21] American Journal of Medicine, 2020: https://www.amjmed.com/article/S0002-9343(20)30418-6/fulltext
[22] Agency for Healthcare Research and Quality, 2020: https://www.ahrq.gov/patient-safety/reports/issue-briefs/teledx-5.html
[23] Rural Health Information Hub, 2019: https://www.ruralhealthinfo.org/topics/telehealth
[24] University of Michigan, 2020: https://labblog.uofmhealth.org/rounds/minority-patients-benefit-from-having-minority-doctors-but-thats-a-hard-match-to-make-0
[25] New England Journal of Medicine, 2020: https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123
[26] American Medical Association, 2020: https://www.ama-assn.org/practice-management/digital/why-achieving-health-equity-so-hard-telehealth-age

Ms. ESHOO. Just in time to answer the phone.

[Laughter.]

Ms. ESHOO. Thank you to Ms. Mitchell for your important testimony.

Now the Chair recognizes Dr. Resneck for your 5 minutes of testimony. And again, thank you, and welcome back to the subcommittee.

STATEMENT OF JACK RESNECK, M.D.

Dr. RESNECK. Thank you, Madam Chair. Thank you, Ranking Member and subcommittee members. It is a pleasure to be back with the subcommittee today.

I am Jack Resneck. I am here as a member of AMA's board of trustees, but I am also a practicing dermatologist and the vice chair of dermatology at the University of California, San Francisco. My specialty is one that has been researching and providing telehealth for many years.

Telehealth has emerged, as you have heard, as a critical tool during the pandemic, maintaining access for patients while supporting physical distancing efforts. This has really been a success story. Changes in coverage have led many of my colleagues around the country in both big and small practices to integrate telemedicine into their work. And our patients have seen benefits far beyond COVID care and social distancing.

This rapid expansion has made millions of patients comfortable with the technology, and it has advanced our knowledge in, frankly, every specialty about when it is most useful and when it is best deployed versus when we need to see a patient in person. We have seen high-quality telehealth increase access and convenience for patients, saving them transportation time, avoiding missed work, and avoiding child care issues. It has helped underserved communities in rural and inner-city areas, where a lack of sufficient medical services has really contributed to health inequities over decades.

It can give us new insights about an individual patient's social determinants of health. Patients on a video visit sometimes share more about their living environment or tell us about their food insecurity, information we can use to better coordinate their care and improve health outcomes. Integrated into existing healthcare practices and systems as one option to access care, telehealth has improved patient-physician communication and has built trust with our patients.

Survey data show overwhelmingly positive patient and physician reactions to telehealth during the pandemic. You have heard some of it from other witnesses. But I would like to share with you how it typically plays out in my own practice.

While I work in a large city, many of my patients drive from suburbs an hour away and rural areas several hours outside of San Francisco. I specifically recall a few patients I was seeing in the year before the pandemic with severe cases of chronic skin conditions like lupus, psoriasis, and one with an autoimmune blistering disease called pemphigus.

Though each of them lived hours away, the initial in-person visit had, in these particular cases, been important to diagnosing their

condition, doing biopsies, and getting them stable on medications. But I felt awful that every time they had to see me, they had to do repeated, several-hour-round-trip car journeys to come back for me to evaluate their progress and adjust their medications. One of them worried she would get fired for missing work. Another had to pile his three kids in the car each and every visit because he didn't have childcare backup.

You know, I knew I could manage most of these follow-ups by telemedicine, but neither Medicare nor most private insurance would cover it at the time. The ones with commercial insurance sometimes had access to corporate Internet-based telehealth providers. But when they tried to use them, the clinicians they were connected to didn't know their medical histories, sometimes hadn't heard of their diseases, and were, frankly, unable to do much. The patients really had to start from scratch with them.

For the last 11 months, being able to offer coordinated telehealth services for some portion of these patients' visits has been a game changer. But, without further action from Congress, my Medicare patients and millions of other Medicare beneficiaries will lose access to covered telehealth services at the end of the public health emergency. We would revert back to the old rules, old rules under which access to telehealth services was restricted only to those Medicare beneficiaries who live in designated rural areas, old rules that only allow those individuals to access care and specific authorized medical sites, not using their own personal devices in their own homes or wherever they may be located at the time.

So I am here to ask you to take two very clear steps this year.

First, we strongly urge Congress to amend section 1834(m) of the Social Security Act to remove permanently the geographic and site-of-service restrictions that bar most Medicare beneficiaries from using widely available, two-way audio visual technologies to access covered telehealth services.

Second, in conjunction with expanded access to telehealth services, we urge Congress to continue to support the expansion of high-speed broadband Internet access to under-served communities. My colleagues and I continue to be surprised by how many patients can't take advantage of telehealth services due to a lack of affordable Internet connectivity.

Telehealth is not a service unto itself, but it is a vital part of high-quality, coordinated healthcare. Congress needs to act now to ensure that Medicare patients can continue to rely on these essential tools after the current emergency ends. The AMA and I welcome the opportunity to work with you to expand telehealth services for our patients, and I am really looking forward to today's conversation and to responding to some of the more thorny topics that have already come up. Thanks so much.

[The prepared statement of Dr. Resneck follows:]

STATEMENT

of the

American Medical Association

U.S. House of Representatives
Energy and Commerce Committee
Health Subcommittee

The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care

Presented by: Jack Resneck, MD
Member, AMA Board of Trustees

March 2, 2021

Division of Legislative Counsel
(202) 789-7426

Statement

of the

American Medical Association

U.S. House of Representatives
Energy and Commerce Committee
Health Subcommittee

The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care
Presented by: Jack Resneck, MD
Member, AMA Board of Trustees

March 2, 2020

The American Medical Association (AMA) appreciates the opportunity to provide testimony to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing on The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care. The AMA strongly supports congressional efforts to ensure that Medicare beneficiaries have access to telehealth services. We welcome the opportunity to support congressional efforts to ensure all Medicare beneficiaries continue to have access to covered telehealth benefits after the COVID emergency ends.

The AMA believes that telehealth is a critical part of the future of effective, efficient, and equitable delivery of health care in the United States. Efforts must continue to build capacity and support access to care centered on where the patient is located to the greatest extent it is clinically efficacious and cost-effective, and to ensure physicians and other health care providers have the tools to optimize care delivery. The AMA has been a leader in advocating for expanded access to telehealth services for Americans because it believes that it has the capacity to improve access to care for many underserved populations and improve outcomes for at-risk patients, particularly those with chronic disease and impairments.

Telehealth usage has expanded tremendously during the COVID-19 pandemic, helping Americans access health care services while maintaining social distancing and reducing strain on hospitals and physician clinics. With this expansion of services has come a recognition from patients, physicians, and other providers that telehealth services offer effective and convenient health care in many circumstances. Congress must act now to ensure that Medicare patients can continue to access telehealth services from wherever they are located after the pandemic ends by modernizing the Social Security Act to keep pace with our digital future.

Section 1834(m) of the Social Security Act Limits Access to Telehealth Services

Under section 1834(m) of the Social Security Act (SSA), Medicare is prohibited from covering and paying for telehealth services delivered via two-way audio-visual technology unless care is provided at an

eligible site in a rural area.[1] This means that, in order to access telehealth services, patients must live in an eligible rural location, and must also travel to an eligible "originating site" – a qualified health care facility – to receive telehealth services, except in limited select cases where Congress has authorized provision of telehealth services in the home of an individual.[2] As a result, the 1834(m) restrictions bar the majority of Medicare beneficiaries from using widely available two-way audio-visual technologies to access covered telehealth services unless they live in a rural area, and with a few exceptions, even those in rural areas must travel to an eligible health care site.

Two-way audio-visual technology is the only communication modality on which Medicare places such a prohibition. Other communication technologies, including remote patient monitoring, do not meet the definition of a telehealth technology and services furnished via these technologies are not subject to the 1834(m) geographic and originating site restrictions and go through regular Medicare coverage and payment processes.

While these restrictions may have made sense given the limited technologies available when they were first instituted in the Balanced Budget Act of 1997,[3] two-way audio-visual technology is now widely available and relatively inexpensive.

In response to the COVID-19 public health emergency (PHE), Congress passed the CARES Act, which, among other things, provided the Centers for Medicare and Medicaid services (CMS) the authority to waive the geographic origination requirement for the duration of the COVID-19 PHE, which CMS subsequently did.[4] Telehealth usage among Medicare beneficiaries has since surged as patients could, for the first time, access telehealth services from wherever they are located, including their home, regardless of where they reside in the country. The AMA remains deeply grateful for these flexibilities, which have allowed Medicare patients across the country to receive care from their homes. With many physician offices closed, elective procedures postponed, and patients as well as many physicians, other health professionals, and practice staff required to stay at home for a long period of time, the ability to provide services directly to patients regardless of where they are located via telehealth has allowed many vital health care services to continue. In addition to facilitating continuity of care for patients being treated for acute and chronic conditions, telehealth has also facilitated initial assessment of patients experiencing potential COVID-19 symptoms and those who have been in close contact with people diagnosed with COVID-19 to determine if referrals for testing or treatment are indicated while minimizing risks to patients, practice staff, and others.

However, without intervention from Congress, Americans that have come to rely on telehealth services during the PHE will abruptly lose access to these services completely. Congress must act now to remove the origination and geographic restrictions on telehealth coverage for Medicare patients. Continued access to telehealth services beyond the PHE is critical for patient populations that have come to rely on its availability.

Telehealth Usage Has Increased Dramatically During the PHE

---

[1] Special Payment Rules for Particular Items and Services, 42 U.S.C. § 1395m(m), https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.
[2] For example, substance abuse disorder treatment delivered via telehealth is explicitly exempted from the geographic and origination restrictions.
[3] Pub. L. No. 105–33, 111 STAT. 251, (1997).
[4] Coronavirus, Relief, and Economic Security (CARES) Act, Pub L. No. 116-136, 134 Stat. 281 (2020), https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf.

Telehealth usage has expanded tremendously during the COVID-19 pandemic. According to the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (HHS), before the public health emergency (PHE), 14,000 patients received a Medicare telehealth service in a week, while over 10.1 million patients received a Medicare telehealth service from mid-March through early-July. Telehealth visits accounted for 43.5 percent of all primary care visits for Medicare beneficiaries.[5]

Other early analyses paint a similar picture. For example, according to one analysis of data by FAIR Health, telehealth claim lines rose almost 3,000 percent from November 2019 to November 2020, from .20 percent of all medical claim lines to just over six percent.[6] A recent survey on telehealth use among U.S. adults age 50-80 by the University of Michigan showed that the percentage of older adults who had ever participated in a telehealth visit rose from four percent in May 2019 to 30 percent in June 2020, including a rise from six percent before March 2020 to 26 percent having had a telehealth visit in the period between March to June 2020.[7]

Patient's views on telehealth are shifting as well. While most respondents in the survey who had participated in a telehealth visit perceived in-office visits as providing a higher quality of care (54 percent), telehealth visits were perceived as more convenient by the majority of respondents (56 percent). Similarly, an analysis done by McKinsey showed that 76 percent of consumers are now interested in telehealth while only 11 percent reported interest in 2019.[8] According to J.D. Power, overall satisfaction for telehealth services is "among the highest of all healthcare, insurance and financial services."[9]

Physicians and other health care providers are also growing more comfortable using telehealth services. In a recent survey of physicians and other qualified health care professionals conducted between July 13 and August 15, 2020, 60 percent reported telehealth has improved the health of their patients and 55 percent said that telehealth has improved the satisfaction of their work. In addition, more than 80 percent reported that patients have reacted favorably to using telehealth and that telehealth has improved the timeliness of care for their patients. As a result, over two-thirds of respondents reported that they are motivated to increase telehealth use in their practices.[10]

However, concerns remain about continued reimbursement and patient access after the end of the PHE. The COVID-19 Healthcare Coalition survey of physicians shows that over 73 percent of respondents cited low or no reimbursement as a barrier to maintaining telehealth usage after COVID-19. Over 64 percent responded that they anticipated technology challenges for their patients to be a barrier as well.[11]

---

[5] Assistant Secretary for Planning and Evaluation, Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the COVID-19 Pandemic (July 28, 2020), https://aspe.hhs.gov/system/files/pdf/263866/hp-issue-brief-medicare-telehealth.pdf.
[6] See FAIR Health, "Monthly Telehealth Regional Tracker," https://www.fairhealth.org/states-by-the-numbers/telehealth.
[7] Telehealth Use Among Older Adults Before and During COVID-19 (Aug. 2020), https://www.healthyagingpoll.org/report/telehealth-use-among-older-adults-and-during-covid-19.
[8] McKinsey & Company, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" (May 2020), https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Telehealth%20A%20quarter%20trillion%20dollar%20post%20COVID%2019%20reality/Telehealth-A-quarter-trilliondollar-post-COVID-19-reality.pdf.
[9] Press Release, Telehealth Patient Satisfaction Surges During Pandemic but Barriers to Access Persist, J.D. Power Finds, https://www.jdpower.com/business/press-releases/2020-us-telehealth-satisfaction-study (Oct. 1 2020).
[10] The COVID-19 Healthcare Coalition Telehealth Impact Study Work Group, Telehealth Impact Study (last updated 21 Dec., 2020), https://c19hcc.org/telehealth/physician-survey-analysis/.
[11] Id.

The PHE Has Demonstrated the Value of Telehealth

The success of telehealth technology adoption during the COVID-19 public health emergency has made it abundantly clear that geographic and origination restrictions on accessing telehealth services are outdated and arbitrary given today's technology that allows for access to digital tools from anywhere. Physicians and patients have seen the value of telehealth services and should not be forced to stop using these tools when the public health emergency ends. Some have argued that statutory changes cannot be made without additional data on how telehealth services are used, however, this has the problem backwards. More data is not necessary to determine that the underlying policy needs to be permanent, but instead can help CMS determine which services ought to be covered or not. In the meantime, the certainty that appropriate telehealth services will be covered would provide physicians confidence in investing in new technology and give patients peace of mind that they can continue to access the services in a way that works best for them.

The rapid and widespread adoption of telehealth by physicians in 2020 was one of the most significant improvements in health care delivery in decades. The new telehealth coverage and payment policies enabled physicians to deliver valuable services they previously could not afford to provide but that their patients needed. With legislative provisions such as the establishment of the CMS Innovation Center and Medicare's Quality Payment Program, Congress has sought for many years to support physician adoption of innovations in the delivery of care. The successful adoption of telehealth throughout the country has demonstrated that, if the financial barriers are removed, physicians will adopt important innovations in the delivery of care that are necessary to improve their patients' health.

Telehealth technologies allow physicians to increase continuity of care, extend access beyond normal clinic hours, and help overcome clinician shortages, especially in rural and other underserved populations. This ultimately helps health systems and physician practices focus more on chronic disease management, enhance patient wellness, improve efficiency, provide higher quality of care, and increase patient satisfaction. Telehealth has helped increase provider/patient communication, increase provider/patient trust, and access to real-time information related to a patient's social determinants of health (i.e., a patient's physical living environment, economic stability, or food insecurity), which can lead to better health outcomes and reduced care costs.

Telehealth services can help patients avoid delaying care that can lead to expensive emergency department visits and hospitalizations. They also cut down on trips to the office that may be difficult or risky for patients with functional or mobility impairments, frail elderly who need a caregiver to accompany them, and patients who are immunocompromised or vulnerable to infection. Providing access to telehealth services creates greater safety and efficiencies for both patients and physicians, delivering value to the Medicare program.

Physician practices are ready to invest in the technology required to provide these services; however, it will be very difficult to invest in incorporating delivery of telehealth services into their workflows if the coverage is only temporary and its future uncertain. The removal of coverage and financial barriers has allowed the explosive growth in telehealth and certainty about future coverage is necessary for it to continue. It has allowed CMS to make more informed decisions about which services to cover, and, in fact, CMS has expanded coverage of telehealth services greatly during the PHE.[12] While more data behind current telehealth usage trends may be valuable to gather evidence about which particular Current Procedural Terminology® (CPT®) codes need to stay on the Medicare telehealth list, that is a much

[12] Medicare Physician Fee Schedule 2021, 85 Fed. Reg. 84,472 (Dec. 28, 2020), https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf.

different concern that whether nationwide coverage and ability to deliver care to patients wherever they are located should be available, and such determinations are appropriately made by CMS.

While CMS has expanded coverage of telehealth services during the PHE, only Congress can assure all Medicare beneficiaries can receive equal access to those services moving forward. Delaying action, such as extending the current 1834(m) waiver authority, will only increase the cost of making this necessary and overdue policy change.

CMS Already Makes Coverage Determinations on Telehealth Services

CMS currently has all the tools necessary at its disposal to make determinations about which telehealth services it should cover. For the duration of the COVID-19 PHE, CMS has added many services to the list of that Medicare pays for when they are provided via telehealth. The newly covered services include emergency department visits, observation care, hospital and nursing facility admission and discharge services, critical care and home care, as well as services like ventilator management that have been especially necessary for COVID-19 patients. The newly added services have greatly assisted physicians during the PHE when both patients and health professionals needed to maintain physical distance from others as much as possible. Through telehealth communications, for example, an emergency physician, potentially assisted by members of the patient's household, can diagnose and treat emergency conditions without sick patients having to be endure difficult travel and expose themselves and others to SARS-CoV-2 and other dangers. In all, CMS added interim Medicare coverage for more than 150 services for the duration of the COVID-19 PHE. In future rulemaking, CMS has indicated it may extend the interim coverage for a longer period of time to help gather more evidence of how the services are used when provided via telehealth outside the context of a pandemic.

The only thing holding CMS back from expanding access to appropriate telehealth services to its beneficiaries are the outdated restrictions currently in the statute.

Telehealth is a Key Component to the Future of Medicare

Furthermore, increased access to telehealth services is urgently needed to effectively address the looming demographic health demands driven by the Baby Boom that will be placed on the Medicare program, health care providers, caregivers and the nation in the near future. The U.S. Census Bureau has projected that by 2030—in a mere 9 years—more than 20 percent of U.S. residents will be 65 and over.[13] During this same timeframe, the unofficial safety net of family providers and caregivers will continue to shrink markedly. From 2010 to 2030, the caregiver ratio (defined as the number of potential caregivers aged 45–64 for each person aged 80 and older) declines sharply from 7.2 to 4.1, and the caregiver ratio is expected to continue to decrease from 4.1 to 2.9 from 2030 to 2050.[14] In addition, as the Baby Boomers moves into retirement and global aging trends accelerate, the labor force in the U.S. (and around the globe) will shrink and strain funding for safety net programs like Medicare.[15] In light of the foregoing, national strategic planning is needed across society right now to develop and scale a sustainable infrastructure to center care where the patient is located to the greatest extent it is clinically efficacious and cost-effective, and to ensure physicians and other health care providers have the tools to optimize care delivery. Telehealth and related services will become an even more essential cost effective and reliable means to

[13] Given current aging and fertility trends, by 2050 developed economies will have twice as many older persons as children. No Ordinary Disruption: the Four Global Forces Breaking All the Trends, Richard Dobbs, James.
[14] The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers, AARP Public Policy Institute, In Brief IB213, August 2013.
[15] No Ordinary Disruption: the Four Global Forces Breaking All the Trends, Id.

expand capacity in a health care system marked with significant and persistent specialty shortages and geographic disparities.

Telehealth Helps Provide Access to Health Care to Underserved Communities

Access to telehealth services can help reduce inequalities in care for underserved communities by providing access to services for patients regardless of where they are located. Patients in rural areas or underserved urban communities often have to travel long distances to access care, especially specialty services including emergency and critical care. Telehealth also can help eliminate commutes to physician offices for those with mobility or transportation difficulties.

In conjunction with expanded access to telehealth services, the AMA supports Congressional efforts to expand high-speed broadband internet access to underserved communities. Patients cannot take advantage of telehealth services if they do not have the requisite internet connection to access them. Solving this requires enhanced funding for broadband internet infrastructure in rural areas and support for under-served urban communities and households to gain access to affordable internet access.

Concerns About Fraud and Abuse and Overutilization Are Misplaced

Some have raised concerns that expanded coverage of telehealth services could lead to greater fraud and abuse or duplication of medical services. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication are of particular concern for telehealth services. Therefore, Congress should not create artificial barriers to telehealth by defining an established doctor-patient relationship inconsistently with the standard of care or otherwise creating unique and burdensome fraud and abuse requirements that would stifle access to telehealth services.

CMS and the Office of Inspector General (OIG) at HHS have all of the typical Medicare coverage and payment and fraud and abuse authorities to monitor telehealth service compliance just as they do any other Medicare covered service. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare & Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority or other technologies such as phone, text, or remote patient monitoring.

Moreover, Telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via the Modifier 95. The Modifier 95 describes "synchronous telemedicine services rendered via a real time Interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. The Modifier 95, along with listing the Place of Service (POS) equal to what it would have been for the in-person service, is also applicable for telemedicine services rendered during the COVID-19 Public Health Emergency. The requirement to code with the Modifier 95 enables CMS to properly decipher and track telemedicine services, thus improving the chances of identifying and rooting out fraud, waste, and abuse.

Data analyzed by CMS since the start of the public health emergency shows that fears of overutilization are overblown. Data from Medicare claims from Q1 and Q2 show that less than 4% of telehealth spending was for new patient audiovisual office visits. Moreover, nothing in the data or anecdotal evidence suggests that telehealth services have been duplicative of in person services rather than used as an alternative or in addition to in person care. The AMA will continue to monitor and analyze the data as it becomes available, but this suggests that there is no reason to think better access to telehealth will lead to an explosion in unnecessary services.

As a result, Congress should refrain from imposing new and discriminatory restrictions on the use of audio-visual communications technologies, such as restrictions on how a physician-patient relationship can be established. AMA policy, established in 2014, states that a valid physician-patient relationship may be established virtually face-to-face via real-time audio and video technology, if appropriate for the service being furnished.[16] It also allows for the relationship to be established in a variety of other ways such as meeting standards of care set by a major specialty society. All 50 states and the territories allow a physician-patient relationship to be established virtually or through other means. The exact parameters vary by state; however, many state laws are based on an AMA model law. Congress should not impose a one-size-fits-all requirement on services furnished via telehealth technology that are in direct conflict with standards of care and that do not exist for other technologies.

Gains made in access to telehealth will be greatly hampered if unique and arbitrary barriers are erected around the use of telehealth services. Such barriers will have dramatic and negative impact on patients seeking care, particularly during the current COVID-19 pandemic and in any future pandemic where patients need access to care without visiting a crowded health care facility.

States Must Continue to Play a Central Role in Licensing Physicians

State medical boards play a pivotal role in protecting the safety of patients through physician licensure, regulations, and disciplinary action. At the start of the COVID-19 pandemic, there was some concern that state licensing requirements would limit physicians' ability to quickly move into those areas hardest hit by COVID-19 and meet the workforce demands on the ground and via telehealth. In response to this concern, the states acted quickly to temporarily allow physicians to practice across state lines by waiving licensure or creating a streamlined licensure or registration processes in response to the COVID-19 emergency.

The AMA believes that it is essential to ensure that physicians and other health care providers are licensed in the state where the patient is located to provide telemedicine services in a secure environment. The AMA opposes proposals that would change which state is responsible for overseeing the physician from the state where the patient is located to the state where the physician is located. This changes which state practice and scope laws apply to the care rendered and raises serious enforcement issues as states do not have interstate policing authority and cannot investigate incidents that happen in another state. This is inconsistent with AMA policy.

Instead, AMA believes efforts should be made to increase membership in the Interstate Medical Licensure Compact (IMLC), a one stop-shop for physicians who are in good standing with their state medical boards to seek a license to practice in multiple jurisdictions in an expedited process. This maintains state-based licensure and the ability of state medical boards to protect the safety of patients, while allowing for greater sharing of information between states and expediting the licensure process for physicians who want to move between states or practice in more than one jurisdiction.

[16] American Medical Association, H-480.496: Coverage of and Payment for Telemedicine, https://policysearch.ama-assn.org/policyfinder/detail/telemedicine?uri=%2FAMADoc%2FHOD.xml-0-4347.xml (last modified, 2019).

Conclusion

The AMA thanks the Subcommittee for this hearing and for careful consideration of the current landscape of telehealth coverage and the best ways to ensure patients can continue to access telehealth services anywhere in the country from wherever they are located after the end of the PHE. We welcome the opportunity to work with the Subcommittee and Congress to seek solutions moving forward.

Ms. ESHOO. Thank you so much, Dr. Resneck. I think all the Members are thinking exactly what I am, and that is that every witness that we have heard from so far—it is a really high value.

And now I would like to recognize Frederic Riccardi, our last witness on the panel, for your 5 minutes of testimony. Welcome, and thank you.

STATEMENT OF FREDERIC RICCARDI

Mr. RICCARDI. Good morning. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, and members of the House Committee of Energy and Commerce Subcommittee on Health, for the opportunity to speak with you today about Medicare telehealth.

I am the president of the Medicare Rights Center, and we are a national nonprofit organization that has worked for over 30 years to ensure access to affordable healthcare for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We are the largest and most reliable independent source of Medicare information and assistance in the United States.

While new information about the COVID–19 virus continues to emerge, it has long been clear that Medicare beneficiaries are at high risk of infection, serious illness, and death. We are grateful that Congress quickly recognized and responded to these threats, ensuring Medicare telehealth coverage could help beneficiaries safely obtain needed care during this pandemic, protecting patients, caregivers, providers, and communities.

The idea of telehealth as only important to people in rural areas or only for a limited set of services has long been outdated. During the pandemic Medicare is allowing more beneficiaries to receive more telehealth services, using more types of technology for more providers and locations—importantly, their own homes.

The uptick has been swift and dramatic. Before the pandemic, about 13,000 beneficiaries received telemedicine a week. By the end of April 2020, that number had skyrocketed to 1.7 million people. This represents the biggest shift in Medicare telehealth policy and utilization since the services were created nearly 25 years ago.

Although these expansions address some longstanding barriers, the beneficiary experience has been mixed. Some clients of our national help line have reported greater access to care, while others have been unable to purchase or use the technology to find a provider that uses the technology, or to feel comfortable with remote care in general. This is concerning, but it is also not surprising. Undoubtedly, there is a lot that we don't know about how this is all really working for beneficiaries. We also don't know the impact of these changes on costs and health disparities, though early research shows inequities in accessing telemedicine across numerous demographic categories.

With so much unstudied, we view sweeping calls to make the emergency system permanent as premature. Medicare's limitations on telehealth no longer reflect the technology landscape or the beneficiary experience. But we must move forward with caution.

We respectfully ask you to move forward deliberately, collecting and following the data, centering beneficiary needs and preferences in a way that recognizes telehealth as a valuable supplement to in-

person care. And to allow time for this, we support a glide path to prevent a beneficiary's access to services from ending the moment or soon after the public health emergency does.

In our written testimony we outline a set of principles. We urge the inclusion of robust consumer protection and oversight requirements, ensuring the provision of high-quality care, increased access to such care, and to promote health equity. Policies that meet these criteria will help create a Medicare telehealth system that works for all beneficiaries, regardless of where they live, the coverage pathway that they choose, or how they want to receive their care.

I also want to add that other near-term Medicare improvements are also needed to promote access to care. We have consistently heard from Medicare-eligible individuals who have been unable to connect with their earned benefits. Most have to wait several months for care. This is why we request a COVID–19 special Medicare enrollment period for premium part A and part B, and expanded relief to help people who are locked out of the system.

Thank you again for the opportunity to be here today, and I look forward to answering your questions.

[The prepared statement of Mr. Riccardi follows:]

Testimony of Frederic Riccardi
President
Medicare Rights Center

"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

United States House of Representatives
Committee on Energy & Commerce
Subcommittee on Health

March 2, 2021

Washington, DC Office:
Medicare Rights Center
1444 I Street NW, Suite 1105
Washington, DC 20006

New York Office:
Medicare Rights Center
266 West 37th Street, 3rd Floor
New York, NY 10018

Introduction

Good morning Chairwoman Eshoo, Ranking Member Guthrie, and members of the House Committee on Energy & Commerce, Subcommittee on Health. I am Fred Riccardi, president of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to nearly three million people with Medicare, family caregivers, and health care professionals each year, including through our national consumer helpline. Thank you for the opportunity to speak with you today about the future of Medicare telehealth coverage.

Medicare Telehealth Coverage

Medicare is the federal government program that provides health care coverage if you are over 65, under 65 and receiving Social Security Disability Insurance (SSDI) for a certain amount of time, or under 65 and living with End-Stage Renal Disease (ESRD). As you know, there are four parts of Medicare: Part A, Part B, Part C, and Part D:

- Part A provides inpatient/hospital coverage.
- Part B provides outpatient/medical coverage.
- Part C offers an alternate way to receive your Medicare benefits.
- Part D provides prescription drug coverage.

People with Medicare can choose to receive their Parts A and B benefits from Original Medicare, the traditional fee-for-service program offered directly through the federal government that was enacted in 1965, or from a Medicare Advantage plan, a type of private insurance offered by companies that contract with the federal government. This option was added in 1996.

Original Medicare covers three types of virtual services: telehealth visits, virtual check-ins, and e-visits. Each has different eligibility standards, provider requirements, and payment rules—many of which are outdated.[1] This system can be hard to understand, overly restrictive, and difficult to navigate, often leaving beneficiaries without meaningful access to remote care.[2]

A main limitation is that most telehealth visits are only available in narrow circumstances. Medicare rules, many of which have been waived during the COVID-19 public health emergency (PHE), require the beneficiary to live in a rural area and to travel to an "originating site"—such as a doctor's office, hospital, or skilled nursing facility—for the service. There, they are connected with a "distant site" provider via real-time audio-video technology.

Virtual check-ins and e-visits can be furnished in the home, but Medicare restricts access in other ways, limiting eligibility to established patients; applying strict frequency limits; and excluding many providers. The services are also less robust than telehealth. Virtual check-ins can include brief telephone calls

[1] Centers for Medicare & Medicaid Services, "Medicare Telemedicine Health Care Provider Fact Sheet" (March 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.
[2] Centers for Medicare & Medicaid Services, "President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak" (March 17, 2020), https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak.

between providers and patients, but e-visits offer no real-time communication, relying instead on portals that allow patients to message their providers and receive an answer back within seven days.

Medicare Advantage plans are required to cover the same virtual services as Original Medicare and can offer additional benefits, including telehealth to people in their own homes and in non-rural areas.[3] This imbalance has led to further confusion, and an unequal system.

Medicare Telehealth Coverage During the COVID-19 Pandemic

The COVID-19 outbreak spurred significant changes in Medicare telehealth. While new information about the virus continues to emerge, it has long been clear that Medicare beneficiaries—people over 65 and those with disabilities—are at high risk of infection, serious illness, and even death.[4] Congress quickly recognized these threats. As early as March 2020, lawmakers took steps to add telehealth flexibilities to the Medicare program. Such PHE-related legislative mandates, in addition to administrative actions, allowed the Centers for Medicare & Medicaid Services (CMS) to broaden Medicare telehealth coverage during the pandemic.

Under these authorities, the agency grew the list of reimbursable telehealth services and providers, waived geographic and originating site restrictions, loosened requirements about pre-established patient-provider relationships, and permitted services to be delivered via a wider array of devices and technologies. CMS also made changes to ease affordability, such as allowing plans and providers to waive or reduce cost sharing.[5]

These and other, related changes paved the way for more beneficiaries to receive more services via telehealth, using more types of technology, and from more locations, including their own home. The uptake was swift. Telemedicine use, particularly in Original Medicare, grew dramatically within a matter of weeks.[6] Before the pandemic, approximately 13,000 beneficiaries received telemedicine in any given week. By the end of April 2020, that number had skyrocketed to 1.7 million.[7]

The PHE developments represent the biggest shift in Medicare telehealth policy and utilization since the services were created nearly 25 years ago. Although these expansions and waivers have addressed some systemic barriers, the beneficiary experience has been mixed.[8] Some callers to our national helpline have reported greater access to care, while others are being left behind.

Consider two recent Medicare Rights clients, Ms. S and Ms. L. They have never met but have much in common. They live in the same New York city neighborhood, are primary speakers of a non-English

---

[3] Medicare.gov, "Medicare Advantage Plans Cover all Medicare Services" (last accessed February 26, 2021), https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services.

[4] Centers for Disease Control, "If You Are at Higher Risk" (last accessed February 26, 2021), https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html.

[5] Centers for Medicare & Medicaid Services, "Information Related to Coronavirus Disease 2019—COVID-19" (March 10, 2020), https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf

[6] *See, e.g.*, Ateev Mehrotra, *et al.*, "The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices are Adapting to the New Normal" (June 25, 2020), https://www.commonwealthfund.org/publications/2020/jun/impact-covid-19-pandemic-outpatient-visits-practices-adapting-new-normal; Assistant Secretary for Planning and Evaluation, "Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic" (July 28, 2020), https://connectwithcare.org/wp-content/uploads/2021/01/HP_IssueBrief_MedicareTelehealth_final7.28.20.pdf.

[7] Seema Verma, "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19" Health Affairs (July 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.

[8] Rupa S. Valdez, *et al.*, "Ensuring full participation of people with disabilities in an era of telehealth" Journal of the American Medical Informatics Association (November 9, 2020), https://academic.oup.com/jamia/article/28/2/389/5988542.

language, are in Medicare Advantage plans, and are dually eligible for Medicare and Medicaid. They also both had COVID last year. During and after her diagnosis, Ms. S had access to her provider through virtual and in-person visits. She also received an iPad and training on relevant technologies. Ms. L, however, was not offered care via telehealth or in-person; her provider instructed her to go to the Emergency Room if she needed help. Despite similar circumstances, coverage, and diagnoses, their encounters with the PHE Medicare telehealth system could not have been more different.

Post-Pandemic Medicare Telehealth Coverage

The PHE telehealth flexibilities have helped many beneficiaries and their families safely and responsibly obtain needed care during the pandemic, likely leading to reduced virus transmission and improved individual and public health outcomes. While we applaud these successes, we note that not all beneficiary experiences have been positive—or studied. The impact of these changes on costs and health disparities also remains largely unknown, though preliminary research suggests inequities in accessing telemedicine across numerous demographic categories: age, race, ethnicity, preferred language, and income.[9] As a result, we view calls to make the full PHE system permanent as premature. Entrenching the status quo without careful analysis risks locking in an unexamined expansion of services that was developed for and during a crisis, and which may not be well-suited beyond it.

We recognize the rapid shift to telehealth has led to pushes for rapid policymaking. We agree that modernizations are needed, but so is restraint. As you consider the future of this coverage, we respectfully ask you to move forward deliberately and collaboratively, collecting and following the data, and prioritizing beneficiary needs and preferences. Since this may take time and extend beyond the PHE period, we support the immediate establishment of a glide path. This would allow the temporary telehealth rules and waivers to phase out gradually, minimizing care interruptions.

Once this safeguard is in place, we urge you to work with CMS and stakeholders to build and implement an evidence-based telehealth improvement strategy that centers beneficiaries. This includes thoroughly examining the system pre-pandemic and currently—e.g., services provided; outcomes and quality; program integrity risks and safeguards; participation rates and utilization barriers; program and beneficiary spending; and impacts on health disparities—identifying areas for reform and developing needed solutions. Any resulting policy changes should be made through regular order, relying on legislative and regulatory processes that allow for public review and comment.

The following principles, grounded in our more than 30 years of experience helping people understand and navigate Medicare, are intended to support your efforts. When contemplating changes to Medicare telehealth coverage, we recommend advancing policies that: (1) Include robust **consumer protections and oversight** requirements; (2) Ensure the provision of **high-quality** care; (3) Meaningfully **increase access** to such care; and (4) Promote **health equity**.

Consumer Protections and Oversight

In response to COVID-19, CMS relaxed several Medicare rules and restrictions. Some of these changes expanded coverage, but others suspended important beneficiary protections. While Congress appropriately takes time to determine next steps for these service-related flexibilities, the protections

[9] Lauren A. Eberly, *et al.*, "Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic" JAMA (December 29, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488.

that undergird this care cannot wait. They must be reinstated and strengthened as soon as practicable. Specific recommendations include:

- **Apply Standard Cost-Sharing**. During the PHE, providers may voluntarily waive cost-sharing obligations for Medicare telehealth services.[10] Our recent casework reveals this has created confusion among beneficiaries and providers about their financial responsibilities. We are also concerned the discretionary nature of this policy may contribute to discrimination and health inequities. We appreciate this flexibility may be needed during the pandemic. Outside of the emergency period, however, we favor a return to the standard system, which imposes the same cost-sharing liabilities on telehealth and in-person services.

- **Improve Cost-Sharing Outreach, Education, and Documentation**. While the cost-sharing waiver is in place, we recommend adopting policies to reduce ongoing misunderstandings and misinformation.[11] Specifically, providers must be required to accurately disclose beneficiary cost-sharing obligations prior to the service, and to fully document such disclosures. CMS must strengthen its outreach, to better help consumers and providers understand their financial responsibilities. The agency must also ensure that cost-sharing waivers are not being applied in discriminatory or otherwise problematic ways, and that plans and providers are not engaging in deceptive marketing, outreach, or billing practices, intentionally or unintentionally.

- **Strengthen Beneficiary Consent Safeguards**. Currently, providers may obtain a beneficiary's consent for care via telehealth at the time the remote service is provided, rather than prior to it. In our experience, when these events co-occur, beneficiaries are more likely to agree to the service without fully understanding their financial obligations. This can lead to confusion and billing surprises, as well as mistrust and fraud reporting. The complexity and novelty of telehealth may make this even more likely.[12] We support sunsetting this waiver in favor of advance consent and written notification processes that are designed to facilitate informed decisions and may also combat certain types of fraud.

- **Reinstate Face-to-Face and in-Person Requirements**. Similarly, the temporarily waived face-to-face and in-person requirements for certain evaluations and certifications relating to hospice, inpatient rehabilitation facilities, and national and local coverage determinations must not be made permanent. These in-person visits are important for proper care delivery and planning, as well as for patient safety and program integrity. As Medicare Rights' helpline callers have observed, these benefits are not easily achieved via remote care. They often report the virtual assessments are of poor quality and little use.

- **Protect Patient Privacy**. Privacy laws and protections must apply to all telehealth interactions between the beneficiary and their provider, and personal health data must also be kept secure. The privacy protection waivers, including the Health Insurance Portability and Accountability Act (HIPAA) enforcement discretion policy, should end with the PHE, and non-HIPAA compliant

[10] Juliette Cubanski and Meredith Freed, "FAQs on Medicare Coverage and Costs Related to COVID-19 Testing and Treatment" (December 4, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/faqs-on-medicare-coverage-and-costs-related-to-covid-19-testing-and-treatment/.
[11] Anna Wilde Mathews & Robbie Whelan, "As Covid-19 Cases Rise, Insurers Reduce Coverage for Virtual Doctors' Visits" Wall Street Journal (September 30, 2020), https://www.wsj.com/articles/as-covid-19-cases-rise-insurers-reduce-coverage-for-virtual-doctors-visits-11601494901.
[12] Gabriela Weigel, *et al.*, "Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond" (May 11, 2020), https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.

devices and apps must not be allowed to benefit from the use or sale of health information. We also endorse more systemic improvements, such as updating privacy laws to reflect new technologies.

- **Strengthen Data Collection and Evaluation**. CMS and other federal agencies, as appropriate, must collect and publicly release data on all Medicare-covered telehealth services, including the type of services being provided; instances and patters of fraud, waste, and abuse; program integrity vulnerabilities and safeguards; beneficiary experience and preferences; programmatic and beneficiary spending; health outcomes; and quality measurements. Such monitoring can inform future policymaking, as well as help verify people are receiving the care they want and need in a way that is affordable for beneficiaries and sustainable for the program.

- **Combat Fraud**. Financial and other scams targeting people with Medicare are, sadly, not new. But the rise of telehealth may put beneficiaries and the program at greater risk for certain types of fraud—including efforts to trick patients into accessing services they neither want nor need, exaggerations about the level of care provided, claims that care was provided when it was not, or even completely fictional provider-patient relationships.[13] These potential problems should be one of the factors policymakers consider when contemplating permanent telehealth changes, as should mitigation strategies. Consumer protections (e.g., advance, written notice and consent to services) and program safeguards (e.g., monitoring and preventing upcoding and gaming of the risk adjustment system) should be adopted wherever possible and strictly enforced. We also urge putting these and other program integrity concerns in the appropriate context: most providers have good intentions and want to serve their patients as best they can. We must not be so attuned to the risk of fraud that we cut off access to care unnecessarily, punishing the many for the sins of the few.

High Quality Care

The determination of what telemedicine services may be appropriately delivered via any given modality must be a clinical one, and subject to revision based on data about efficacy, beneficiary satisfaction, and outcomes. Efforts to evaluate, update, and improve the system should be continuous, to ensure that at any given time, the care being provided is of the highest possible quality. Specific recommendations include:

- **Update Service and Provider Coverage as Clinically Appropriate and Supported by Evidence**. All covered telehealth services and providers must be clinically appropriate, as determined through CMS processes. Changes to the list of allowable telehealth services and providers should be made through notice-and-comment rulemaking—rather than through sub-regulatory guidance or statute—to maximize policy responsiveness, program nimbleness, and public engagement. Any coverages that are found to not meet clinical or other standards should be addressed quickly and seamlessly, to avoid breaks in or inappropriate care.

- **Update Modality, Device, and Technology Coverage as Clinically Appropriate and Supported by Evidence**. Two-way audio video devices are important, but they are not the only possible

[13] Alicia Diaz, "Federal watchdog raises concerns about increasing telehealth fraud during pandemic" STAT (February 21, 2021), https://www.statnews.com/2021/02/22/federal-watchdog-raises-concerns-about-increasing-telehealth-fraud-during-pandemic/.

modality. Seldom reimbursed prior to the pandemic, audio-only visits can make telehealth available to people who lack the technology or strong internet signals needed for useful video communications—potentially reducing disparities and improving health. Indeed, initial reports indicate people with Medicare have relied on such devices for care during the PHE: one-third of beneficiaries that received a telemedicine service between March and June 2020 did so using audio-only technology.[14] But these services are not without risks. Audio-only telehealth may be of lower quality and lead to unnecessary care;[15] fraud is also a concern.[16] Policymakers must balance the potential gains with the potential harms. To that end, decisions about what kind of care can be delivered safely and effectively using different modalities, including through audio-only interfaces and other non-broadband technologies, should rely on clinical determinations and outcomes and be subject to rigorous and ongoing oversight and data collection. Any eventual expansions must put guardrails in place to protect beneficiaries.

- **Ensure Appropriate Provider Relationship Requirements**. Where appropriate clinical and evidentiary support is present, telehealth services should be available to both new and established patients. As with other potential expansions, any such changes should be accompanied by robust oversight and data collection to confirm that beneficiaries are receiving the care they need, and that clinicians are providing the care they claim to be.

- **Promote Continuous Quality Improvement**. Policymakers must continuously study, evaluate, and adjust Medicare telehealth, to make sure it keeps pace with evolving technologies and beneficiary needs. This includes using and developing telehealth-specific quality measures that capture beneficiary satisfaction and outcomes. When service components are found to be clinically ineffective, or to worsen health, reduce access to care, or widen disparities, they must be swiftly corrected or curtailed.

Increase Access to Care

Telehealth should serve as an additional access point—supplementing, but not supplanting, in-person care. Some beneficiaries and their families may prefer telehealth for certain services. Virtual options can reduce caregiving burdens, require less time spent off work, and allow remote caregivers and loved ones more interaction with providers, as requested by the patient. But others may find telemedicine to be unavailable, unworkable, or uncomfortable. An effective Medicare program must support the full range of beneficiary needs and preferences. Specific recommendations include:

- **Remove Geographic and Site Restrictions**. Under current law, Original Medicare generally can't pay for telehealth for beneficiaries in urban areas, or at all unless the beneficiary goes to a qualifying health care facility to connect with a doctor remotely. These restrictions may have been appropriate in 1997 when the services were created, but they no longer reflect the technology landscape or the beneficiary experience.[17] Preliminary 2020 Medicare claims data bears this out—beneficiaries across the country are accessing telehealth during the pandemic,

[14] Seema Verma, "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19" Health Affairs (July 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.
[15] Lori Uscher-Pines, *et al.*, "Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic" JAMA (February 2, 2021), https://jamanetwork.com/journals/jama/fullarticle/2776166.
[16] The U.S. Department of Health and Human Services Office of Inspector General, "2020 National Health Care Fraud Takedown" (last accessed February 26, 2021), https://oig.hhs.gov/documents/root/230/2020HealthCareTakedown_FactSheet_9dtlhW4.pdf.
[17] Centers for Medicare & Medicaid Services, "Information on Medicare Telehealth" (November 15, 2018), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf.

including 22% of beneficiaries in rural areas and 30% of beneficiaries in urban areas.[18] Medicare Advantage and many commercial insurers currently reimburse for telehealth services without geographic or originating site limitations.[19] Congress must allow Original Medicare to do the same.

- **Properly Align Payment Incentives**. During the PHE, CMS is paying providers the in-person rate for qualifying services furnished via Medicare telehealth. This means providers are receiving higher reimbursements for virtual services than they did before the pandemic. Making this payment change permanent could create financial incentives that undermine access to in-person care, putting beneficiary health and agency at risk. We urge policymakers to ensure Medicare telehealth payments are sufficient, sustainable, and properly structured.

- **Safeguard Network Adequacy**. Medicare Advantage network adequacy rules exist to make sure enrollees can access needed care. Troublingly, the 2021 Part C & D rule dilutes these consumer protections with respect to certain telehealth services.[20] We urge you correct this. Care that is only available virtually must not count toward meeting network adequacy standards.

- **Examine Interactions with Other Systems**. All post-PHE changes, which should be promulgated through normal legislative or regulatory procedures, must ensure that interrelated existing protections are either sufficient or updated in a coordinated way. For example, access to telehealth must not create loopholes that allow offices and facilities to skirt Americans with Disabilities Act (ADA) compliance, and privacy laws may need to expand to cover the growing number of entities that have access to Personal Health Information (PHI).

- **Equalize Access in Original Medicare and Medicare Advantage**. Telehealth service expansions must be identical in Original Medicare (OM) and Medicare Advantage (MA), so that all beneficiaries have equal access to care. We also support correcting existing imbalances that allow MA plans to offer telehealth services that OM cannot.

Promote Health Equity

Older adults and people with disabilities, in particular those in underserved communities, can disproportionately lack access to or comfort with the devices and internet services that are a necessary component of telemedicine.[21] Some PHE flexibilities may be appropriate longer-term policies, but careful planning and evaluation is needed to make sure that any expansions or other changes advance health equity goals. Specific recommendations include:

- **Prioritize Underserved Communities**. Congress must direct funding and other aid to communities with low rates of technology access and use—including Black Americans, Latino Americans, Indigenous people, other people of color, individuals with disabilities, and people

[18] Seema Verma, "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19" Health Affairs (July 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.
[19] MedPAC, "Mandated Report: Telehealth Services and the Medicare Program" (March 2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0.
[20] Medicare Rights Center, "Comments on Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" (April 6, 2020), https://medicarerights.org/pdf/medicare-rights-2021-c-d-rule-comments.pdf.
[21] Yohualli Balderas-Medina Anaya, *et al.*, "Telehealth & COVID-19: Policy Considerations to Improve Access to Care" (May 2020), https://latino.ucla.edu/wp-content/uploads/2020/05/Telehealth-COVID-19-Report.pdf.

with limited English proficiency—to improve utilization.[22] Community-based organizations are uniquely positioned to provide these vital services and supports.

- **Collect and Analyze Data**. Telehealth expansions must not exacerbate health, racial, or income disparities. To align future policymaking with these goals, federal agencies must purposefully collect and publicly report data on telehealth use and barriers, including detailed demographic data (e.g., race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socioeconomic status, insurance coverage, and geographic location). Data collection and analysis must be culturally competent and consistent with patient privacy laws.

- **Close the Digital Divide**. Research indicates one-third of adults age 65 and older never use the internet and almost half lack at-home broadband. The digital divide is even greater for Black older adults: 55% do not go online and 70% do not have broadband access at home.[23] Congress must reduce these disparities, in part by improving beneficiary access to digital literacy training, reliable broadband, and remote technologies.

- **Support Workforce and Infrastructure Development**. Advancing equitable access to telehealth will require investing in non-health care systems—like telecommunications and technology infrastructure—as well as reforming the health care workforce in ways that build capacity and economic security.

- **Protect Beneficiary Rights**. Policymakers must monitor the marketing and provision of Medicare telehealth services to guarantee compliance with anti-discrimination rules and guidelines, including requirements around the use of interpreters and the provision of materials in alternative formats and non-English languages.

Conclusion

Through our work with people with Medicare and their families, we frequently hear from beneficiaries who are struggling to access and afford needed services.[24] Many face limited financial resources, rising health care and prescription drug costs, antiquated coverage and enrollment rules, systemic inequities, and burdensome program requirements. In addition to these longstanding barriers, older adults and people with disabilities, and particularly those of color, have been among the hardest hit by the COVID-19 pandemic and its economic fallout.[25]

Because of the risks COVID-19 poses to many people with Medicare, Medicare Rights greatly appreciates congressional and administrative efforts to widen Medicare telehealth coverage during the PHE. Amid calls to make these sweeping changes permanent, we caution that rushed policymaking can yield

---

[22] Older Adults Technology Services from AARP (OATS) & the Humana Foundation, "Aging Connected: Closing the Connectivity Gap for Older Americans" (January 2021), https://agingconnected.org/wp-content/uploads/2021/01/Aging-Connected_2021.pdf.
[23] Monica Anderson and Andrew Perrin, "Tech Adoption Climbs Among Older Adults" (May 17, 2017), https://www.pewresearch.org/internet/2017/05/17/tech-adoption-climbs-among-older-adults/.
[24] Medicare Rights Center, "2018-2019 Medicare Trends and Recommendations" (October 9, 2020), https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations.
[25] *See, e.g.*, Hannah R. Abrams, *et al.*, "Characteristics of U.S. Nursing Homes with COVID-19 Cases" (last accessed February 26, 2021), https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16661; Robert Gebeloff, *et al.*, "The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes" (September 10, 2020), https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html; Samantha Artiga, *et al.*, "Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19" (April 7, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/.

undesirable results, such as perverse incentives and exacerbated inequities. Going forward, we urge a thoughtful and evidence-based approach that centers the needs and preferences of people with Medicare. To allow time for that, we support a glide path, and contemporaneous heightened oversight, to prevent a beneficiary's access to services from ending the moment the public health emergency does.

Critically, other near-term improvements are also needed to promote access to affordable, high-quality care. Throughout the PHE, we have consistently heard from Medicare-eligible individuals who are unable to quickly connect with their earned benefits. Most have to wait several months to sign up and several more for coverage to begin. These are dangerous gaps in general, and for at-risk populations during a pandemic in particular. A COVID-19-specific Medicare Special Enrollment Period (SEP) for Premium Part A and Part B and expanded Equitable Relief would help, creating pathways for older adults and people with disabilities to obtain needed care.[26]

Thank you again for the opportunity to be here today. I look forward to working together to advance a system that works for all beneficiaries.

[26] *See, e.g.*, Leadership Council of Aging Organizations, "Letter on COVID-19 Relief" (February 23, 2021), https://www.lcao.org/wp-content/uploads/2021/02/lcao-chair-letter-to-hill-on-covid-relief.pdf; Medicare Rights Center, "Letter to Senate Leaders on COVID-19 Relief Priorities" (July 29, 2020), https://www.medicarerights.org/pdf/072920-covid-letter.pdf.

Ms. ESHOO. Thank you very much for your testimony.

On the last point that you made, Mr. Riccardi, we can write to CMS on that. So we will follow up with you on that.

We are now going to move to Member questions. And I think all of us have many of them, but we have to squeeze them into 5 minutes—not just 5 minutes of us asking questions, that includes your answers. So I recognize myself for that 5-minute period.

At the heart of the debate around Medicare's coverage of telehealth is whether telehealth will increase utilization and, in turn, increase costs. So Ms. Mitchell says we can save money. Dr. Mehrotra pointed out the costs. So my question to Dr. Mahoney is, when we use the word "utilization," what does that mean?

Dr. MAHONEY. Thank you——

Ms. ESHOO. Is all utilization the same?

Are the—will one reimbursement cover the costs, can you give us some direction on that? And do you think that it is possible to write that type of clinical determination into law?

Dr. MAHONEY. Sure. So thank you for the question, Ms. Eshoo.

Yes, the utilization typically refers to patient consumption of healthcare services, whether it is——

Ms. ESHOO. Does that mean the time that is used?

Dr. MAHONEY. So, yes, so the time that the physician would spend seeing the patient, and also any related ancillary services that are provided: lab tests or imaging studies.

So, yes, so there is a concern that telehealth would be additive, and so I would see a patient through a video visit, and then I would later see them that week in person because I wasn't able to complete what I wanted to do. But that simply hasn't been what we have observed.

Really, like I mentioned earlier, the time that the physician has is the rate-limiting factor. And really, we just use our schedule, our templated schedule, to spend our time on either an in-person visit or a telehealth visit. And so it is actually substitutive, it is not additive in the way that we——

Ms. ESHOO. So does your——

Dr. MAHONEY [continuing]. Provide our care——

Ms. ESHOO [continuing]. Show that telehealth could substitute for in-person care?

Dr. MAHONEY. That has not been our experience. Or our experience has been that it has been substitutive, exactly. Yes.

Ms. ESHOO. And, Dr. Mehrotra, when you gave your testimony, you were cautionary. Do you agree with Dr. Mahoney?

Dr. MEHROTRA. Yes, though I think during the pandemic we haven't seen an increase in utilization. But I think it is hard to use the data from the pandemic. At least my patients, and I think many of us today are—I mean, it is a bit nervous right now to go to the provider. And so I think we need to look at the period prior to the pandemic to try to assess that.

And there is—honestly, right now, we don't have that much research on this particular topic. We did one study looking at one form of telemedicine, and we found that the vast majority was additive and it increased healthcare spending.

Ms. ESHOO. I think that we need more data.

Have any of you examined the CONNECT bill? Do you think it accomplishes what we want to accomplish?

Do you—I know this is not a legislative hearing, but since, you know, receiving all of your testimony, I am just curious to know if you have read it, if you think it is going to accomplish what we need to do. Any of you?

Dr. RESNECK. This is Jack.

Ms. ESHOO. Go ahead.

Dr. RESNECK. So we have been tremendously supportive and appreciative of the efforts on this front, including last year's version of the CONNECT bill, and we are generally supportive. I think we prefer the approach this year of the Telehealth Modernization Act, and the CONNECT for Health Act could certainly incorporate this provision. But adding sort of permanent repeal of the rural exclusions and the originating site exclusions, rather than giving CMS the authority to do ongoing waivers, really would give us the certainty in our practices to be able to——

Ms. ESHOO. I only have 33 seconds left.

So Dr. Mahoney, do you want to add anything, and the other witnesses?

Dr. MAHONEY. Oh, I was actually going to say something very similar to what Dr. Resneck said——

Ms. ESHOO. OK.

Dr. MAHONEY [continuing]. That we would be supportive of anything that expands access to care, removing geographic barriers and the——

Ms. ESHOO. Frederic?

Mr. RICCARDI. Yes. And we also support the CONNECT Act, and we believe that it would provide important assistance.

Ms. ESHOO. And Dr. Resneck, Ms. Mitchell?

Going, going, gone. No? No weighing in?

Dr. RESNECK. Can I come back to this utilization issue?

Ms. ESHOO. Pardon me?

Dr. RESNECK. Can I come back to one point on this utilization issue?

Ms. ESHOO. Well, I have 2 seconds left.

Dr. RESNECK. I will get to it later.

Ms. ESHOO. All right, OK, so now we will move to—recognize Mr. Guthrie, the ranking member of our subcommittee, for your 5 minutes of questions.

Thank you to all the witnesses.

Mr. GUTHRIE. Thank you. Thank you, Madam Chair. And yes, thank you to all the witnesses.

I would like to enter into the record a February 23rd technical assistance document from the Department of Health and Human Services Office of Inspector General that I mentioned in my opening statement.

The OIG highlights critical vulnerabilities that could exist within telehealth. As Congress thinks about expanding these very important benefits, we need to carefully weigh the potential vulnerabilities expressed in the documents.

I would like to enter that in the record and look at these vulnerabilities.

First, Ms. Mitchell, you write in your testimony that there is relatively little academic research regarding the clinical appropriateness of telehealth as an alternative to traditional, in-person care.

I support the expansion of telehealth but want to make sure we are balancing the needs of patients and doing our best to ensure their care is provided in the setting best suited for them.

So my question: As Congress examines making some of these flexibilities permanent, how do you think we should address clinical appropriateness?

Ms. MITCHELL. Well, if that is to me, I want to be very clear I am not a clinician. However, I do think research is absolutely needed on clinical effectiveness. We need to measure both the quality and patient experience of the telehealth service itself, as well as the outcomes and experience within the practice when telehealth is integrated.

I think you heard already that telehealth, in many cases, is not duplicative, but substitutive. However, when you look across the different providers, that is where you can come up against real problems with coordination. So let's say a private vendor calls you for a visit. They don't share the data with your practice. You have to have another visit for the same reason. We think there has to be coordination across the system to—and then true measurement of patient outcomes and experience.

Mr. GUTHRIE. OK, thank you for that. And I will go to Mr. Riccardi on the next issue.

Some of the healthcare providers in my district would like to continue—because we have some of the broadband areas and some of the issues—using technology that has only been able to be used for telehealth during the pandemic, due to enforcement discretion of HIPAA, such as Facetime, Google Hangout that may not be HIPAA-compliant. How do we balance the accessibility of technology with patient privacy?

Mr. RICCARDI. Thank you for that question. And we also support the permanent expansion of some telehealth services. But an expansion must not, you know, exacerbate existing health disparities, and also go back to prior, prepandemic protections such as the HIPAA rules.

So we would like to see a glide path, where people do not automatically lose access to such important services. But it is incredibly important that the HIPAA rules be reapplied again as—the waivers during the public health emergency have allowed use of technology such as FaceTime or Skype that may be appropriate during an emergency situation but potentially exposes beneficiaries' information and data to sometimes, you know, predatory companies and app makers. So it is really important that we must not permanently waive HIPAA enforcement for the future of telehealth services and Medicare.

Mr. GUTHRIE. OK, thank you for your answer.

Then, Dr. Resneck, you stated in your testimony that State medical boards play a pivotal role in protecting the safety of patients to physician licensure regulations and disciplinary action. And before coming to Congress I was in the State legislature and chair of our licensing professionals committee, and understand the role States play in regulating healthcare. Can you tell us more about

the safeguards State legislators—legislatures and medical boards have put in place to ensure the safe practice of telemedicine?

Dr. RESNECK. Thanks, Ranking Member Guthrie. I think it is an important question.

You know, States really do set the rules of the road for physicians through their State medical practice acts. And I get nervous when I think about things like Federal licensure, because those rules determine how we deal with end-of-life care, medical marijuana, age of consent, reproductive health. All of those things are enforced through licensure and State medical practice acts, and I get very nervous at the thought of Congress trying to unify that with a Federal license nationwide.

I also get nervous when I hear about people being licensed in the State where the physician sits instead of the patient sits, because the State medical boards are really what hold physicians accountable for the care of patients and their jurisdictions. And that is where the enforcement lies. And they don't really have interstate policing authority. If I take care of a patient in Florida, or Texas, or another State without a license there, it doesn't give authorities in those States the ability to come and see about the quality of care I have been providing to their patients.

Mr. GUTHRIE. OK, thank you very much. I only have 7 seconds, so I will stop there, and I will yield back to the chair. Thank you.

Ms. ESHOO. The gentleman yields back.

I am reminded that we don't really examine what takes place in terms of quality and whatever in in-person appointments, the—when doctors see their patients. So, you know, we are—we need to build something, I think really credible, relative to telehealth. But, you know, we don't—the scale seemed like this to me. It is just an observation.

The Chair now recognizes Mr. Pallone, the chairman of the full committee, for his 5 minutes of questions.

Mr. PALLONE. Thank you, Madam Chair. Theres still a lot of questions about whether telehealth service is a substitute or add to in-person services. And CBO, MedPAC, and others have raised concerns that telehealth services could be overutilized, given Medicare's fee-for-service payment system, which can incentivize volume over value. So I wanted to start with Dr. Mehrotra.

What does the data from before and during the pandemic say about whether telehealth services tend to substitute or add to in-person services?

And could you discuss strategies for incentivizing high-value telehealth services and avoiding overutilization? Quickly, of course, because I have other questions, if you could, Doctor.

Dr. MEHROTRA. So, as I noted before, in terms of the pandemic, we have not seen an increase in overall use, how many visits people are receiving in the U.S. But that, I am not sure, can really generalize to after the pandemic. Prior to the pandemic, the limited research that I have done and others have done has demonstrated it does increase use of care.

So then the question that you asked was how do we address that we have high-value uses. I will maybe just touch upon one or two that haven't been addressed so far, and the first one is really payment reform. I think it is a really key issue that we have a fee-

for-service system and we are paying for each visit. And there is a lot of interest and, I think, appropriate movement in—particularly in primary care—to moving towards a capitated or an alternative payment model. And we give the primary care provider or other provider the flexibility of which model to use, in terms of payment.

Mr. PALLONE. Right——

Dr. MEHROTRA [continuing]. Which model of care to provide, excuse me.

Mr. PALLONE. Thank you. I wanted to ask you another question about whether telehealth can be cost effective for Medicare and other payers. What does the research show in terms of cost effectiveness of telehealth services relative to in-person services?

And are there any policy considerations you would recommend with respect to cost effectiveness?

Dr. MEHROTRA. You know, one thing I would like to emphasize is that we should think about telemedicine not as this monolithic, but there are certain applications of telemedicine conditions, patient populations where it will be cost effective, and others where it has not. We have some evidence in certain areas—one that we have already mentioned today is stroke care, where telestroke, we have evidence that it has saved lives, and the Congress has expanded access to that.

And so that is the kind of model in which I think we should move forward. As we gain more evidence clinically, then we expand into those clinical areas where it is clinically effective——

Mr. PALLONE. Thank you——

Dr. MEHROTRA [continuing]. And cost effective.

Mr. PALLONE. Thank you, Doctor.

Ms. Mitchell, in cost effectiveness—like, is cost effectiveness an important consideration for purchases?

And are there other factors that warrant additional study? If you would.

Ms. MITCHELL. Absolutely. And I really want to underscore the need to move away from fee-for-service. We do not believe tossing in another service, however beneficial, into the dysfunctional system will help make it better.

So we believe we need to thoughtfully increase the use of telehealth within a total cost of care or other model. And we also think that payment parity assumes that there is similar input on a cost basis. Medicare is, you know—pay is by relative value units, or RVUs, which are derived from an assessment of the time and intensity required to provide the service. We are not convinced that it is the same requirement for telehealth. We believe providers may be able to see more patients in a shorter amount of time.

So again, we strongly support adoption of telehealth but believe it needs to be within a total cost model.

Mr. PALLONE. Thank you. Then I was going to ask last, Dr. Mahoney, is there a need for additional data on cost, quality, and outcomes of telehealth services, compared to in-person services?

And if you would like to comment—I have got about a minute left—I would appreciate it.

Dr. MAHONEY. No, thank you for the question. I absolutely agree that now we have 12 months of real data, a real-world data set on

scaled telehealth implementation across the country, and we definitely have an opportunity to leverage the data to conduct large-scale analyses and determine conclusively what is the association between clinical outcomes and telehealth.

I think that, largely, those questions are unanswered, but we need to have continued access to telehealth to be able to answer those questions, in addition to the questions that are related to health equity that have come up, as well.

Mr. PALLONE. Thank you. I have to tell you, I always worry that when CBO, MedPAC, and these other agencies look at overutilization, they don't pay enough attention to whether or not—yes, OK, maybe there is more utilization because it is actually better, you know?

And so imaging is always the one that comes to mind, where, you know, they say, "Oh," you know, "you have come up with these new diagnostic methods, and everybody is using it, and it is overutilization." But on the other hand, it is good, because they find things out that they didn't know before. And so I always worry how these analyses are actually done.

But thank you so much. Thank you, Madam Chair.

Ms. ESHOO. We thank the chairman. Well, the outfits that you just referred to, Mr. Chairman, are number crunchers only, so they don't take other things into consideration. We have learned that.

It is a pleasure for the Chair to recognize the ranking member of the full committee, Mrs. Cathy McMorris Rodgers, for your 5 minutes of questions.

Mrs. RODGERS. Thank you, Madam Chair. Today is Teen Mental Wellness Day, and my heart is burdened over the crisis that our Nation's children face, both before this pandemic, when we were seeing record depths of despair, the suicides, addiction, opioids, substance abuse. And it has only been magnified because of COVID, where we are seeing the tragic headlines about the increases in suicide, mental health, anxiety.

Just last night I got a text from a friend. His beautiful teenage granddaughter, McKenna, had attempted to end her life. Unfortunately, because of COVID and the continued lockdowns and isolation, this is too common these days. I believe that one of the best ways to help our kids is to get them back in school.

But I also believe that telehealth has great potential to help address behavioral and mental health challenges. So, Dr. Mehrotra, I wanted to start with you, and I just wanted to ask if you would talk about what the data shows on patient outcomes and satisfaction with mental and behavioral health treatment using telehealth. Speak to the data about its use in children and adolescents. And what can we in Congress do to make sure that our kids get the care that they need?

Dr. MEHROTRA. So I think that there is broad consensus that this is an area of great crisis in the United States and an application of telemedicine which has great, obviously, potential. And that is reflected in the recent congressional action to permanently expand telemedicine for behavioral health services.

I think the research is, in this particular area, pretty consistent, that when we look at patients who receive their care via telemedicine versus in-person care, the outcomes are generally the same

or—and sometimes even better for, you know, the treatment of mental illness. And that is also true among our adolescents and children. And so I think there is a lot of excitement, and this is a clear area of telemedicine where I think I would term it as high value, or where we should focus on.

You asked a really important question, which is how can we then—what can the Congress do?

I would emphasize maybe a couple of things that have already been touched upon. I think there is consensus among many of us that licensure is an area that can be addressed, because there's a lot of private companies that have been coming into this space that offer an option for parents who are really struggling to find a therapist or a psychiatrist nearby. And those companies struggle, in terms of their business model, because they have to get licensure in all 50 States. And so how can we—I think that is a key area for the Congress to potentially focus on.

The other thing is that there have been laws and—to require an in-person visit before they have—they can start mental health treatment. And I think those kinds of regulations are inappropriate, because they will limit the ability of Americans and adolescents to access care.

So those are two points that I wanted to emphasize to increase the access to care for our adolescents in the U.S.

Mrs. RODGERS. Thank you. The rapid expansion of telehealth, especially over the last year with COVID–19—and maybe one of the bright spots in this tragedy, in this trying time—we now have three safe and effective vaccines in less than a year, and the hope that the pandemic, the end of the pandemic, is in sight.

I wanted to ask each one of the panelists to speak as to what they see as the future of telehealth being. Just what do you think telehealth should look like 10 years from now?

And how do you see patients using it, being paid by private plans, employers, Medicare?

And if you want to speak to licensure again, that is great. But let's start with Dr. Mahoney, and then Mehrotra, Ms. Mitchell, and Dr. Resneck, and then Mr. Riccardi. And let's—a little over a minute, but just whatever you want to add would be great.

Dr. MAHONEY. All right. Thanks, Mrs. Rodgers, for this fascinating question. I think about the future. How I envision the application of telehealth in the next 10 years, let's say, or how it will progress is I first of all think that the office space visit will change quite a bit. Our need to and expectation for an annual physical, in-person visit and primary care will definitely change. And we will start to think about the specific indications for an in-person visit, because of the inconvenience on the part of the patient.

It is just proving to be much better for patients to receive all sorts of services through telehealth. So I think it will be part of our toolkit. Like we mentioned earlier, are we substitutive? And it will be used when it is most appropriate, taking into consideration the clinical conditions, and then also the patient, the preference of the patient. And we are already seeing that come to light.

I also would say that the application of remote patient monitoring will also be probably increasingly utilized, and home diagnostics. And so it is exciting to think about how all of these,

in combination with e-visits, e-consultations, we will be able to meet the needs of our patients, and then also get that value that we are expecting out of telehealth.

Mrs. RODGERS. Thank you. And I ran out of time. I have to yield back, but I just really want to continue to hear from others about the future.

Ms. ESHOO. The gentlewoman yields back. And of course, every Member can submit written questions to our witnesses, as well.

Now we will go to the gentleman from North Carolina, Mr. Butterfield.

And I just want to—I think it is worth stating the following, that Members are called on based on seniority at gavel, arrival after the gavel, and waive-ons. So that is the way we do it.

And so, again, the gentleman from North Carolina, Mr. Butterfield, is recognized for his 5 minutes of questions.

[Pause.]

Ms. ESHOO. Where are you, Mr. Butterfield?

[No response.]

Ms. ESHOO. All right. Going, going, gone.

We will—I will recognize the gentlewoman from California, Ms. Matsui, and thank her for her leadership on this issue.

You are recognized for 5 minutes.

Ms. MATSUI. Thank you, Madam Chair. And I really appreciate this hearing. It has been fascinating.

The pandemic has brought on serious increases in anxiety, depression, and other mental health concerns that are likely to last long after we get the virus under control.

In my district, WellSpace Health, our local FQHC, has found that conducting an initial assessment virtually has been critical to breaking down trust issues and building relationships with new patients. That is why I am working on a comprehensive legislation to ensure access to tele-mental health—clinically appropriate without limiting access. This legislation would take a close look at the inequities of an in-person requirement for tele-mental health, and address other outstanding access issues like maintaining coverage for a wide range of delivery platforms.

Dr. Mahoney, from your practice experience, can you expand on how new patient visits by modality has changed over the course of the pandemic?

What has been a primary driver of these changes?

Dr. MAHONEY. Sure. So what we have noticed is that the in-person requirement, as—is probably outdated at this point. We are able to provide high-quality care through telehealth, even at the initial visit with our patients. And, in fact, we had a high percentage of new visits this year because of the lockdown. And we were happy that we were able to deliver a high-quality care through telehealth for our new patients into Stanford.

I also wanted to highlight the important point that you are making about behavioral health, and we would like to be able to provide access to patients when they are ready when it comes to behavioral health and addiction services. And I have heard from my colleagues who practice in addiction medicine and behavioral health that they have actually seen an increase, an uptick in the number of patients who are showing up for their visits because of

the added convenience of being able to see them through telehealth.

Ms. MATSUI. Certainly. And Dr. Resneck, in your view, what is the clinical necessity of an in-person requirement for tele-mental health services?

Dr. RESNECK. For mental health services, in particular?

I mean, so we really look to each specialty to figure out the standard of care for a variety of conditions. In the last year, built on top of several years of evidence before, has brought us a long way. So that, for example, a psychiatrist in mental health knows—just like I know in dermatology—which conditions they can take care of with and without an in-person visit first.

So we are not in favor of freezing in statute arbitrary things like a requirement for an in-person visit first, because that standard of care is evolving. We have a big evidence base. We have 50 States that allow a new patient relationship to be established via a virtual visit, and we just wouldn't want to see that frozen in statute.

Ms. MATSUI. Certainly. And we have seen a surge in audio telehealth use in the past year, particularly, as you know, among lower-income patients. Audio-only telehealth services were rarely reimbursed by commercial payers and government programs before the pandemic. And now we have critical policy decisions to make about the long-term scope of coverage for audio-only visits. Quality and cost are important factors to consider, but we cannot lose sight of the role audio-only has had in promoting health equity.

Dr. Riccardi, CMS has said it may stop reimbursing for audio only. Can you comment on how that might impact the one-third of Medicare beneficiaries who used telehealth during the pandemic?

Mr. RICCARDI. Yes, and that is concerning. You know, what we have heard from our clients and through our help line is that audio-only visits have been a lifeline through this pandemic. As you had mentioned, one-third of these visits have been audio-only because a significant number of Medicare beneficiaries based on age, race, ethnicity do not have access to audio-video technology.

And so, as we think about the purpose and use of audio-only going forward, I think decisions can be made on the clinical appropriateness of them, although there is quite a bit of research and data that suggests that audio-only visits are applicable and should be used for people who need behavioral health services. So that is another consideration.

And I agree with some of the sentiments that Dr. Mehrotra had shared earlier about the importance of audio-only services.

Ms. MATSUI. Right, certainly. And I think, particularly for behavioral health, there is that sense of hearing the voice and not necessarily having to face the person many times, in tele-mental health in particular, with audio-only.

I see my time is gone, and thank you very much.

And thank you, Madam Chair, and I yield the balance of my time.

Ms. ESHOO. We thank the gentlewoman again for her leadership on this.

It is a pleasure to recognize the former chairman of the full committee, the gentleman from Michigan, Mr. Upton, for your 5 minutes of questions.

Mr. UPTON. Well, thank you, Madam Chair. And I just—you know, as we all think about telemedicine, this is such a win-win, one of the best things, probably, since sliced bread. It is a no-brainer. We should move on this as fast as we can, not only for the physician and medical community, but also for the patient community, as well. And so I appreciate the opportunity for this hearing.

I just have to relate a story that I had earlier this—last year. I spoke to the urologists nationwide, and one of the doctors said—you know what she said? "I am from the Bronx. We are at the very center of the COVID issue right now. I am so grateful that I can practice medicine and talk to and communicate with my patients because we are using the telemedicine. Don't take those tools away. This is the best thing that we have to do."

But I have got a couple of questions. I want to first go to Dr. Resneck.

In your full testimony you talked a lot about the concerns about fraud and abuse, and the possibility of overutilization. And I just wonder if you think that the OIG, the Office of the Inspector General, in fact—the tools to really go after fraud and abuse, and if there is anything more that we should be doing to clamp down on that Medicare fraud, all those different—because, I mean, it makes us all furious when we see that. Do we have the tools to stop the unscrupulous folks, the very few who are ripping off the system?

Dr. RESNECK. Congressman, thank you. I share your frustration when I see those examples. And I am glad OIG and the Department of Justice are keeping an eye on it. I am actually serving as an expert on some of the national takedown cases that have come up related to telehealth fraud. So I have some insight into this, and I feel pretty strongly that they have the tools they need, and they are doing a good job.

Most of what they are describing in terms of telefraud actually has nothing to do with telemedicine. It is unscrupulous marketing companies that are reaching out to patients saying, "Hey, do you want free, durable medical equipment, or free compounded medications, or free genetic testing that you don't need?" And then maybe, since some of the subcases—they might document a telehealth visit, which is not even a real telehealth visit, just to justify their prescription, but they are not even billing for the telehealth visit. They are not using these new codes, largely, that Medicare has authorized. So this is a type of fraud that existed before Medicare's expansion during the pandemic.

Frankly, when I look at the before and after, it feels to me like denying patients, Medicare patients, access to telehealth as a result of these few fraudsters doesn't solve the fraud problem and just harms our patients.

And the waivers have really tipped the balance. We are seeing more and more patients following up, seeing physicians they know, as opposed to being tempted to go to corporate—other telehealth providers, or being ripe for fraud. So I think the tools are there for OIG and for DOJ.

Mr. UPTON. So you don't think we need harsher penalties for those that are actually convicted?

Dr. RESNECK. Well, I am not sure I commented on the level of penalties, and I need to refresh and get back to you on the level

of penalties. But in terms of OIG and DOJ's ability under the law to investigate this fraud and telehealth fraud, it is no different than any other healthcare fraud that is going on, and I think they have the tools to investigate it.

Mr. UPTON. My last question—I don't have a lot of time left, a minute—a broad body of research links the social isolation and loneliness to poor mental health. Data from April of this year showed that significantly higher shares of people who were sheltering in place reported negative mental health effects resulting from worry or stress related to coronavirus than among those not sheltering in place.

Additionally, research shows that job loss is associated with increased depression, anxiety, et cetera, suicide. We need to make sure that these issues are not forgotten while we work on the physical toll that coronavirus took us on. That is why I am anxious and continue to work with colleagues on both sides of the aisle that would help give access to mental health services through telehealth platforms.

Who would like to comment on that, in terms of expanding it even further on the mental health side?

Ms. MITCHELL. Congressman, as a representative of jumbo employers, this is a top priority for them, expanding access to mental healthcare. We believe telehealth can play a critical role there.

However, we also know that the concentration of mental health providers is often inversely related to the need. So you might have a lot of psychiatrists in Los Angeles, for example, but the need might be in rural communities, and they don't have those practitioners there. We think telehealth can play a critical role in expanding access, but we are going to need to address broadband, because many communities don't even have the broadband they need to enable telehealth services. And we are going to have to look at licensure to make sure that we are not limiting access unnecessarily.

Mr. UPTON. Well, thank you. To all my colleagues, we all—clearly ought to be unanimous within our committee to do all that we can to help those really most in need.

And with that, Madam Chair, I yield back my time.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for your 5 minutes of questioning. Great to see you.

Ms. CASTOR. Good morning, Chairwoman Eshoo, and thank you so much for calling this hearing on the future of telehealth. And you are right, our witnesses have been outstanding this morning. Thank you very much.

And let me just say that, during this very difficult past year, while we have been grappling with COVID–19, I have heard from many of my neighbors back home in Florida and many health professionals on what telehealth has meant to making sure that they can continue to receive the health services they need, and that all-important connection during a time of enormous disconnection from everyday life.

So we know that, in addition to the flexibility provided by Congress, CMS added a number of new covered telehealth services for Medicare beneficiaries over the past year. And now we know that

CMS has indicated that they will not continue to cover all of these services after the pandemic, due to the lack of strong evidence of clinical benefit. But what I have heard from a number of our witnesses today is that certain telehealth services simply have been studied more than others and have clear quality outcomes and all of that important data.

So, as the committee moves forward with telehealth legislation, we need to ensure that we are funding or supporting that research, and that—so that we can balance the quality needs of the patient. Dr. Mehrotra talked about this, and I appreciate that.

So I would like to ask you all—start with Mr. Riccardi. Where would you prioritize additional research to build the evidence based on quality and outcomes for certain services to ensure that our older neighbors are getting the services they need?

Mr. RICCARDI. Yes, and thank you for the question. We think it is important that the geographic and the site restrictions for telehealth are reviewed.

And speaking to your point, I think that is why it is so important that there is an established period of time where individuals who are receiving these vital services are not cut off from them. And this would allow more time to examine the system prepandemic and currently, looking at the services provided, the outcomes and the quality, the participation rates, any barriers based on either beneficiary spending and, importantly, the impact of health disparities. Because there are many older adults and people with disabilities that just don't have access to either the technology or the broadband. And so clearly there needs to be more research done to ensure we are setting up a system that works for all people with Medicare.

Ms. CASTOR. So, Dr. Mahoney, you are conducting some of this research at Stanford. Where would you prioritize research so that we have the data we need on patient outcomes and quality?

Dr. MAHONEY. So thank you, Congressman Castor. Yes, we need to complete peer-reviewed research to quantify the clinical quality, costs, and safety outcomes of telehealth compared to in-person. At this point we are applying the standard quality measures for in-person and virtual care, but we still want to better define those associations.

So, as you mentioned, we are conducting research with MedStar Health and Intermountain Health to develop one of the Nation's largest cumulative data sets of primary care video visits looking at longitudinal outcomes, and this is funded by AHRQ. So what we are trying to determine are the clinical outcomes.

And then, furthermore, we need to better understand the association between access to Internet, smartphone or computer, and digital literacy, and how that might affect the clinical outcomes that we can expect with telehealth, looking at the health equity issues.

Ms. CASTOR. OK. Dr. Mehrotra, the same question to you. And then, if you could also add in quickly, have we—is there data available for Medicaid, where Medicaid systems have been using telehealth to a greater extent?

Dr. MEHROTRA. Yes. On the Medicaid side, unfortunately, we don't have that—as much data yet. I am sure that will be coming very shortly.

I do want to emphasize that—you have emphasized, and other committee members have emphasized the lack of evidence right now, and it creates a dilemma right now on where to go. There are a number of States that have either proposed or have implemented trial periods after the end of the pandemic—1, 2 years—for a broader coverage of telemedicine in that—in the effort that that would allow for an opportunity to study more, and see where it is most effective. And that is something that the committee could also consider.

Ms. CASTOR. Thank you very much.

Ms. ESHOO. The gentlewoman yields back. It is noted that there is a vote on the floor, so I am going to excuse myself and ask Congresswoman Kuster to chair.

And I would now recognize Mr. Burgess from Texas for his 5 minutes of questions.

And thank you to Congresswoman Kuster. I know the gavel is safe in your good hands. I will go as fast as I can to the floor. Thank you.

Ms. KUSTER [presiding]. I am happy to help.

Mr. Burgess, you are recognized for 5 minutes, and please remember to unmute.

Mr. BURGESS. Well, I have unmuted. Did it work?

Ms. KUSTER. Yes, we can hear you.

Mr. BURGESS. Very well. So, look, we all know we are not going back to what was the status quo a year ago, before the expansion of telehealth occurred during the pandemic.

I do have a concern, and I think it has been brought up by several of our witnesses today: We do need to be mindful of cybersecurity. Yes, there are criminal elements who might seek to exploit the system, but there are also state actors. And the security of the network has been underscored several times with events in recent weeks, but this is another area where I believe we have significant vulnerability. Of course, it is the task of this committee to identify and prevent those vulnerabilities.

Elizabeth Mitchell, first off, thank you for your service on the Physicians Technical Advisory Committee, a committee that was created by this committee back in 2014 with the Medicare Access and CHIP Reauthorization Act. You have talked some about data collection and how we don't know exactly how much money we might save, because we don't have the data. But is there any congressionally directed research that might be useful in assessing the cost-effectiveness of telehealth?

Ms. MITCHELL. Thank you, Congressman. And yes, and thank you for recognizing PTAC.

And one of the reasons that I am as confident as I am that telehealth can be used to expand access meaningfully is because so many of the PTAC models envisioned alternative sites of care, like hospital at home. We need to be able to reach patients where they are, where they live, and we can improve access, affordability, and patient experience.

I would say that more research is definitely needed. We need to evaluate and increase the use of patient-reported outcome measures. Are patients able to resume their activities of daily living? Are they pain free? Are they able to go back to work? These meas-

ures have existed for decades, but they have not been adequately used. So we want to increase that.

And we need to measure total cost of care, the impact of telehealth and other innovations on the use of—on total cost of care. So we believe that that is an important area of research.

We have also conducted significant research on patient experience. We have the largest data set of patient experience in the country, of over 40,000 patients a year. And we are seeing significant opportunity for improved patient experience with telehealth.

Mr. BURGESS. Very good. Now, you mentioned in your testimony how this moment for telehealth is not unlike the rollout of electronic health records. I was mindful, at last Saturday morning at 2:30 a.m., we were passing a big stimulus bill, and it was actually the stimulus bill of 2009 that brought electronic health records into the world of the practicing physician.

And I do have an article I want to make available for the record, how health experts misjudge clinician burnout. So we do need to be mindful of the potential negative effects.

But at the same time, is there anything that Congress can do on the front end to ensure that telehealth does not become overly burdensome to further silo health records or health data?

Ms. MITCHELL. Well, I think that we need to ensure that data is effectively shared. Again, this isn't about me, but I had a telehealth visit with my health plan provider, and they did not share the information with the primary care provider. That just makes the primary care provider's job even harder to get the information they need to—duplicative service. We have got to ensure data is meaningfully shared in a way that is easy for physicians to use.

Mr. BURGESS. Well, and Dr. Resneck, I so appreciate your testimony on this panel. You may remember it was this committee that—in the world of dermatology, it was this committee that worked very hard on allowing the use of a camera that might help in the detection of melanoma. And you could just imagine now extrapolating that to the telehealth world.

But are there any services that you provided via telehealth in the past year, where you felt limited in treating the patient because of the virtual nature of the visit?

Dr. RESNECK. Thank you, Doctor, Congressman Burgess, I appreciate the question.

Yes. And that is part of the evolving evidence base. So I know that, when I—when a patient reaches out to me who has had five skin cancers and needs a full body check, to tell them, you know what, you need to come in person and see me because I need to look you over for—from head to toe, and telehealth is not perfect for that.

When a primary care colleague refers me a patient with a new rash that needs to be seen urgently, and I have the whole wonderful history from the primary care physician, I can take a look on video. Perfect.

So, yes, we have learned over the last few years what things work well, what things don't. We actually have a pretty large evidence base in most specialties now about what things work well, and that really is built into the standard of care for each of us.

Again, we wouldn't want to see that in statute, because it does evolve over time, and those coverage decisions can be made by Medicare and by commercial insurers.

Mr. BURGESS. Yes. And—but, you know, there is so much that—where it depends upon the type of patient you have in your practice, how comfortable you are in accepting their assessment of things. And we can't forget that as we go forward——

Dr. RESNECK. Yes.

Mr. BURGESS [continuing]. With policy. There are going to be significant differences between practice types, and I hope we are mindful of that.

Thank you, Madam Chair. I will yield back.

Ms. KUSTER. Thank you. The gentleman yields back, and the Chair now recognizes Representative Peter Welch for 5 minutes of questions.

Mr. WELCH. Thanks very much.

First of all, I want to thank Chairwoman Eshoo for giving this hearing to all of us who are really committed to expanding telehealth. Thank you.

And I want to thank many of my colleagues, but particularly the ones I have been working with on legislation: Congresswoman Matsui and, of course, Congressman Johnson and Congressman Curtis. But I know all of us on this committee have a real interest.

I want to start with a preliminary observation. In listening to the witnesses, it appears that telehealth works. It works for patients, and it works for providers. And that has certainly been the experience that we have had in Vermont. And many of my colleagues have raised similar instances of it really working. And it is not just in rural areas, it is in urban areas, as well.

The concerns that were raised—Mr. Pallone did a good job of raising some of those concerns, where—will this result in overutilization? Will it result in effective care? Will it result in fraud? I want to make a point, and then I will go to our panelists for reactions.

But those concerns that are raised about fraud, about overutilization, about efficacy, they apply to every procedure, to every item that is delivered in the healthcare system. So it seems to me that, if we are going to address those concerns—we should always be addressing those concerns—we don't cherry pick telehealth and bring down those concerns as a reason not to expand it and integrate it into the delivery of care.

And I want to go back to something that Ms. Mitchell mentioned, and that was about the cost of care. We have a crisis in this country on healthcare, in my view, that neither the Republicans or the Democrats have effectively addressed. It costs too much.

In 1970 the U.S. spent 60—6 percent of its GDP on healthcare. The European countries that are our near competitors spent 5 percent. We are now at 18 percent, they are at 11 percent. And my view is that, unless we can address the cost of healthcare, we are not going to have access to healthcare. The burden on employers, the burden on taxpayers, the burden on individuals is unsustainable. But that should not become an excuse not to utilize a method of delivery that works for people and makes it easy.

So, Ms. Mitchell, you mentioned the fee-for-service system. What—as long as you have a fee-for-service system, you encourage utilization. And we can do all the patient surveys we want, we can do all the utilization studies we want, but if you have that embedded in the system—the more services you provide, the more money you make—how are we going to get out of this? Perhaps you could address that.

Ms. MITCHELL. Thank you, and thank you for raising the issue of affordability. It is a crisis, and it is a drag on U.S. employers who are truly absorbing those costs on behalf of their employees. Employers, private purchasers, provide all of the profit to the U.S. healthcare system, and the accountability for spending is simply not there.

However, to your point, adding another service to the fee-for-service system is not optimal. There are ways that we can use telehealth in our current system to reduce total cost. For example, expanded access to primary care can and does reduce unnecessary visits to the emergency room. That is better care in a more cost-effective setting.

So there are ways that we can be intentional and smart about integrating behavioral up, integrating telehealth. But we do need——

Mr. WELCH. [Inaudible] time, but thank you very much for that. I just want to hear from Dr. Mehrotra about this, as well. But thank you, Ms. Mitchell.

Dr. MEHROTRA. Yes, no, I think you—Representative Welch, you raise some really critical issues. I will make two quick points.

The first is why do we care more about telemedicine than we—say, surgeries or endoscopies or et cetera?

And I think the issue and the reason that so many people have particular concern is that its basic strength, convenience, makes the risk of overutilization or overuse higher. So I just wanted to emphasize that.

The only other point I wanted to make was Representative Rodgers had asked the question of where are we headed with telemedicine, and I think the key thing is the idea of remote patient monitoring. And when we are now moving away from visits to all sorts of other ways of communicating with your provider for—text messages, for example, adolescents love text messages, they don't like video visits. And yet we then face a problem that, when we get to the fee-for-service system, we are not going to pay for each text message.

And that really emphasizes Ms. Mitchell's point that we need to—and your point, that we need to move away from paying for everything fee-for-service to more models, alternative payment models.

Mr. WELCH. Thank you very much. I yield back, Madam Chair.

Ms. KUSTER. Thank you, Mr. Welch.

The gentleman yields back, and the Chair now recognizes Representative Griffith for 5 minutes of questioning.

And Mr. Griffith, please remember to unmute.

Mr. GRIFFITH. Thank you very much. I hope I can be heard.

I would—I would start by just touching on a couple of points that have been brought up previously. And I know that we are worried

about overutilization, but I represent a relatively economically poor area of the mountains of Virginia. And a lot of folks have a hard time getting healthcare, as it is. Telemedicine is a wonderful concept that is helping them greatly.

And somebody mentioned telestroke. I was one of the sponsors of that, and it took us a long time to convince people that that would be helpful. So I am glad that it is working out well.

But I will tell you also that I am worried about the—and I know we want a glide path, and I recognize that that has merit, but for a lot of my district, even when we get—and we are now deploying low orbit, satellite broadband in the district, it is just starting. But even when we get access to that, it is $100 a month, and a lot of the folks in my district can't afford $100 a month. So we have to try to figure out how to do that because, for a lot of these people, when it works the audio makes a lot of sense.

Dr. Resneck, I would like to learn more about your opinion on audio-only versus audio-video patient interactions. CMS estimates about 30 percent of telehealth visits to be audio only, and a recent study of California-based FQHCs found that audio-only visits accounted for nearly half of all telehealth visits. When is it appropriate to use audio-only?

Dr. RESNECK. Thanks, Congressman. I would say it is interesting. It is typically not our first choice, but it has been a lifeline for patients in rural areas and disadvantaged patients, as you have heard from some of my colleagues today.

I am surprised at how many of my patients don't have broadband access, even in a technologically advanced bay area like where I live. And I know it is true in rural areas, as well. Sometimes it is just an emergency backup. A patient will be with you on a video visit, and something will go wrong with their technology. You know, who among us today has not had a Zoom or Microsoft Teams meeting go awry, where we end up using the phone as a backup? And being able to have that be a covered service is important.

We have entire Native American reservations in the United States where there is no broadband access. We have Black and Brown communities who particularly have less broadband access.

So I think, while it is—while we wouldn't want to go to it as a first choice for any particular patient population, any arbitrary end to it as a backup option would particularly harm disadvantaged patients. And that would leave me worried for the future, and our work on disparities for those patients.

Mr. GRIFFITH. And I would agree, sometimes that problem exists in areas you wouldn't expect, because just a few miles away from Virginia Tech, a highly wired community, are pockets where we currently don't have any broadband. Now, some of those folks could afford it once we get the satellite broadband going, but they are not able to now. And I do appreciate that.

So do you believe it is appropriate for providers to receive a lower reimbursement rate for audio-only visits, compared to the audio-video visits?

Dr. RESNECK. I don't. That was in effect in the past. It hasn't been true during the pandemic, but a lot of the patients I end up taking care of via audio-only are just as sick as the person I saw before via video. The care is congruent.

You know, the audio visit in itself is not a service to be valued differently. We think of it as just another method to deliver care. And the value of that service should depend on how long it takes me and how sick the patient is, just like any other service. From an overhead standpoint, I am still maintaining my entire office and my office staff, the nurse who calls the patient in advance to the med reconciliation, the backup space to bring the patient in, if they need to come in person.

So, unlike remote patient monitoring and other things where it is not equivalent to an in-person service, it is a totally newly defined, different thing that needs to be valued, I see it as equivalent.

Mr. GRIFFITH. Let me get one more question in, and I appreciate that, and I hate to cut you off, but I am running out of time.

Many devices that we use in telemedicine are able to operate entirely on 2G cellular networks. And this helps for a lot of folks in areas that don't have better service. These devices can remotely monitor things like blood pressure, et cetera. Do any of you—and this will be for anybody—do any of you know of any capabilities that are lacking among 2G-capable devices?

I will open it up to any of the witnesses, but I only have 26 seconds.

[No response.]

Mr. GRIFFITH. Does that mean that everything you know of applies to 2G, or you just don't have the knowledge base to answer? Which is fine, I mean, we can't know everything.

Dr. MEHROTRA. You have a bunch of dumb docs here, we don't know about 2G, I think, is the key point.

[Laughter.]

Dr. RESNECK. I will have to get back to you on that one.

Mr. GRIFFITH. I appreciate that. And look, I understand, that is why I am asking the question. I don't know the answer, either. But I appreciate you all being here today.

And thank you very much, Madam Chair. And I yield back.

Ms. KUSTER. Thank you.

The gentleman yields back, and the Chair now recognizes Representative Schrader for 5 minutes of questions.

And Kurt, you are already unmuted, so you are good to go.

Mr. SCHRADER. Thank you, Madam Chair. You look pretty good up there, if I may say so. Good to see you again.

This is a great hearing, a nice hearing, and it is nice to see that telehealth has more from do it or do we not, but yes, we are going to do it, and how do we do it best. And I think that is a much better spot to be in.

It has been a lifeline for folks in my rural district, for veterans with comorbidities who have a tough time getting into the office. I had some personal interactions with a physician and a veteran, both very leery of telehealth, only to find out that, geez, they really like that, as the pandemic curtailed their in-person visits. It—more accessible, more opportunity, going forward.

And to that end, I guess, Dr. Mahoney, you talked a little bit about your experience with the relatively flat utilization. You haven't seen a big increase in overutilization. Do you have any cost data you can share with us on the—on maybe the savings the system is seeing, as a result of telehealth?

I mean, quite frankly, I have always been convinced that if you get to these people early on, make it easy and accessible, you can prevent a lot of much more costly problems later on.

Dr. MAHONEY. Yes, thank you for the question, Congressman Schrader. I agree with you. I like that story about the veteran who initially thought that, you know, he would not be interested in doing a video visit. I have seen that across many of my patients who, you know, traditionally, I would have just thought that they would have been resistant. But then they are the biggest fans, because they gave it a try and maybe had a caregiver help them get on. So I appreciate that comment.

You know, telehealth has the potential to reduce total cost of care across populations because it is providing more timely access to care by ensuring the right level of care by the right provider at the right place and time. And we heard about the association between timely care and the prevention of emergency room use.

And so, you know, we don't have any cost savings data at this point. But at Stanford Healthcare we are committed to analyzing our cost data and providing that as soon as it is available. We suspect that we will see—we definitely have seen no increased utilization, it is just related to the question of cost savings. I think that is a——

Mr. SCHRADER. Well, some of my groups, you know, we do a lot of capitated healthcare in the State of Oregon and in my district, and several of the providers have found significant savings, you know, not tremendous, but, you know, 15 percent, 20 percent. That is great. That is great. It is good for the system, it allows more flexibility. You can redirect, frankly, some of the payments to those who really need it. And I think that is important.

I think one thing I am hearing—I guess I would go to Dr. Mehrotra now about, you know, alternative payment models. With fee-for-service I think it is a little constraining, to be very honest with you. I would suggest in human medicine it is a—it is an older-school, somewhat outdated way of providing healthcare. It is unavoidable in some areas. I do get that.

But to coordinate the best healthcare for that individual, I think bundling healthcare payments with groups that are grown up locally and regionally based, that know what their constituents, their clients need at the end of the day, their patients need, is really important. So what needs to be done, from a policy perspective, to help facilitate that transition from fee-for-service to alternative payment models, and make sense out of the—if—because you can—if there are some savings, maybe there are some rate changes that could go into play for different types of visits, telehealth versus in-person. I would love your opinion on that.

Dr. MEHROTRA. Yes. So first I want to emphasize I agree with your sentiment, that it is very difficult for us to determine what is clinically appropriate for each clinical circumstance. And we want to provide as much as possible that the physician or other provider can choose: this is worth a text message, this can be a phone call, "I will do a video visit," or "I will have to bring them in for an in-person visit."

And so we want to provide that flexibility, and that is—flexibility is going to be most easily provided via those sort of models that you

are describing in Oregon and that are all across our Nation. And so it is really about how do we build the next generation of the ACO models that we already have, as well as CPC–Plus, Primary Care First, and others, all these models that are being developed, and how do we accelerate the adoption and refine them so that they are better accepted by providers? Because I think that is really going to drive a lot of telemedicine use.

Mr. SCHRADER. I totally agree, Doctor.

Thank you so much, Madam Chair, and I yield back.

Dr. RESNECK. Madam Chair, do you mind if I jump in for 15 seconds on the APM issue?

Ms. KUSTER. Sure, go right ahead.

Dr. RESNECK. Well, so the AMA and physician groups across the country have been very supportive of and worked towards developing more APMs. We are with you on this. But I would say two quick things.

Number one is the massive innovation in telemedicine that happened during the pandemic mostly happened in the fee-for-service setting. So we shouldn't forget that, that innovation can happen in both spaces.

And the other thing is, as hard as we are all working to advance alternative payment models, Medicare has only adopted so many of them yet, and they are not available to many physicians. So if we all of a sudden say telehealth is only available to patients in alternative payment models, we would be stripping it away from enormous parts of the Medicare beneficiary population. Thank you.

Mr. SCHRADER. And just to emphasize we need to have more opportunities for APMs for those that don't have access right now.

Ms. KUSTER. Sounds good. Thank you very much. The gentleman yields back, and the Chair now recognizes Representative Bilirakis for 5 minutes of questioning.

Mr. Bilirakis, you are on.

Mr. BILIRAKIS. Yes, thank you, Madam Chair. Can you hear me?

[No response.]

Mr. BILIRAKIS. Can you hear me?

Ms. KUSTER. Yes, we can, yes.

Mr. BILIRAKIS. Good, thank you. Thanks for, again, Chairwoman Eshoo, for scheduling this hearing. And I thank the participants, they have done an outstanding job.

And I do want to see us—and we may have done this in the past, just a suggestion—having a demonstration available to us with regard to behavioral health, telehealth services, but also primary care services. I have done it in my district, and I encourage other Members to, and I am a strong supporter.

We have seen throughout this pandemic that telehealth services have provided a critical lifeline for millions of Americans, especially seniors, allowing them to receive quality medical and behavioral healthcare from the comfort and safety of their homes. They are more comfortable, they really are.

As we build on the successes of the previous administration's response to COVID–19 and look beyond, we must ensure patients, especially our seniors and those managing chronic conditions, are able to confidently access the appropriate care they need.

Patients and their providers should also be empowered with more, not less, options to capture health statuses accurately, safely, and conveniently.

I have a question here for Mr. Riccardi and Dr. Mehrotra. As a supporter of the Medicare Advantage Program—and most of us are—I was pleased to see CMS provide much-needed flexibility to allow healthcare providers to offer telehealth services under the Medicare Advantage plans.

However, CMS guidance requires that these services include a video component, which is not an option for some patients. And I know some of our members have expressed concern about that. Low-income and rural patients, for example, may have trouble accessing technology or broadband services supporting video communications.

Additionally, seniors or frail populations may have physical limitations that prevent them from using video communications. And that is true. For these patients an audio-only telehealth visit may be the only option—again, as our witnesses have stated, it may be the only option besides delaying needed healthcare, and we don't want that.

On August 3rd, 2021 CMS updated the risk adjustment telehealth policy for ACA plans to allow for reimbursement for audio-only visits for purposes of risk adjustment. However, the same has not yet been extended to Medicare Advantage plans, even though the same audio-only services are being provided by the same clinicians using the same coding guidelines.

Are there any—and this is the question—are there any ongoing concerns that you are aware of with programmatic fraud that may merit differences between the two programs?

Or should certain guardrails be put into place if such a policy was extended to Medicare Advantage plans? And if so, what should those guardrails be?

Again, the question is for Mr. Riccardi and Dr. Mehrotra.

Mr. RICCARDI. Thank you for your question. I have just three quick points that I would like to share.

First, you know, we support the flexibilities for telehealth in the Medicare Advantage program, and also through the demonstration projects and the alternative payment models.

It is crucial that the expansion of telehealth benefits, such as the geographic site—removing those restrictions, it is really essential that it is also applied to fee-for-service original Medicare, because we could potentially leave behind millions of people who have been using these services and where this innovation has truly occurred over the last several months.

In respect to the barriers that people face using technology, that is correct. People may have compromised immune systems, physical disabilities, an inability to leave the home, a lack of transportation. So telehealth really is essential across the program coverage options that people use to access their services.

And so, with respect to program integrity, fraud is always a concern, and utilization. But we recommend removing barriers to access, and then using data and information on the back end to kind of detect any potential fraud, you know, waste, or abuse. And audio-only clearly, you know, has a role in helping people, in par-

ticular with behavioral health issues, access the services that they need. So it should be considered.

Mr. BILIRAKIS. Very good. Thank you, Doctor.

Dr. MEHROTRA. Yes, two points. On the risk adjustment aspect, Representative Bilirakis, I don't know the details behind that, but I do think that, if those visits have diagnoses that should go into the risk-adjusted algorithm, it seems reasonable to me.

But, more to your point about the audio-only telemedicine visits, I think—and the Medicare Advantage program—I think I would emphasize that, if we look at both private insurers and those in the Medicare Advantage plan who, obviously, have to worry about overall spending, they are also very judiciously moving forward here. And I think their experience should also give us a lesson because they are concerned about the same issues. And, to my knowledge, most are not planning on covering audio-only telemedicine visits in the future.

And so I think that should be, like, a lesson to all of us, as we think about the Medicare fee-for-service program, also.

Mr. BILIRAKIS. All right, thank you very much.

Madam Chair, for inclusion I provide this committee with a copy of a letter of support for a bipartisan bill I plan to soon reintroduce called the Insurance Parity and Medicare Advantage for Audio Only Telehealth Act, which includes guardrails to prevent potential Medicare fraud and abuse by ensuring patients have an established provider or practice relationship where audio-only diagnosis is being utilized, and that diagnoses were previously documented in person. I think it is so important. So I would like to admit this into the record, please.

Ms. KUSTER. Did you just read the letter to us?

So ordered.

[The information appears at the conclusion of the hearing.]

Mr. BILIRAKIS. Thank you so——

Ms. KUSTER. We will make it part of the record.

Mr. BILIRAKIS. Yes, I have got a couple more questions, but I am not going to go into them.

But I will tell you this—and I have got 30 seconds—I remember years ago we did one of these field hearings in Pennsylvania, rural Pennsylvania, and I was really impressed because the patient actually came to the hospital, and was treated—or maybe it was a clinic—was treated for primary care. However, a specialist was needed. And then the telemedicine, the telehealth was done from Philadelphia, I believe, and the specialist was able to speak with the primary care physician and the patient. And I thought that was a great idea.

So I think that that is being done quite a bit. But anyway, my time has expired, and I appreciate it very much. Thank you.

Ms. ESHOO [presiding]. Thank you, Mr. Bilirakis.

Mr. BILIRAKIS. My pleasure.

Ms. ESHOO. I remember many years ago bringing the FCC Chairman to Stanford Hospital—actually, Lucile Packard Children's Hospital—and he wanted to know why he was going there. I said, "You will see when you get there." But I wanted him to see the surgery that was taking place on a baby, and an entire wall of equip-

ment relative to broadband. So these are all advances. He never forgot that and became a great advocate for it.

So it is—thank you to Congresswoman Kuster for chairing in my absence while I voted, and it is a pleasure to recognize Mr. Cárdenas from California for his 5 minutes of questions.

Mr. CÁRDENAS. Thank you, Madam Chairwoman, and I would like to thank you and the ranking member for—Guthrie for having this important hearing. And you are the—two of the nicest Members of Congress, even though it seems they only give one award a year.

But anyway, since the beginning of the pandemic, we have seen the disproportionate impact of COVID–19 on communities of color and low-income communities. Telehealth has the potential to improve health equity by increasing access to care for rural and underserved communities across America. Some studies indicate that those same communities are having trouble accessing telehealth. It is critical that we make sure that populations who can benefit the most from telehealth can access it, so that telehealth, in the long term, does not contribute to health inequities that are so prevalent in our country.

Mr. Riccardi, what are some of the potential barriers to accessing telehealth that exist today, and what can be done to break down those barriers?

Mr. RICCARDI. Yes, thank you for your question. I think this is an opportunity to invest in telehealth to improve health outcomes and not exacerbate existing health disparities.

Crucially, research shows approximately one-third of older adults age 65 and over do not use the Internet, and half lack broadband. And it is even worse for Black older adults. Almost 70 percent don't have broadband access at home, and this is for a variety of reasons. And so this is why it is incredibly important that there are investments in the infrastructure of broadband and technology in general. People lack broadband coverage where they can't afford the technology. They just generally may be uncomfortable with telehealth. And so it is important that the investments are also made into digital and technological training to improve health literacy.

Mr. CÁRDENAS. Yes——

Mr. RICCARDI. And many individuals are also challenged because they may have cognitive impairment, physical limitations, or disabilities. And so telehealth really can be a supplement to in-person care. But, you know, follow-up care may be needed after a telehealth visit. So I think it is really important that we envision this as an opportunity to eliminate these disparities.

Mr. CÁRDENAS. OK, thank you, Mr. Riccardi.

And there are many, many factors that limit people with low income in this country. And when I say low income, I want to point out two things that are derogatory, in my opinion, in too many minds of Americans. When Americans think of low income, far too often they have been convinced that the low-income person is lazy, they don't work, and they don't want to work, and they are just sucking off the system. Well, with all due respect, we have the working poor in America, which are millions and millions of adults and children, and they deserve—they are hard-working, they are probably minimum-wage workers. They deserve the opportunity to

get the same healthcare that anybody else in our great country deserves.

And then, in addition to that, when you are talking about seniors, seniors already spent their whole life working maybe 30, 40, or maybe 50 years, and they are finally retired, and they have limited incomes, and they don't—can't afford the kind of broadband access that maybe everybody on this call can afford. And they are limited in being able to take advantage of telehealth.

So those are some of the things that I think that we need to be respectful about in this country, and not to make assumptions that people are just in that plight, situation, and they deserve it, or they don't care, or they are not taking care of themselves. With all due respect, I am saying that every person in America, regardless of their circumstance, deserves to have that dignity and opportunity to have that quality healthcare.

Mr. Resneck, I will give you a few seconds. Go ahead.

Dr. RESNECK. Yes. Well, you mentioned employed low-income Americans. And I just want to say the worst—one of the worst things we could do is if we implemented telehealth in a way that cements existing disparities.

An irony I have noticed is that commercial insurers before the pandemic were sending my patients postcards saying, "Hey, you can access these commercial direct-consumer telehealth sites for free. We will waive your copays." But they wouldn't cover coordinated care with the physicians who already knew those patients.

So, going back to closing down that access for commercial payers, I think, would actually worsen disparities, especially for that employee-covered working poor.

Mr. CÁRDENAS. Again, thank you, Mr. Resneck. And I think it is really important for everybody to understand, and that is why this is complicated, because it is not as simple as black and white. There are a lot of guardrails that we need to make sure exist, because in every environment there is going to be bad actors, and there is going to be folks who just want to keep pushing and pushing and pushing across that gray line. So thank you very much.

My time is limited, and I yield back.

Ms. ESHOO. I thank the gentleman, excellent observations and questions. We keep learning, we keep learning. That is why hearings are so great.

It is a pleasure to recognize the gentleman from Missouri, Mr. Long, for his 5 minutes of questions.

Mr. LONG. Thank you, Madam Chairwoman, and I appreciate you putting on the hearing here today.

A few weeks ago I conducted a 3-day, districtwide tour of six hospitals, two clinics, and one vaccination center. And what I wanted to do was I wanted to hear from frontline doctors, nurses, people that have been dealing with this for right at a year at the time that I went. At every visit, they praised the expansion of telehealth services and said that it worked well for them.

One of the concerns was that telehealth might revert to pre-COVID policies, once the public health emergency is over. We are here to examine telehealth in a post-COVID world. Aren't those nice words, "post-COVID world"?

And I think it is important, as we consider its cost, coverage, and program integrity we don't lose sight of its value and end up throwing the baby out with the bath water.

Dr. Resneck, can you talk about how telehealth can deliver value to our healthcare system beyond just replacing the face-to-face visit? How can it lead to greater efficiency for both patients and physicians?

Dr. RESNECK. Thanks, Congressman. You know, mental health has come up. I think, broadly, what we are on the verge of seeing—and we have seen in this last year, and I think people asked about the next 10 years—the growth of telemedicine for chronic disease, where we have a huge possibility to impact value of care, so whether that is mental health, prediabetes, hypertension, things that affect so many Americans, and that we know have been exacerbated in this year due to COVID, and measuring the financial savings from that, those are things—benefits we are going to see in years out, in terms of decreased chronic care for those diseases.

So having that as a part of the toolkit, we are seeing physician offices and health systems around the country doing really innovative things in the diabetes and hypertension and mental health spaces. So there is tremendous value there.

I also think it is really important that we measure—when we offer somebody who lives 3 hours away telehealth, one of the benefits that I mentioned earlier is they are not missing a day of work. They are not having the economic impact on their family of that, they are not paying to park at my health system, they are not spending all those hours in the car. So I think there are just so many areas of value, and I really look forward to seeing the progress in the chronic health space.

Mr. LONG. One of the unfortunate trends in healthcare is a shortage of physicians and nurses, as you know. I mean, there was a terrible nursing shortage in this country before anyone had ever heard the word "coronavirus," particularly in rural areas, which—I represent a lot of rural areas in southwest Missouri. Over the years I focused on closing the gap in the rural healthcare workforce.

How can telehealth help overcome clinician shortages, and especially in rural areas and for our underserved populations?

Dr. RESNECK. Well, thanks to Congress for the GME, for the downpayment on improving GME funding in the last couple of months. That was a huge thing. Thank you.

Telehealth, in particular, it is not a magic sort of panacea for workforce issues because, at the end of the day, we don't have doctors and nurses twiddling their thumbs. They are busy everywhere. So we certainly have some maldistributions, and particularly in rural areas and some inner-city areas where there is not enough healthcare infrastructure. It is a piece of the puzzle for folks who live in those areas to be able to access specialty care, primary care. It is an important piece.

Mr. LONG. You say that it will be very difficult for providers to invest in the technology required to provide telehealth services and incorporate telehealth into the work flows if its future is uncertain. What constitutes certainty?

In other words, is a statutory coverage expansion the only way to provide certainty to providers?

Dr. RESNECK. I think, one way or another, we need to know that payers, including government payers, understand that this is part of the future of healthcare delivery, and that it is not going to suddenly disappear, or its coverage is not going to suddenly disappear.

So I think permanently removing the Medicare restrictions is a really important part of that. You know, the big investments are not always technology investments on this. Yes, you oftentimes have to acquire software that works with your EHR, et cetera, but it is really about retooling your entire office to be able to try and figure out in advance which patients need to come in in person and which don't, how to coordinate all that care. So there is a real expense there.

Mr. LONG. There is a concern that expanded telehealth could lead to greater fraud and abuse or duplication of services. You say that these concerns are misplaced. Why?

Dr. RESNECK. So I think that OIG and DOJ already have the tools.

I am involved in some of these cases of telehealth fraud. They really have little to do with telemedicine and are really about, you know, using almost sham telemedicine that they are not even billing for to try to provide prescriptions and unneeded genetic testing and other things.

It is interesting, the statement that came out 3 or 4 days ago from the Deputy IG, Mr. Grimm, on telehealth really corroborated that and said that the telefraud cases that they are seeing and investigating right now are mostly related to telefraud, not telemedicine fraud. Again, where these unscrupulous marketing firms are convincing patients to sign up for things they don't need, but they are not actually using telehealth or any of these codes that we are contemplating, or the Medicare broadened coverage that we are talking about.

Mr. LONG. OK, thank you.

And Madam Chairwoman, I have no time to yield back. But if I did, I sure would.

Ms. ESHOO. I thank the gentleman. Wonderful, straightforward questions and wonderful, straightforward answers from our witnesses.

It is a pleasure to recognize the gentleman from California, Dr. Ruiz, for your 5 minutes of questions.

Mr. RUIZ. Thank you very much for holding this hearing today on this important subject. The expansion of telehealth has played a critical role in the access to care during the COVID–19 pandemic. And we have seen on a large scale how beneficial it can be for both the patients and their providers.

So, as we move forward past the current health crisis, it is important that we take a hard look at what the future of healthcare delivery looks like and strategically adopt policies that will move us in that direction with a key eye on equity. We must reimagine and redesign healthcare. Home and community-based care is the future of healthcare delivery in this country. It is already moving there, organically.

However, in my experience as an emergency physician taking care of very complex chronic patients who visit the emergency department, there has been studies conducted by insurance companies, hospitals, and academicians who have seen that, if you provide home-based care with tailored protocols, usually accompanied with a nurse after discharge or even before, then patients actually have better satisfaction, you reduce costs because their health outcomes have improved, and they have less emergency department visits, and their health is better. So the trifecta, or the Holy Grail, of a healthcare system has meant better health outcomes, lower costs, and patients and providers are happy.

So more and more we are seeing the importance of being able to meet people where they are. The question we need to ask ourselves is, What are the current barriers to home-based care, and how do we address them?

How do we make better use of promotoras, or the community health worker, to get to patients that can't get to a clinic or health center, someone who can—from the community, who knows the community, who can visit patients and help them connect with their provider?

How we ensure equity—how do we ensure equity and create policies that not only increase telehealth coverage when appropriate, but ensure that everyone has access to the technology that allows them to take advantage of its availability?

I don't just want to only increase convenience accessibility for high-paying concierge patients who already have access, and leave behind the same communities being left behind now. I want to increase accessibility for all people, especially those that currently go without seeing a doctor because of time, money, or distance; or the seniors in my district that can't drive anymore and can't find someone to take them to multiple follow-up appointments; for the farm workers that can't afford to take hours off of work to go to the clinic, and then another to go to another appointment to see the referred dermatologist; for the single mom working two jobs who can't offer to cut her hours to see a doctor for something that she thinks can wait until she has more time.

Increased focus on telehealth and home health will change the face of healthcare for many communities like the one I grew up in and now represent in eastern Riverside County, California, California's 36th district.

My first question is to Dr. Mahoney.

Can you tell us how telehealth can be used to improve and expand the use of home healthcare?

Dr. MAHONEY. Dr. Ruiz, I really appreciate your comments, and I wholeheartedly agree with the sentiments that you have made about the potential promise of telehealth in meeting the needs of all of our patients across the United States, and particularly patients who historically have been underserved.

You know, just the idea of tapping into the resources that are available, promotoras, you know, other caregivers who are in a community who will help us overcome the well-described issues that we are already talking about today along the lines of digital literacy or, you know, being disadvantaged from understanding the technology that—it is required. If we are skillful in leveraging the

existing resources that are available, that are culturally sensitive, language concordant, I have seen as a frontline provider that those barriers can absolutely be overcome.

I will also mention that there are a number of licensed nonphysician practitioners who are incredibly useful in helping us extend the access to care, people like pharmacists or physical therapists. And currently these vital team members are not eligible to bill for telehealth services——

Mr. RUIZ. So I think that——

Dr. MAHONEY [continuing]. That can in person——

Mr. RUIZ. I really do believe, since 80 percent of what we spend in healthcare is—are on 20 percent of the complex patients, we can focus—to reduce those costs, focus on home care for those patients, as well, to put them on a protocol to improve their health and prevent them from going to the emergency department.

In addition, we can reduce healthcare disparities, promote equity by doing a concurrent community-based healthcare promoter track with telehealth and home-based medicine, combining those two with good, old-fashioned community public health, and we can change the health of Americans, and we can extend our lifespan, and reduce costs, and satisfy patients and providers in doing so.

And I yield back.

Ms. ESHOO. The gentleman from Indiana—I am sorry, the gentleman from Indiana, Mr. Bucshon, is recognized for his 5 minutes of questions.

And I am going to run to the floor to vote and turn the gavel over to—is she there? Oh, we are waiting for her.

All right, well, we will wait for her. And when Congressman Kuster returns, I will get a—put the gavel in her hand.

But meanwhile, Mr. Bucshon, you are recognized.

Mr. BUCSHON. Thank you, Madam Chairwoman. And providers and patients like telehealth, so let's do our best not to mess this up.

I want to thank all of the witnesses today. It is a critically important hearing. I was a cardiovascular surgeon before I was in Congress, and it is too bad that it took a pandemic to finally get us to recognize that we need to make some advances here in telehealth. But it is what it is.

I applaud the committee for beginning the process of reviewing what has been accomplished by the unprecedented steps made by the by the administration, the previous administration, and continued by this administration, and examining which policies should be made permanent as we look towards life on the other side of the pandemic. In order for telehealth to continue to be effective, Congress must advance policies that support accessibility and quality of care.

Dr. Resneck, in your testimony you referenced a recent survey of physicians which shows that over 73 percent of respondents cited low or no reimbursement as a barrier to maintaining telehealth usage after COVID–19. As a physician, this is a real concern of mine, moving forward. I believe doctors should be reimbursed appropriately for telehealth services based on the standard of care. And if we want to find a very quick way to end telehealth, then

we can not reimburse providers for the services that they are providing.

Dr. Resneck, would you agree that doctors should be reimbursed for audio-visual visits at a same or similar rate as in-person visits?

And secondly, can you elaborate on the provider concerns expressed in the survey and share what you are hearing on the ground regarding provider reimbursement for telehealth services?

Dr. RESNECK. Dr. Bucshon, thank you. I do agree. I think, again, telemedicine is a mode of delivering a service, and not a service unto itself. And the coding should be based on the amount of time you spend, and the complexity of the patient, whether you are on the telephone, on a video visit, or in person.

I think on the ground what I am hearing is, you know, coverage at parity rates has allowed physicians to provide this care to our patients, which we have wanted to do for a long time. It has not created some giant inappropriate incentive. Telemedicine is actually hard to do. It is a lot of work. And it is work we like doing, and want to do for our patients. But just paying equitably for it has made a lot of sense and allowed people to do things they have wanted—services they have wanted to provide for a while.

Mr. BUCSHON. And I will bring up another concern that, as a physician, you might imagine I would bring up. It is the liability issue and how we address that. For example, say a primary care doctor does a virtual visit, or a dermatologist does a virtual visit, examines a mole on a patient's arm. The doctor determines that it is not suspicious and doesn't need further evaluation. But, unfortunately, later on it turns out to be something more severe, like a melanoma.

Is the doctor going to be liable if the picture quality wasn't what it should be? And was the tech company that provided the Internet access liable? Is it the camera—the person that developed the camera? Is it the provider? These are serious questions that maybe we will have to address. Do you have any comments on that——

Dr. RESNECK. I do. Those are serious questions. And, as you can imagine, liability reform is something that is on a lot of physicians' minds.

I think, you know, you won't be surprised that this happens. I sometimes get very blurry photos. I sometimes get a patient thinking they are photographing their skin, and I see the dog on the grass in the background. Right?

Mr. BUCSHON. Absolutely.

Dr. RESNECK. So it—on the one hand, I can't be held accountable, nor can my colleagues, for what we weren't shown or can't see. And that would be really frustrating if we were.

On the other hand, what I would say is we hold, ethically, physicians to the same standard of care, no matter how they are providing that care. So, if you see somebody—you know, if I see a patient with a mole, and I think that is a mole that I would need to look at under a dermatoscope in person, it is my responsibility to tell that patient, "You know what? You have got to come in person."

Or if the pediatrician feels like they really need to look in someone's ear, that standard of care should still apply when they are doing telehealth. And if it is something where what you see is ade-

quate to make a diagnosis and treatment plan, then you should go ahead and do it via telehealth. But that standard of care should really be the same.

Mr. BUCSHON. Yes, I would agree. The standard of care should be the same. I think there are technical—there can be technical challenges.

And I would also agree that it is not the patient's responsibility to do the right thing. I mean, if you can't get an adequate evaluation of the patient by telehealth, then you have to see them in person.

Dr. RESNECK. Yes.

Mr. BUCSHON. I do think, though, that this will become an issue. I think it will become an issue for the technology space, for the Internet providers, and others, because we all know how that goes in healthcare, when this comes down. So we will have to think about all those things.

Dr. RESNECK. Dr. Bucshon, that reminds me, this is another reason why we support physicians being licensed in the State where the patient receives the service, because if the standard isn't met by the technology company, by the doctor, the physician or the technology company can be—the patient can pursue that in their own State.

Mr. BUCSHON. I am in agreement with you. I think a national licensing is not the way to go.

I have—well, I am out of time. So with that, I yield back. Thank you.

Ms. ESHOO. The gentleman yields back. I think what I am learning is that there are many commonsense practices right now that just really need to be retained. The answer is already there, when I listen to the answers of the witnesses. But it is good to have an exchange between two doctors.S

It is my pleasure to recognize the gentlewoman from Michigan, Mrs. Dingell, for her 5 minutes of questions.

Mrs. DINGELL. Thank you, Chairwoman Eshoo and Ranking Member Guthrie, for this important and very timely hearing to discuss telehealth. This subject really matters, and I think that telemedicine is here to stay.

We have seen a dramatic increase in its use during the pandemic, but we need to thoughtfully explore reforms that build on what works while coming together in a bipartisan way to address challenges in the implementation moving forward, some that were just discussed in the last questions.

Dr. Mehrotra, in 2018 Congress allowed clinicians working with the U.S. veterans—with the VA Health System—to practice both in-person and telehealth across State lines, as long as they were licensed in good standing in their home States. At the time, veterans were experiencing long wait times for care, which required action, and Congress responded. Congress did the same thing for DHS providers last spring in the CARES Act.

Given the extraordinary public health crisis we are now facing, what is your view on a temporary, time-limited licensing—I can't even talk today—proposal to address the current public health emergency like that in the TREAT Act, which my colleague Representative Latta and I have introduced?

Dr. MEHROTRA. First, I really appreciate the question. I think there is broad consensus. I think most everyone here that—we need to address licensure reform. And how do we facilitate interstate practice of medicine?

It is—we—I was—in a recent piece we were just describing how we created this very silly situation where you have a patient crossing the State line, driving a mile down the street, so they can have a telemedicine visit with their primary care doctor, because the primary care doctor is not licensed in the State they live in. So they are now having a telemedicine visit via the—in their car. That is silly.

I think, in terms of how we make that reform, I think you have—I think the TREAT Act is a great—and I am very supportive of the—where—of creating a licensure reform, so that there is reciprocity across States. And I have argued, actually, that we should do something that is more—also go further, and make something that is permanent, because I do think we need to address that artificial barrier of licensure.

Mrs. DINGELL. I mean, it is very real. The University of Michigan treats many patients in Ohio, Indiana. It is—and it is facing real problems in treating its patients during COVID on this. So—and there are other hospitals. Many hospitals are experiencing that. So thank you.

I look forward to continuing to work on this issue, and I would like to hear your ideas for making it more permanent. However, I also want to make sure that we are taking steps to protect the Medicare program integrity, given the dramatic changes we are seeing in telehealth adoption and uptick. And, while we all recognize the many legitimate benefits of telehealth and how impactful the expansion has been during the pandemic, we shouldn't ignore the potential for new, sophisticated schemes that could leave our Nation's seniors at risk of fraud.

I have already met with seniors that are experiencing this. For example, cold calling beneficiaries will get personal information from a senior and then bill Medicare for services or equipment the beneficiary did not request and, in one case, didn't even receive.

Mr. Riccardi, do you have any suggestions for how we can strengthen Medicare program integrity to, for example, prevent cold calling or billing for unnecessary services?

Mr. RICCARDI. Thank you for your question. And I think that, you know, as we consider moving forward with telehealth, that we can draw upon, you know, previous experiences with fraud, waste, or abuse, and also the privacy concerns that many older adults have, you know, with the advent of and expansion of telehealth during this pandemic.

And just stepping back, it is just important to remember that, as we consider any measures for combating, you know, fraud and scams, that we don't arbitrarily impose barriers onto people who need access to that care. I think that there are sophisticated technologies that can be used to analyze the data that is available as it is connected to telehealth.

But also, as we move forward, we have to consider other protections that are related to Medicare law, like HIPAA, you know, considering whether we should include additional entities that should

be covered by HIPAA, and investing in the infrastructure of the technology, ensuring that the protections are there in place to prevent seniors from these types of scams, and lastly to draw upon not only the healthcare system, but also on supporting the community-based organizations that serve Medicare beneficiaries to help them combat fraud and scams.

Mrs. DINGELL. Thank you.

I am out of time. I yield back, Madam Chair.

Ms. ESHOO. The gentlewoman yields back. The Chair wants—will recognize Mr. Mullin from Oklahoma for his 5 minutes, but I am going to hand the gavel over to Congresswoman Kuster because I am going to go to the floor to vote. So I shall return.

Mr. MULLIN. Thank you, Chairwoman Eshoo, and I appreciate you. And I know you asked earlier about my son, except the irony of that is I was actually doing a telehealth with my—with the neurologist. And so, while you asked me, I was actually on the phone with the—or on the telehealth with the neurologist, speaking. Because, you know, my son has had a traumatic brain injury.

And I will say this real quick: My son is doing great, but his specialist, we meet through telehealth. There are several—his—several specialists that we haven't even had an in-person meeting with, because he is case study number one for accidents, for pediatric neurology care, and what he is going through. He is actually experimental. And so UNLV—or UCLA, I am sorry—has taken on his case. Then there is a specialist out of Beverly Hills that is overseeing it. And then we have another specialist in Illinois, while we are in Oklahoma, rural Oklahoma.

Telemedicine and telehealth is something that has opened up an opportunity for all of us, no matter where we live, to have those specialties come into our home, come into our communities, and allow us to have the same adequate care as we would if we were living in California or we were living in Houston or we were living in Chicago or Washington, DC.

And, while the pandemic has been horrific, it has also advanced the technology that we knew was here, but we weren't—as Congress, we weren't ready to look at it, we weren't ready to embrace it, because we didn't know how to reimburse doctors. We didn't understand how to regulate it. We didn't understand how the doctor visits would work. But because of technology, we are here.

And I have a good friend of mine that is an orthopedic surgeon that—he does surgeries robotic. And while he has to be in the same room, he actually never has to lay his hands on the patient, other than to comfort the patient. But he stands 3 foot away and replaces hips or does surgery on the shoulder or does surgeries on the knee. And by the way, he came to us through our Army, because he was in the service, and performed surgeries even at the—at Walter Reed.

And our Government is the one that taught him this technology. And it is capable now for us to bring home to our rural hospitals, where it was hard for us to get specialists to be there. And so the technology exists, but a lot of people, they don't even know how to embrace it yet.

And so that is—and by the way, my family has been the recipient of this. I mean, it is—this whole year, because of the traumatic brain injury that my son had, we have embraced this.

And I will tell you personally, at first I didn't know if I liked it or not. I am a very in-person—I like to be in person. But once I started it, I realized that I became the physician assistant. I became the P.A., which was positive because, as a caregiver for my son, I also—I am interacting with the doctor. I am putting my hands on my son.

Or the—or we are having the conversation, we are having a conversation about costs, really. Because when they send over the prescription, they send it to me. Instead of me just being on my phone, checking my emails, waiting for the doctor to schedule the next surgery, or schedule the imaging or lab work, I am having to interact. And so it made me more cognitive of the care that my son was given. But it also made me more cognitive of the cost, which is a good thing. There is nothing wrong with that.

I have actually embraced it fully, where I enjoy them now. And I know I went long on explaining that, but I want to understand that I am living this life, and it is beneficial. It is beneficial for us in rural parts of America, because we had the same access to the care of those in major metropolitan areas.

Now, with that, real quick, Dr. Resneck, I have a couple of questions, because rural providers in my area are having a hard time actually understanding even how to gain access to telehealth grants. Do you feel like there is more that can be done to provide this information to the providers?

Dr. RESNECK. I know the AMA and specialty societies have, just in the last several months, rolled out a lot of additional information about some of the grants to help with implementation. You know, CMS has actually been very cooperative and supportive in terms—over the last year, in terms of helping us when we have needed to reach out to improve that process.

So—but definitely put your colleagues in touch with me, and I am happy to see what we can do to help.

Mr. MULLIN. Do you think it would be helpful to maybe have a one-stop shop for funding opportunities for telehealth?

Dr. RESNECK. I don't see any harm in that, and it could be helpful.

Mr. MULLIN. OK. Maybe we can work with you on doing something like that too.

And my office has been working on a bill with Chairman Eshoo's office to ensure the Federal Government creates a national telehealth strategy that streamlines and coordinates these things. Would it be beneficial for maybe there to be an elevated presence within HHS to coordinate these telehealth investments and policies across our Government?

Dr. RESNECK. We would love to talk more with you about that. I mean, I think our observation, again, has been that CMS has actually made this a big priority and been incredibly responsive to physicians and patients during the pandemic around this. And we are optimistic that that responsiveness will continue.

But this is a really important issue, and we do need to continue to have a national strategy. So let's follow up and talk more about what we can do.

Mr. MULLIN. Absolutely, because we—I—this is a great opportunity for rural America to have adequate and quality healthcare like all others. And I think this is a great starting point.

Dr. RESNECK. I am so glad to hear your son is doing better. And I know this——

Mr. MULLIN. Thank you.

Dr. RESNECK [continuing]. Has been a really hard year for you and your family.

Mr. MULLIN. It has, but we have been very blessed. The Lord has been good to us.

Thank you, I yield back.

Ms. KUSTER [presiding]. Thank you so much, Mr. Mullin, and thank you for your remarks. I think, as a rural member, I can certainly say this is a really important hearing.

So, as chair, I will now recognize myself for 5 minutes, and I want to thank Chairwoman Eshoo for holding this hearing today. It is so important.

In New Hampshire and rural States like Oklahoma, attending in-person treatment for substance use disorder can be a big challenge in and of itself due to our weather and geography and lack of access to transportation, work obligations, child care, and all the rest. And that was before COVID–19.

So, when the coronavirus added yet another barrier to addiction to mental health treatment, our behavioral health providers transformed their delivery of care to ensure that they could continue to provide critical treatments while this country battles two epidemics, the opioid crisis and COVID–19. This was made possible by flexibilities during the pandemic, and I am so grateful for this discussion to highlight these measures and provide a framework as we look ahead to expanding access to care through telehealth post-COVID–19.

I have heard from treatment providers, addiction treatment providers, who emphasize how telehealth has in many ways resulted in greater appointment attendance, fewer cancellations, and more patients arriving on time.

Dr. Mehrotra, you and your colleagues at RAND recently released a study examining transitioning to telemedicine for opioid use disorder treatment, outlining how buprenorphine prescribers quickly transitioned to provide telemedicine benefits—visits. Could you please describe how the current flexibilities around prescribing medication-assisted treatment has actually improved access to care?

Dr. MEHROTRA. Congresswoman Kuster, thank you for the question. And the study that we did was looking within the pandemic for treatment of opioid use disorder, and I think that is a real success story, and a feel-good story that, in the context of the pandemic, patients who were in treatment were able to use telemedicine to access care, stay on their medications, and get the appropriate care and not go back to, unfortunately, using opioids again. So that is a real success story from the work we have done.

And through the SUPPORT Act, post the pandemic, that is going to be accessible to folks.

I think there has been some frustration with the changes that have been asked for—the Ryan Haight Act—to allow all providers to prescribe Suboxone and other medications for opioid use disorder and have that flexibility so it can be done via telemedicine. And I think that is a key area for us to provide that flexibility so we can provide that treatment in New Hampshire and the rest of the Nation.

Ms. KUSTER. Well, I think it is so important.

Now, you have mentioned that several of the participants were hesitant to see new patients, and that is concerning. What can be done to encourage greater uptake among providers who might be hesitant for using some of these new flexibilities, and especially for new patients?

Dr. MEHROTRA. So I think we have been surveying and talking to a lot of opioid use disorder providers, and there is wide variation in how comfortable they feel.

One thing that we have called for is—this is more not on the congressional side, but on the clinical side—to create guidelines among the treatment community so that people feel more comfortable that this is a reasonable way to treat opioid use disorder. And I think that is going to be the key to convincing providers to move in that direction.

Ms. KUSTER. OK, great. Thank you. Thank you so much.

I wanted to question you about flexibilities allowed for opioid use disorder treatment providers in providing telehealth across State lines. So New Hampshire is a small State with a lot of State lines: Vermont, Massachusetts, Maine. And I would love to get your thoughts on delivering telehealth across State lines to some of our most vulnerable, including addiction and mental health patients.

Dr. MEHROTRA. Right. So, in New Hampshire—we are very close by, obviously, where I am. And it is difficult in many of those communities to find an opioid use—to get treatment, and providing that flexibility across the Nation. And we do see a number of private companies that are providing very innovative new models to expand the use of telemedicine, and they can work across all 50 States, so people can have that access.

And, as I articulated before, the keys to providing that in New Hampshire and the rest of the Nation are licensure reforms, so that we can make that easier for those providers to do so, as well as—as I think all of you know, and it is a really key aspect of this committee—which is broadband expansion. It is very frustrating in 2021 that so many Americans don't have access to that necessary technology.

Ms. KUSTER. Well, absolutely. And you have read my closing remarks, which are about exactly that. In places like northern New Hampshire, my district, Coos County, broadband is very limited in the western part of our State, and the successes of telehealth are only as great as the access to the digital infrastructure.

And so, lastly, I just want to submit for the record a recent report from Dartmouth-Hitchcock on telehealth as a tool for rural health equity.

[The information appears at the conclusion of the hearing.]

Ms. KUSTER. And with that, I will yield back. And, as chair, I will now recognize Representative Dunn for 5 minutes of questioning.

Representative Dunn?

Mr. DUNN. Thank you very much, Chairwoman. I appreciate that. Let me say I am enjoying this discussion about the future of telehealth, and I appreciate hearing all of the thoughtful views of our panel of witnesses.

You know, among the myriad ways which COVID–19 pushed the limits of our health system, telehealth expansion was a bright spot in that mess. Obviously, it means treating our patients and meeting our patients where they are. And I too have a large rural district, Florida 2, and telehealth expansion during the public health emergency enormously facilitated access to care for some of my most vulnerable constituents. Telehealth is helping Americans stay in touch with their healthcare, while so many other aspects of life have been put on hold.

I do think audio-only telehealth has to remain a backup option. Many of the most rural of my constituents lack reliable Internet access or, in some cases, the ability to employ video technology. And again, I would say who among us has never struggled with video conferencing?

I continue to be extremely concerned about the medical care that was foregone during the pandemic and quarantine, and what that is going to mean for everyone and for everything, from cancer screening to management of chronic disease. I am encouraged that telehealth offers the opportunity to bridge some of those gaps that are occurring.

We had a great case right here at Children's National Hospital, a place where I trained many years ago, who was able to—they were actually able to virtually see the family a day after a very concerning newborn screening. And the family didn't have a car, no care for their other children. And instead of having to wait for answers, they saw a physician the very next day and started to build a care plan—virtually saw a physician, and the physician even had a Spanish translator on the call. So that is a model for timely care and coordination that we absolutely want to continue in the post-COVID world.

I want to focus my questions and also offer my support for exploring ways to expand the use of remote patient monitoring technologies. We have made some mention of that during this discussion. Remote patient monitoring can offer physicians improved abilities in postoperative management, chronic disease management, a lot of tertiary benefits there, and even if it just triggers a phone call, you know, because something in monitoring technology indicates that, or it is not sending anything in.

So, in that vein, Ms. Mitchell, I would like to start with you. Remote patient monitoring, I think, can help these issues of no-shows, missed appointments. I think it can ultimately decrease the cost of chronic disease for—managing that for patients. It reduces frequent flyer ER visits, and it is an almost office-style care without exposure to communicable diseases.

I know there are detriments in the physical examination and testing remotely. Technology continues to get better. But is there

data now to determine the degree to which remote patient monitoring can generate savings?

And how should we be thinking about accounting for the cost and the savings in regard to remote patient monitoring?

Ms. MITCHELL. Well, thank you for the question. I completely agree, this—telehealth will enable much more innovative and patient-friendly models of care in the home, in the community. But we do need to remove the payment barriers to that.

I wanted to add, in our research we survey over 40,000 patients a year on their patient experience in California. And I—to your point about audio versus audio-visual, the satisfaction across both methods was the same. People do appreciate both, and we can share those results with you if you are interested.

We don't have any data that I am aware of that quantifies the savings from telehealth at this point. Again, we do believe if it is deployed correctly and, again, used to avoid unnecessary hospital visits or ED visits, we believe there are significant savings.

We ran a Federal—federally funded program in California with small practices for several years. And we found that, by working with those practices, utilizing telehealth, utilizing, you know, new methods of monitoring patients, we saw significant total cost reductions and better outcomes. So we think we can extrapolate that, but we do believe there is more research needed on the outcomes and cost.

Mr. DUNN. So we are running out of time, but I do think this is a terrific aid to practice. I think it can—it is a leverage for more—access to more patients.

I am going to be submitting some questions in writing, since we are out of time here. And with that, Madam Chair, I yield back.

Ms. ESHOO [presiding]. The gentleman yields back. It is a pleasure to recognize the gentlewoman from Illinois, Ms. Kelly, for her 5 minutes of questions.

Ms. KELLY. Thank you, Madam Chair. I thank the committee for bringing us together to discuss the future of telehealth. And I thank the witnesses for being here today.

States play an essential role in licensing providers and ensuring that providers practicing in the State are in good standing. During the pandemic, many areas experienced increased demand for providers and, in response, States moved early on to loosen or waive licensure requirements so that out-of-State providers could support areas overwhelmed by COVID–19.

However, even prior to the pandemic, many States partnered on licensure issues. Dr. Resneck, can you discuss what States have done before and during the pandemic to increase care across State lines?

And also, should States improve Medicare plans—should States improve Medicare plans—can contribute to creating an unequal system in healthcare delivery?

Dr. RESNECK. Congresswoman, thanks for the question, and thanks for your leadership in maternal health and health equity on that front. We look forward to continuing to work together on that.

Ms. KELLY. Definitely.

Dr. RESNECK. You know, there are a couple of things that help us with some of these licensure issues. So one is a thing called the

interstate compact, which actually makes it easier for physicians who are in good standing with their own State medical board to get licensed in multiple States. It is a new thing and already we have, in the last few years since it has gone live, 30 States, the District, and Guam have all signed on. We have got six or seven States that are considering legislation.

So it essentially—once you are licensed in one place, you can very easily check boxes on a form to get licensed in multiple other places. We would like to see the fees go down for that. I think that would be an improvement.

I think I also recognize that State medical boards do need some ability to create unique local reciprocity solutions around State border areas. And we have supported local reciprocity of licensure as long as, again, fundamental safeguards are met around the site of service being where the patient is located.

There is one more thing which people may not be aware of, which is there are a set of codes that CMS has approved called interprofessional codes that also—sometimes when I get consulted about a patient in a States where I don't have a license, where it wouldn't be responsible for me to take care of the patient and assume care and do all the prescriptions and everything else, because maybe I wouldn't be available if urgent things came up or side effects came up, I do what is called an interprofessional consult.

So there are codes that actually recognize my doing the consult with them and their primary care doctor, or them and their specialist, where I give advice and thought and consult on the case, but the responsibility for the daily care remains local. And so that is another opportunity we have to work on the interstate issue.

Ms. KELLY. And let me just ask my question again. Can you expound on how our already unequal system is made worse by the way these virtual services are provided?

And how can we address and remedy these inequities in virtual services provided through Medicare?

Dr. RESNECK. Oh, so sorry I missed that, the broader issue of disparities.

I mean, I think the last year has actually ameliorated some of that. So we have talked about broadband issues today. That definitely affects patients of color, low-income patients more than others, and that still needs a substantial amount of work.

But in the old—before, we had this irony where it was largely wealthier patients who were able to use the convenience of telehealth, where many of our minority and other disadvantaged patients weren't. And so, by fixing this Medicare issue, I think we will go a long way towards helping us work on health equity. Is that what you were asking about? OK.

Ms. KELLY. And I look forward to continuing to work with you. Thanks for all of your partnership. We really appreciate it.

And with that I yield back with an extra minute.

Dr. RESNECK. I hope we can get the MOMS Act passed.

Ms. KELLY. Yes.

Dr. RESNECK. Mortality issue.

Ms. ESHOO. Absolutely. The gentlewoman yields back.

It is a pleasure to recognize the gentleman from Utah, Mr. Curtis, for your 5 minutes of questions.

Mr. CURTIS. Thank you, Madam Chairman. And what a very interesting hearing. As I have listened, it is clear to me that there is broad consensus that we have something very important here. I like that it is bipartisan.

I have been impressed with the depth of knowledge from the members who have participated in this community, everything from personal experience, Representative Mullin, to our constituents. It seems to impact every single one of us. And many of us have talked about the impact on rural parts of our district.

We have been fortunate in the sense that we have had this opportunity as we have gone through the pandemic to try things we might not have otherwise tried. And it occurs to me that most of us can see intuitively a lot of good things. But there is also a strong sense, as I have listened to the Members, for more data, for more information, for worry about abuse, worry about fraud.

And I have introduced a piece of legislation that, Dr. Mehrotra, I would like to ask you about. It is called the COVID–19 Emergency Telehealth Impact Reporting Act. I am really pleased that it has some really good, strong bipartisan support from members of this committee. In essence, it would require the Federal Government to collect and analyze telehealth data from the pandemic.

And Doctor, it seems, like, almost so obvious that it would be a rhetorical question, but I want to ask it, particularly in light of other options, which is, How important is it for the U.S. Department of Health and Human Services to work with Congress to obtain better telehealth data?

And maybe contrast that to academia or, you know, to industry that would be also looking for data. But what is the role here for us, here in Congress?

Dr. MEHROTRA. Representative Curtis, as a researcher who studies telemedicine and does exactly what you are describing, this is obviously of great interest, and I think, really, critically important.

And in terms of—I would definitely agree that we need more data, both on what is happening during the pandemic—myself and many others are studying that right now—but also in that postpandemic period, hopefully very soon, where we can start to see how things get into more of a steady state.

One thing that I might emphasize where I see a real weakness and that Health and Human Services could act is in Medicaid. It is a real area where it is such a critical aspect of the U.S. healthcare system, yet we don't have as much data right now that people are looking at, in terms of what has been the impact of telemedicine in that patient population.

Mr. CURTIS. So that is great. I would also like to kind of get your thoughts on the metrics. What metrics should we be using to determine if we make a lot of these things permanent?

What—you know, in your community, what metrics would you like to have available to you that would help us make better decisions?

Dr. MEHROTRA. I think the key here is obviously—and the thing that we are all hopeful of—is that telemedicine will improve health. And so I think that would be the metric that I would love to look at.

In a paper we just looked at yesterday—or published yesterday—we found that roughly a third of U.S. hospitals have now introduced telestroke, and that is leading to decreased mortality. And that is the kind of work that we really want to demonstrate across many areas of telemedicine.

The only other—you know, the similar measures of patient satisfaction, and whether physicians and other clinicians are following those guidelines is also a really key aspect, as we assess the impact of telemedicine across these different areas.

Mr. CURTIS. Could you weigh in on just the little bit of time that we have left on not only this, but behavioral telehealth and total medication-assisted treatment?

And how do we, you know, capture this opportunity for cost savings?

Dr. MEHROTRA. Yes. No, I think in the area of, say, opioid use disorder or other substance use, how long patients are in treatment is going to be the key aspect of that.

And then, in terms of looking at—the hope would be—is that if we can control—address the people's substance use disorder better, they won't end up in the emergency department or will have further complications. And those are the types of metrics that we can look at.

Mr. CURTIS. Excellent. Thank you. I have got just a moment left and didn't want to ignore some of the other witnesses. I don't know if you have any comments. If not, I will yield my time back. But do any of the other witnesses want to comment on those questions?

Ms. MITCHELL. Hi, I just wanted to let you know that we will have early data on patient experience using telehealth for the Medicaid population this spring. We are happy to share that with you.

Mr. CURTIS. Thank you, that is awesome.

Madam Chair, I yield the balance of my time.

Ms. ESHOO. The gentleman yields back. It is a pleasure to recognize the gentlewoman from California, Ms. Barragán.

Ms. BARRAGÁN. Thank you, Madam Chairwoman, for this very important hearing. It has been really great to hear all the conversation about telehealth.

This is something I am quite new to, and I represent a district that is majority minority, very working class, and, frankly, hadn't heard a lot about telehealth. And when COVID hit, my own mother had to have a telehealth visit.

Now, the problem was, number one, my mom doesn't have any technology that has video. She has a flip phone and can hardly answer that phone. And so it became a challenge to make sure that somebody either took the day off or was able to go over there to make sure that she had video access. And she still has an old-fashioned landline. And so, for me, this was happening in my backyard with my own mom. I thought to myself, How often is this happening to constituents of mine who don't have that similar access, or older Americans who are having the same kind of access?

And so I know that community health centers have also moved to telehealth to make sure that they are providing safe access to care for constituents. And something—in my district community health centers are still very key.

Many of the providers are still offering over 50 percent of their care via telehealth. Now, my concern is the equity issues, and making sure underserved communities are not left behind and having access adequate to technology, and think that it is only going to help provide access to care.

So, Dr. Mahoney, you have discussed this, but I just want to, you know, get more of your thoughts on this issue, on what we can do to make sure, you know, underserved communities are not left behind. There is certainly a benefit here for those who don't have access to transportation to be able to get that telehealth. But, you know, on the broadband issues and access to technology, what you think Congress should be keeping in mind when we are doing all we can to keep telehealth but also making sure that there are going to be instances where maybe a telephone for some time is going to be the only available means.

Dr. MAHONEY. Thank you, Congresswoman Barragán, and thank you for the question. And also thank you for sharing the story about your mother. I think that that scenario does reflect a large number of the patients I see. And throughout my career I have been a telehealth provider, and I have seen firsthand the ways in which we can make tremendous progress using the phone alone.

And so, when we think about the medical decisionmaking that is required, the clinical effort on the part of the practitioner that is required, that should be reimbursed and compensated in the same way as we reimburse and compensate for other modalities of care. So I think that that would be something that we should keep in mind.

The other is, as we have already mentioned, is the expansion of broadband access to all communities, so that all communities can enjoy the benefits that come along with that technology. So, in the circumstances where a video is feasible, maybe going to that first but having the phone as a vital backup so that we can ensure access to care. I think we have—already have heard from many of our panelists, and I share the sentiment as well, that tremendous, high-quality care can be provided by audio-only means and should be reimbursed accordingly.

Ms. BARRAGÁN. Great. Thank you, Doctor.

Dr. Resneck, my next question is directed at you. At the beginning of this Congress, I reintroduced the Improving Social Determinants of Health Act. This is legislation that would empower public health departments and community organizations to address social, economic, and societal barriers to health access in underserved communities. The COVID–19 pandemic has underscored that internet connectivity is a social determinant of health. Dr. Resneck, can you discuss ways community organizations and community healthcare providers are leveraging telehealth to address social determinants of health?

And how can Congress better support these efforts?

Dr. RESNECK. We really need everybody on the team helping with particular disadvantaged and minoritized patients that we can get involved in their care. And broadband has been an issue. Getting the previous grants that were out there for broadband expansion renewed would be great.

You know, I think about the individual patients that I see who are coming from those areas with no broadband, and it is—still, it is unbelievable sometimes to me that—the lack of broadband that they face. Last night, after clinic, I was talking to some of my colleagues in the hallway and just asking them about cases, telling them I was going to be doing this hearing.

And one mentioned a farm worker from rural northern California who has a condition called scleromyxedema, where their hands and face thickened. This guy could no longer make a fist and do his work and could not put the apples that he was picking in his own mouth. It is a really terrible condition. We admitted him to the hospital, got him treated. He got back home. We were able to coordinate a month's worth of his care. And using that whole team and his community of local physicians, local nurses and PAs and community workers and others to help coordinate his care, he is now doing great.

But we do find ourselves sometimes doing this audio visit with a patient who is literally on break in the fields, or who is literally a frontline grocery worker between shifts, or who lives on an indigenous reservation with no internet, or who has to get on a bus in the midst of COVID to come and see us, all of which are difficult.

So the broadband issues are tremendously important for us to continue to be able to provide telemedicine to those patients.

Ms. BARRAGÁN. Well, thank you, Doctor, for sharing.

And with that, Madam Chairwoman, I see our time has expired. I yield back.

Ms. ESHOO. The gentlewoman yields back. I really think that our—the public healthcare systems, Medicare, Medicaid should be sending something to the beneficiaries in both of those systems and just ask the simple question, "Do you have access to broadband?"

We don't even know what we are talking about. We—well, we do when we give the stories, as Ms. Barragán did, her own mother. That story is replicated in inner cities, in rural areas in the country. And—but we have no yardstick by which to measure this by. So I—the committee, obviously, is going to have to do something about that. But I can't help but think these agencies should be informing us so that we can build on good data. And it seems to me that Dr. Mahoney and others are doing that.

Wonderful to recognize the only pharmacist—are you still the only pharmacist in the House?

Mr. CARTER. No, we have another one now. We have two now.

Ms. ESHOO. But we don't know who that——

Mr. CARTER. She is much better looking.

Ms. ESHOO. Let's put it this way. The only pharmacist on the Health Subcommittee——

Mr. CARTER. There you go.

Ms. ESHOO. Yes, the gentleman from Georgia, Mr. Carter.

Mr. CARTER. Thank you, Madam Chair. I appreciate this. And I appreciate all the panelists being here today.

You know, at some point, when this pandemic ends—and it will end—at some point, people are going to list the silver linings. They are going to list the things that were good that came out of all this. And there are good things coming out of this. And one of those, at the top of that list, is going to be telehealth.

You know, we have heard that there has been 10 years of progress in 1 week in telehealth. In fact, prior to the pandemic, there were roughly 13,000 telehealth appointments per week. Yet we have seen an increase during the pandemic. And even a few months after the pandemic started, we saw it go up to over 3,000 percent of that. Unbelievable, what has happened with telehealth. We knew it was there, and I had been looking at it for years. But this was the opportunity for us to really see it flourish. And I just—I think it has been great, and I think it is going to be even better and an important part of our healthcare delivery system.

The benefits are endless, there is no questions about it. Patients with comorbidities were able to continue to get care without having to be physically present with the physicians. And we have seen it, and I have seen it work. I saw it work even before that, but we have all seen it work now, during this pandemic. And it truly has been part of the silver lining, again, that we have noticed.

Dr. Resneck, I wanted to ask you. In your testimony, you discussed that Congress should make the telehealth flexibilities from the pandemic permanent. But I hear others say, well, we need more data, we need more research. Yet we have got a year's worth of data collection and tens of millions of telehealth visits that provide us the data to review the success of expanded telehealth services. In your opinion, is that enough, what we have experienced thus far?

Dr. RESNECK. Yes, these are not new services we are providing, and the data have accumulated exponentially in the last year, thanks to Ateev and other colleagues on this panel. So I think we have data to move ahead with making the expansion for visits permanent.

I am all for continuing to study all of the subareas of telehealth because we, as physicians, are going to learn from that and continue to learn what things are best done by telehealth and what things we need to see a patient in person for. But that is really at the standard of care level, and not the coverage level. So I think we have got a lot of data, and we are ready to move forward.

Mr. CARTER. Would you agree that it has increased access to care, as well, particularly in minority communities, even?

I represent south Georgia, which—you know, we struggle a lot with rural broadband. And that is certainly something that we are addressing in this committee, as well, and certainly something that needs to be addressed. And there is no better example, obviously, than our educational system, but also with our healthcare system, with telehealth.

But it does—and it also decreases costs. So would you agree that it increases access, as well as decreases cost?

Dr. RESNECK. Clearly, it does increase access. There will be instances where it is cost effective and reduces costs. There are instances.

You know, when I see a patient who comes to see me from a rural area, and they have something that I know I am going to need—it is going to be chronic, and I am going to be taking care of with them in partnership for quite a while, I feel really bad when I tell them they are going to need to sit in traffic and miss work and all those things to come back and see me.

So, whether it is your constituents in south Georgia and their physicians or my folks in rural California, just having the option to know that it is covered for me to be able to pick which visits are most appropriate to see them via telehealth is a huge improvement to their access.

Mr. CARTER. And not only that, but, just as you are pointing out, it decreases health inequities because it increases access, it helps people who are disadvantaged—at a disadvantage because of various reasons, but some that you just stated right there.

Dr. RESNECK. It was this—we were in this very ironic situation, prepandemic, where there was a big, like, a growth in telehealth. But again, it was mostly—the fastest growth were in these direct consumer providers, which were for people who had spare money and could go online and just pay for it out of pocket. They got access. But people who paid into Medicare and had Medicare coverage, or many who had commercial insurance, couldn't follow up with their own physicians who knew them well.

So this has been a great improvement, in terms of disparities, and in terms of patients'——

Mr. CARTER. So basically——

Dr. RESNECK [continuing]. Telehealth.

Mr. CARTER. Right. So basically, we have got the research and the data. We know that it increases access. We know that it decreases costs. We know that it decreases health inequities. To go back now, I think, would be a disservice to our citizens and a disservice to healthcare, in general.

That is why I have—cosponsored a bill, along with one of my Democratic colleagues, the Telehealth Modernization Act, that essentially would make the flexibilities from the pandemic permanent. Common sense. We got the data, we know that it decreases costs. We know that it decreases health inequities. We know that it increases compliance and access.

Dr. RESNECK. Yes, we——

Mr. CARTER. A common-sense bill.

Dr. RESNECK. We strongly support it, and I know my Medicare beneficiaries that I take care of would be unhappy to have this access yanked away from them. So thank you.

Mr. CARTER. And once again, bipartisan that I am cosponsoring with another member of the—Lisa Blunt Rochester with—on the Energy and Commerce Committee, a bipartisan bill that we should all support. And I hope my colleagues will do that.

And thank you, Madam Chair, for your indulgence.

Ms. ESHOO. I thank the gentleman.

You know, there is something else that the Members, if you don't realize this, when the waivers are no longer in place and we don't do something on this issue, it is only Medicare Advantage patients that will be able to receive telehealth services. Those that are enrolled in just straightaway Medicare will not be eligible. So we have got some work to do to make sure that no one falls through the cracks.

Now it is always a pleasure, and we are all, I think—I know we are a better committee because she is a part of it, the gentlewoman from Delaware.

Ms. Blunt Rochester, you have 5 minutes for your questions. And thank you for being here from the very beginning of the hearing.

Ms. BLUNT ROCHESTER. Thank you, thank you, thank you, Madam Chairwoman, for the recognition and especially for your leadership on a topic that I think is transformational in our healthcare system. And because of the telehealth flexibilities granted under the COVID–19 public health emergency, physicians and health systems across the country have been able to rapidly scale up and deploy telehealth services.

Dr. Resneck, a lot of questions have been asked of you, and there has been a lot of conversation with my colleagues Mr. Buddy Carter, Robin Kelly, and Nanette Barragán about just the waiver itself and the impact that it has had. And I was curious, number one, if there is anything else that you want to add about making it permanent.

But also, you hinted at the impact that it would have for your patients, those Medicare beneficiaries, if they were abruptly to lose access to telehealth services. Can you talk a little bit about that?

Dr. RESNECK. Well, they have gotten comfortable with the technology. And I think, you know, they have a better understanding of when it is appropriate to use it, I have a better understanding of when it is appropriate to use it. And that partnership and trust has grown between us. So I would have a very hard time looking them in the face at the end of the public health emergency and saying, "Sorry, we are done with all that. That is going away." So I feel really strongly.

There are—you know, there are just so many side benefits, and many of them have come up today. We have talked about a lot of them. We haven't talked a lot about social determinants, even though we have talked about differences in access. And I never cease to be surprised about how much more I learn about my patients' lives that they are willing to share when I am on a video visit that just might not come up in my office.

Ms. BLUNT ROCHESTER. Yes.

Dr. RESNECK. You know, I have colleagues who—endocrinologists who take care of diabetes patients, where the patient might walk over and open up their fridge and put it on the video to say, "Do you think I am doing the right thing with this, Doc, with the way I changed my diet?"

You know, this is not a social determinants issue, but I had a patient with just constant dermatitis that wasn't going away, and wasn't going away, and they didn't have any pets, and we couldn't figure out what their allergy was. And they showed me the lovely foliage all down the side of their house, which was poison oak, and we solved their problem.

So there are just so many things you don't expect for a new technology like this to be helpful with that you discover as you go. You also discover the situations where it is, like, "OK, it is not so helpful for this. You really need to come to my office. This is different." It has just been a wonderful learning year, and I have been so proud of colleagues all over the country who have implemented this so quickly and all of whom have, I think, learned a great deal.

Ms. BLUNT ROCHESTER. Yes, I appreciate you sharing that. I actually have legislation on the social determinants of health, as well, and it is a big topic for our committee, and bipartisan, as well.

Buddy Carter, as has mentioned, he and I both reintroduced the Telehealth Modernization Act that would permanently waive Medicare's geographic and originating site—for telehealth coverage for Medicare beneficiaries.

And what you just talked about, in terms of the social determinants of health, goes right into the H.R. 1332, our bill, as well as others that we are working on for equity. Could you talk about just how this opportunity intersects with broadband, transportation challenges, and other things that both, whether you are rural or urban, might experience or face?

Dr. RESNECK. Yes, I mean, you have heard from several of my colleagues on the panel, this same idea that we just are constantly surprised by how many patients struggle with the broadband access. And I just was not aware, I think, until this year of how widespread an issue that is.

And I thank you for bringing up the urban issue, because I think there is a sense that this is unique to people who live very far from an urban area and really is an issue of the rural parts of our country, where it is real, and it is a real issue for our rural citizens. But I have plenty of urban patients who simply can't afford broadband access or the devices that they need. And so, again, it is another reason for having backup audio-only for them and working to improve affordability for broadband access for those patients.

Ms. BLUNT ROCHESTER. I was happy to hear a mention about Medicaid, even though it is a—slightly switching gears. But we know that close to 40 million children are enrolled in Medicare. And in my State of Delaware alone, 39 percent of children are in Medicaid or the CHIP program.

And so Congressman Burgess and I reintroduced the Telehealth Improvement for Kids Essential Services Act, which is TIKES, H.R. 1397. And I would love to follow up in writing and ask the entire panel about how Congress can best support State Medicaid programs in their efforts to expand telehealth. And are there supports, incentives, and learnings—and I think it was Ms. Mitchell who talked about a report that is coming out. So we would look forward to hearing about that report, as well, and we will follow up in writing.

And I yield back 1 minute of my time. Thank you, Madam Chairwoman.

Ms. ESHOO. Well done. My goodness. The gentlewoman yields back. I now would like to recognize the gentleman from Texas for his 5 minutes of questioning, Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Madam Chairwoman, and thank you to all of our witnesses for being here. If I am going, it means you are near the end, so great.

This is a great conversation. There is a lot of consensus about the benefits of telehealth. And so the question is, How do we properly regulate it? I think this body tends to try to answer every question with regulation, whether that is through mandates, incentives, or punishments, or restrictions. And maybe there is a tendency sometimes to have 1,000 of them, right, to make sure that we have

thought of everything. I tend to think that the opposite is true. I tend to think that simple rules for complex problems are the best approach. And so I will direct this to Dr. Mehrotra.

What would—if you had to pick maybe a top five, or just two or three essential regulatory incentives, restrictions, mandates, whatever it is, what do you think we should be focusing on, as this body moves forward, to properly regulate this?

Dr. MEHROTRA. Yes, so the first part that I want to emphasize is that—that you sort of touched upon with your question, but I think it is really important—is that one of the barriers to providers using telemedicine has been just pure confusion. It is a very complicated landscape to try to navigate both Medicare, Medicaid, private insurers, State medical boards in five different States that you are providing care for, and that becomes a real impediment to providing telemedicine care. And it becomes, at least in our conversations with providers, a real deterrent: "I just can't bother, it is just so confusing. How the heck am I going to do this and pay for it?"

We have seen a lot of change in the last year, but I still think that that is a major issue, and something that I hope Medicare will kind of simplify a bit to make sure that it is easier for providers to bill.

But you asked the question about—in terms of regulations and so forth. I mean, I think here—I think it is a real balancing act that we don't want too many different regulations. And so I have argued that we should try to limit—when we are making limitations on telemedicine, to try to only focus on one dimension. I focused on the aspects of different diagnoses and conditions where there is cost-effectiveness data to support it, but I think that would be the place that I would focus.

Mr. CRENSHAW. OK, and I appreciate that answer. It is helpful, as we all go forward, right? There is always a balance of how much risk do you accept in the regulatory world. You know, some of us are more risk tolerant than others. I would love to dive down that rabbit hole for about an hour.

But Ms. Mitchell, I want to ask you a question, because you mentioned a large employer is projecting 8 percent cost savings using telehealth. And if that is just one employer, any idea across all of your large members how much we would save in telehealth?

And then the second part of the question would be, What are some of the best practices that you might suggest small and medium-sized businesses could use to incorporate telehealth and, more importantly, pass these savings on to patients?

Ms. MITCHELL. Well, thank you for the question. We haven't measured across our other employers, but again, we don't think 8 to 10 percent is unreasonable. And, when they are collectively spending $100 billion a year, that is not an insignificant amount.

I will remind you that our members are mostly self-insured. So those savings go back to them fairly immediately. And they are looking for ways to reduce the cost of healthcare for employees, waiving cost sharing, or lowering premiums, ideally.

But again, the barriers that we are currently facing are in the payment model, and we have not seen commercial health insurance companies actually change payment that would enable more flexible use of resources, particularly for physicians. So we think that

there is enormous potential here. We—and we have heard it supported by physicians, patients, and employers.

So we would like to move this forward as quickly as possible, and we need both CMS and commercial health plans to enable that.

Mr. CRENSHAW. Well, can you expand on that, and on the payment models?

Do you mean moving away from fee-for-service? Is that what you are referring to?

Ms. MITCHELL. Yes. And again, more flexible, prospective payments, particularly for primary care. We work directly with small, primary-care practices. They need to figure out how to enable teams to do this work or to connect with some of the community health workers. Current payment systems create barriers to doing that. They create barriers to giving optimal care.

But right now, most health plans will only pay fee-for-service. So we really need to move past that.

Mr. CRENSHAW. I am a big fan of direct primary care. I have introduced legislation to promote direct primary care, and I think direct primary care is deeply intertwined with telehealth——

Ms. MITCHELL. Agreed.

Mr. CRENSHAW [continuing]. As well. And it is—I think it is a perfect model for this. And I can go down a rabbit hole for an hour, but I only have 5 seconds left.

So I yield back my 3 seconds. Thank you, Madam Chairwoman.

Ms. ESHOO. Great job, Mr. Crenshaw.

I am not so sure what the average reimbursement is for an appointment online, but I don't—this is not, I don't believe, an expensive part of healthcare. I mean, you know, surgeons are not operating on people while they are talking to them. So I don't think that is something to be really concerned about. There has to be a reimbursement, of course, but I don't think we need to make a bigger deal out of it than need be. At least that is my view.

A new member to the committee, a wonderful addition, the gentlewoman from Minnesota, Ms. Craig, you are recognized for 5 minutes.

[Pause.]

Ms. ESHOO. Are you there, after I said all those wonderful things about you? I guess you are not there.

All right, another new member to our committee. Everyone is—each member is value added. It is Dr. Kim Schrier, recognized for 5 minutes for her questions.

[Pause.]

Ms. ESHOO. Are you there? You need to unmute.

Ms. SCHRIER. You would think that, after this long in a pandemic, I would know to unmute. Thank you, Madam Chair. Thank you for that very warm introduction, and thank you to our witnesses.

Telehealth is definitely here to stay. Docs love it, patients love it. And this pandemic has been devastating in so many ways. But the silver lining is that we have this real-world data that shows that telehealth can strengthen provider and patient relationships, and maybe even improve care.

Certainly in my family, my parents are 78 and 82 years old, and telehealth, over the last couple of months, has allowed me to join

their medical visits, remember the things that they don't, ask the questions that they might not think of, clarify things, and then I even send them an email, summarizing the visit, and then giving the plans afterwards. And this has been an absolute godsend.

Then myself, as a patient with type 1 diabetes, access to telehealth has been great. My doctor also has type 1 diabetes, so it reduces risk for both of us and keeps my health in good shape.

And as a pediatrician, I hear from my colleagues that telemedicine has actually strengthened their relationships with their patients and enhanced care in many ways, because you can see kids kind of in their own—know what the environment is like at home, and get a better snapshot of developmental issues.

But there is a lot that you can't do remotely, so I have a couple of questions. One—and my first one is for Dr. Mahoney.

Just as a doc, I would send my patients to specialists. They would come back to see me. I would also get a note from the specialist. And oftentimes the two stories did not match up. And now that I am going through these health issues with my parents, I am just curious about whether you could take telehealth even a step further and have, say, the primary doc and the neurologist and the neurosurgeon and the interventional radiologist sort of all in the room together making a decision and coming up with a plan so everybody hears the same information. And so I was wondering if you could briefly comment on how that might improve medicine.

Dr. MAHONEY. Yes, thank you, Dr. Schrier, for the question. And as a fellow primary care provider, I really do resonate with your stories of the benefits of talking to caregivers who are doing heroic work for our senior population, taking into account work schedule, child care responsibilities. And then, also as a family physician, I do have the benefit of seeing children and watching their developmental milestones, and observing those within their home environment, which is a lot more helpful.

So I—can you repeat the question, again? I am sorry, I lost——

Ms. SCHRIER. I guess just, you know, do you see that as a possibility, where you could have multiple layers of specialists——

Dr. MAHONEY. Oh, right.

Ms. SCHRIER [continuing]. In the room, all hearing the same story?

Like, would that improve a care coordination, if you had everybody——

Dr. MAHONEY. Right.

Ms. SCHRIER [continuing]. There at the same time?

Dr. MAHONEY. Absolutely. So there are models out there, and we have experimented with that in the inpatient setting and also in the outpatient setting, where we have video conference, multiple consultants, family members, also the patient. We do this in the inpatient setting when we want to have a family conference, if it is an end-of-life discussion, in particular. So that has been successful.

The barrier is the coordination of scheduling of all these very busy individuals. And what is also helpful is asynchronous communication through the electronic health record. So that is—that has also been incredibly helpful, in also——

Ms. SCHRIER. Oh, that is great.

Dr. MAHONEY [continuing]. Being able to——

Ms. SCHRIER. Can I ask one more question? I wanted to—this one is for Dr. Mehrotra about pediatric care.

You note in your work for the Commonwealth Fund there has been a 24 percent decrease in visits. There has been about a 30 percent decrease in vaccinations. You can do some things really great in pediatric care with telemedicine, but other things are going to fall through the cracks. And so I was just wondering if you could talk about the good, bad, and the ugly with pediatric care, specifically. What are the wins? And where are the liabilities—we have some improvements?

Dr. MEHROTRA. Yes, one of the things that we—while there has been a big resurgence in visits in the United States and back to baseline, one big area that we haven't seen that is in pediatrics, and I think that is a combination of both good things and bad things.

The good part, and the silver lining, is kids are less exposed to illnesses, and so we are seeing a dramatic drop in acute respiratory illnesses, colds, gastroenteritis, eye infections, and so that is the positive part. But, as you highlighted, Dr. Schrier, there is a real concern that there has been a real deficit in immunizations and preventive health visits. And so that is a key place that, as we come out of the pandemic, how do we make sure we catch up with those kids? And telemedicine could play a role there.

Ms. SCHRIER. Thank you. I am going to add one more thing from experience. When Microsoft patients had to pay a copay to come see the doctor, they stopped coming in the first time their child sneezed. And so, as we talk about overutilization, sometimes just a little copay makes a big difference.

Thank you, I yield back.

Ms. ESHOO. I think money is always involved in just about everything in life.

The gentleman from Pennsylvania, Mr. Joyce, is recognized for his 5 minutes of questioning.

Mr. JOYCE. Thank you, Madam Chair Eshoo and Ranking Member Guthrie. This is an important hearing, a topic of telemedicine. As a physician myself, I understand the increased telehealth services during COVID–19 has spurred substantial changes, positive changes in the delivery of healthcare.

Last year, when in Congress we acted to provide the Secretary of HHS with additional flexibility surrounding telehealth, I don't think any of us envisioned the full impact that this would have. The pivot to telehealth has raised many new questions surrounding patient care access, rural availability specifically in broadband, and even privacy and security issues.

I want to thank the witnesses for appearing today, and for answering our questions.

Dr. Resneck, as another board-certified dermatologist in this conversation, you and I realize that derm is a very visual field of medicine, and visual access to patients is sometimes all that is necessary for an evaluation, diagnosis, and treatment. But this isn't always the case with all subspecialties, specifically surgical subspecialties, which our Chair Eshoo talked about, that surgeons aren't going to be doing these procedures via telemedicine, but also

in obstetrics. Do you see any long-term consequences for these fields, given the shift that we all know is occurring to telemedicine?

Dr. RESNECK. Thank you, Doctor, Congressman Joyce. So I think every specialty has found its places where telemedicine can be useful.

So you mentioned surgeons. I have surgical colleagues who—their patient gets discharged from the hospital, lives a couple hours away, and maybe they do a post-op visit via telehealth. So, you know, every specialty is figuring out this—OK, this is where telehealth does not work for me, and this is where it does.

You know, you and I are both dermatologists. Sometimes a still image can be way more useful than a blurry video for us. So we are—you know, I am grateful that we have a variety of codes to use, including the e-visit codes, where a patient can upload really high-quality photos into my EHR portal for me to look at. So I think having a variety of tools at our fingertips, the continuation of every specialty figuring out where this is useful and isn't, is going to bring us to a place of ongoing progress here.

Mr. JOYCE. I certainly enjoyed hearing about your treatment of the patient with scleromyxedema, knowing how complex with the cardiac and pulmonary, that you required ultimately that that patient be brought in hospital for ultimate care. But your ability to keep that patient working is significant.

I also wanted to address another issue that I think is important, and that is the training of residents and medical students in telehealth. And I will ask the physicians on the table at this conference.

Dr. Mahoney, do you think that that should be integrated as part of training, both to medical students and to residents?

Dr. MAHONEY. Thank you, Congressman Joyce. This is an excellent question. I wholeheartedly endorse and am enthusiastic about integrating telehealth and more modern modalities of care into the training of medical students and our residents. We really do need to prepare for the next generation of providers, and we need to ensure that they are empowered with all of the knowledge to do so effectively.

We have been training our residents. We have been bringing them in, either in the visit that we have with the patient directly, so they can observe—they are able to see patients directly, we can conference in as attendings and observe—and then they can also have one-on-one appointments with their patient, and then present to us later, depending on their level of training. But absolutely, I endorse that recommendation.

Mr. JOYCE. Dr. Mahoney, do you recommend this as a requirement to complete residency training?

Dr. MAHONEY. You know, I am not an expert in that field, but I am very enthusiastic about that, that idea, absolutely.

Mr. JOYCE. Dr. Mehrotra, would you weigh in on this, as far as medical students and residency requirements in telemedicine?

Dr. MEHROTRA. You know, I think it is a key point, and it is already happening—let's be clear—just because all—as you know, residency is often an apprenticeship. You follow attendings around, and you see their care that is being provided. And, as all of healthcare has moved to telemedicine, I am seeing so rapidly how

education is moving in that direction. So I am very enthusiastic and excited about how the future will incorporate telemedicine in training.

Mr. JOYCE. Thank you all for being present.

And Madam Chair Eshoo, I will return my remaining 12 seconds.

Ms. ESHOO. Well, I thank you, Doctor. You raised a very important, wonderful point, just as we were kind of winding down in the hearing and we think that we have covered all the corners and then some. And you raised the point about training. So good for you. See what each person brings to the committee? It is really wonderful.

I think Ms. Craig—has she returned? Yes.

It is a pleasure to yield to you 5 minutes for your questions, the gentlewoman from Minnesota, Angie Craig.

Ms. CRAIG. Thank you so much, Madam Chair and Ranking Member, and thank you to all of the panelists who have been here for so long today.

I know that each one of us shares the goal of ensuring that our constituents can safely and affordably access healthcare, and, of course, virtual care, telehealth, has been just a critical, critical piece of this during the COVID–19 pandemic.

I am particularly encouraged by the potential for telehealth and virtual healthcare to expand access to mental health services in rural parts of my congressional district and to help alleviate a provider shortage for so many communities, including my own. In 2017, rural areas in Minnesota had only one licensed mental health provider for every 1,960 residents while my metro areas had one mental health provider for every 340 residents.

As others have noted, one of the silver linings of the past year has been the adoption of telehealth, virtual healthcare, for mental and behavioral healthcare. One telehealth vendor in our State saw an over 300 percent increase in visits to their behavioral health platform last year. Telehealth for mental healthcare has also shown great promise for, especially, our Medicare beneficiary population, who might otherwise feel stigmatized or have other limitations preventing them from seeking out care in person.

I want to start with Dr. Mehrotra.

You have highlighted that telehealth could lead to the potential for overuse of care. HRSA has designated the majority of the U.S. as health professional shortage areas for both primary and—primary care and mental health. And the same, of course, is true in my district. In your view, how do we best expand the reach of our existing healthcare workforce, especially for services like mental health, behavioral healthcare, and, at the same time, balance the appropriate use of care and guard against overuse?

Dr. MEHROTRA. I think that first, Representative, I just want to highlight I think what many of you know, that if we were to look at rural areas of the United States versus urban areas, and we look at how much care patients are getting, it is much lower often in rural areas, in particular for specialty care. And that is why there has been so much of a focus on telemedicine to increase access there.

One other point that we haven't really addressed here that I thought might be important is that States are also under a quan-

dary of how do we address this balance of increasing access but addressing this overuse. And so a number of States have said, you know what, we don't have enough data from the pandemic, it is such an unusual time in our lives, and that they will extend temporarily telemedicine expansion for 1 to 2 years afterwards, and use that as a period of time to try to understand what the impact is and whether this overuse concern is valid. So I wanted to highlight that point.

Ms. CRAIG. It is an incredibly important point, and I think you are exactly right. As we look at this, we are going to need an additional level of research on what is appropriate and for how long for each particular healthcare action.

My next question is for Mr. Riccardi.

You discussed the digital divide in your testimony, and many of our districts, including mine, lack full access to broadband. A recent study published in Health Affairs found that telemedicine and overall outpatient access during COVID–19, of course, were lower in rural than urban areas. The authors theorized the difference could potentially be attributed to limited broadband availability in rural areas. I could tell them that is probably true.

In expanding access to telehealth, what additional policy tools do you think Congress should consider to address this digital divide and ensure that health services reach these underserved communities?

Mr. RICCARDI. Yes, thanks for your question. I am concerned about the regional variation. We still only have early 2020 Medicare claims data, and that information has not been publicly released, and physicians still have additional months to submit that data. But early we know that about 30 percent of beneficiaries who receive telehealth services were located in urban areas, and 22 percent of beneficiaries were in rural areas. So there is that discrepancy there.

Earlier, you know, you had mentioned, you know, concerns around affordability. As we think about expanding Medicare telehealth going forward, it is also important to consider the types of facilities that people can receive care from, including community-based clinics is particularly important. And, as the CMS releases this data and it is analyzed by researchers, we should be looking at what impact the cost-sharing waivers that have been in place have had on the utilization of services. And we recommend that there is standard cost-sharing applied both to telehealth services and in-person services to create parity, to avoid incentivizing one form of care over another.

And then, as we consider finances, we should look towards CMS's current telehealth payment schedule for the starting point to determine what is the appropriate payment for telehealth versus in-person care, not only looking at the emergency waivers.

Ms. CRAIG. Thank you so much. And there's about a million questions for follow-up that calls for. But, sadly, I am way over my time.

So, Madam Chair, I will yield back.

Ms. ESHOO. The gentlewoman yields back. Now I would like to move to Members that are waiving onto the subcommittee.

To the witnesses, these are members of the full Energy and Commerce Committee, and we always extend the legislative courtesy to any of our Members that would like to join our subcommittee for questioning. The only thing is that they have to be—they have to wait, wait, wait, and be taken toward the end of the hearing. Nonetheless, they all count.

And the Chair is pleased to recognize the gentleman from Ohio, Mr. Latta, for 5 minutes of questions.

Mr. LATTA. Well, I thank the chair, my friend, for holding this very important hearing today and for allowing me to waive onto the subcommittee.

You know, we are approaching 1 year since the way Americans lived, worked, and learned all changed due to the outbreak of the COVID–19 global pandemic. We have seen how quickly the virus has spread through our communities. The response to the pandemic—action was taken by the Trump administration. Thanks to the leadership of the President, telehealth services have really expanded to provide care and assistance to the most vulnerable at a distance.

Even with these efforts, I have had numerous constituents contact me with concerns regarding the lack of access to telehealth services. Whether it is related to issues with broadband connectivity, electronic appliances, or a lack of available care, it is clear that more needs to be done.

Early in the pandemic, students in my district who were receiving higher education were abruptly notified that they be required to return home, even if it meant traveling long distance in and out of State. This severed relationship with campus-based mental health providers during a stressful time.

In addition, people fighting cancer and other rare conditions weren't able to travel safely for care due to lockdown protocols.

Because of the concerns, I introduced the TREAT Act, along with my good friend and colleague, the gentlelady from Michigan, Mrs. Dingell. This bill would establish temporary reciprocity at the State level for a provider in good standing to virtually see patients during the COVID pandemic. With only—groups representing patients, physicians, universities, health systems, employers, and many others, this bill would alleviate the overall healthcare professional shortage we are facing and provide immediate relief to providers and patients.

I address my first question to you, Dr. Mahoney. In light of the immense stress and pressure that has been placed on our hospitals and mental health providers and addictions counselors, do you believe that temporarily waiving State licensure requirements would help ensure that patients can receive the quality care they need?

Dr. MAHONEY. Thank you, Congressman Latta. I—we believe the TREAT Act is a step in the right direction that will ensure continuity and access to care for patients nationwide during this pandemic. The issue of specialty care access and behavioral health access across State lines will last beyond the pandemic. And so we encourage, as well, the re-evaluation of the system with that in mind.

And so we are excited about potentially enabling providers who are licensed in good standing to treat patients at any State, and

they can require, you know, oral and written acknowledgment of services, require notifying State and local licensing boards within 30 days of first practicing in another State. And many of the other parts of the TREAT Act make a lot of sense. We definitely believe this is a step in the right direction.

Mr. LATTA. Well, let me follow up. In your experience, could you share any examples of licensure challenges faced by Stanford's providers and why the current patchwork of State laws is making providing care for those patients more difficult, especially during the pandemic?

Dr. MAHONEY. Right, right. So, after lockdown, our providers received requests for care from all 50 States. And we were able to provide that care during this time in States where there wasn't a pediatric rheumatologist available in the entire State, or a pediatric endocrinologist. Academic medical centers are unique in that they are able to provide subspecialty services that are not available throughout certain States. And so we were very honored and enthusiastic about having that ability to do so.

Mr. LATTA. Well, thank you very much.

Dr. Mehrotra—I hope I pronounced that correctly—in 2018 Congress allowed clinicians working within the U.S. VA Affairs health system to provide care to patients both in person and across State lines through telehealth services, due to veterans experiencing long wait times. And that emerged into Federal action.

Would you agree that the severity of this crisis also demands that Congress address the licensure issue and expand deployment of care during the duration of this public health emergency?

Dr. MEHROTRA. I definitely agree, Representative Latta, and I would say that—two other points there is that I would go beyond the TREAT Act and make this—using—under the Medicare system, allowing any Medicare beneficiary to receive care from a physician who is licensed in the State that he or she is located in.

One nuance that I might bring up is that there was this issue of the interstate medical licensure compact as another way of improving the ability of providers to get licensure in other States. And I think, in theory, it is a great idea. Our data highlights that very few providers have used it to do so, to provide telemedicine across State lines, simply because it has a lot of administrative paperwork, and the cost of it. So I would say that that is one thing I wanted to flag.

Mr. LATTA. Well, thank you very much for our witnesses.

And, Madam Chair, again thank you very much for your indulgence and me waiving on to the subcommittee. Thank you very much.

Ms. ESHOO. We are always happy to have you with us, Mr. Latta. You are—when we say "gentleman," you are truly a gentleman. You are always welcome at the Health Subcommittee.

Mr. LATTA. Thank you, ma'am.

Ms. ESHOO. Yes. The Chair is pleased to recognize another one of our new members to the full committee from Massachusetts, the gentlewoman by the name of Ms. Trahan.

You are recognized for 5 minutes. Thank you for waiving on. Oh, no, you are a member of our committee. You don't need to waive on.

Ms. TRAHAN. I am, but I would have waived on if I wasn't.

Ms. ESHOO. Right.

Ms. TRAHAN. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, as well as all the witnesses here today. I really appreciate all of your—all of the insight.

Missed appointments, or no-shows, are a measure of health disparity, with low-income, Medicaid, and minority patients traditionally having the highest no-show rates. Lack of private transportation, access to healthcare, inflexible work schedules contribute to higher no-show rates in an already underserved community. Given the ability of telehealth to improve patient convenience and eliminate barriers to care, I want to just discuss how 1 year of accessing telehealth has resulted in a decrease in no-show rates for hard-to-reach patients in the pandemic.

Greater Lawrence Family Health Center is a community health center in my district that serves a diverse population. Approximately 70 percent of patients are non-English-speaking, approximately 75 percent have Medicaid. Excluding testing and vaccination appointments, this health center has had more overall visits at this point this year than they did last year. And they have also seen a 10 percent decrease in no-shows, which providers at the center attribute to the expansion of telehealth services.

Also, a study was conducted by a member of the Massachusetts Medical Society on all patients that completed or no-show appointments with the dermatologist at the campus during the months of May and June 2019, compared to 2020. And the study found that, compared with the clinic visits, televisits had significantly lower no-show rates, with the greatest reduction seen for Black, Latinx, and primary non-English-speaking patients.

So I know that there's limitations to the study, you know, with a small sample size, and single institution experience. However, the study provides early evidence that teledermatology may play an important role in mitigating no-show rates and improving access to care for our most vulnerable populations.

So, Dr. Resneck, are the findings from the study I mentioned consistent with your clinical experience? And do you believe these findings represent a trend across practices and institutions?

Dr. RESNECK. Congresswoman, those findings do not surprise me. This is what I am hearing from my colleagues around the country and experiencing myself.

As you sort of highlighted, traditionally—at least in my practice and colleagues who work around me—some of the highest no-show rates are in patients who already suffer from health disparities. Their lives are more complicated, it is harder to get out of work, transportation issues, child care issues. And the decrease in no-show rates, I think, has had a particular impact on improving care for those minoritized and disadvantaged populations.

So I am seeing it in my own practice. I am hearing about it from colleagues. And I think, as we see more national data, they will confirm what you read from U Mass.

Ms. TRAHAN. You know, another opportunity that our Chairwoman Eshoo actually brought up in her opening remarks is that telehealth creates the opportunity to get Black and Brown patients in front of physicians who look like them. Data suggests that indi-

viduals are more inclined to visit a medical professional if they share their same race or ethnicity.

So, given the historical context that, you know, people of color, particularly Black people in our country being mistreated and exploited by our healthcare system, it may take more time and effort for a provider to build trust with a patient of different demographics in a virtual setting.

So, Dr. Mahoney, I was wondering if you can shed some light on the impact telehealth is having on making the case for investing in a more diverse medical workforce, including physicians, pharmacists, nurses, and medical professionals, and how that will help to build trust with patients across cultural, ethnic, and racial dimensions.

Dr. MAHONEY. Thank you, Congresswoman Trahan, for that excellent question. And I appreciate the acknowledgment of the data that is out there, supporting the association between race concordance, between patient and provider and clinical outcomes along the lines of patient satisfaction, trust, but also perhaps even quality of care might be better when there is race concordance.

And some of the studies that I participated in, we found that if there is a single team member—it doesn't have to be the physician, because we know that we don't have high numbers of people of color who become physicians now—hopefully, that is something we can work on and improve in the future. But if there is a single team member—so I am glad you have highlighted the idea of a team member being someone who is culturally or racially concordant with the patient, and the importance of that.

Absolutely, access to telehealth, any modality that is going to improve access to care, is going to, as a result, improve the trust and the connection that a patient will have with her providers. It will improve the availability of multiple team members to engage with that patient.

Ms. TRAHAN. Terrific. Well, thank you. I am out of time. I appreciate those answers.

I yield back.

Ms. ESHOO. The gentlewoman yields back. Thank you for your patience. Thank you for your patience in waiting to be recognized.

The Chair recognizes another wonderful member of the full committee that is waiving on, Mr. Johnson of Ohio.

Thank you for joining us and for, I think, just being with us since we started at 10:30 this morning.

Mr. JOHNSON. Yes, I have. I have been paying very close attention. And Madam Chairwoman, I thank you and Ranking Member Guthrie and the subcommittee for allowing me to waive on and to try and contribute today.

As cochair of the House Telehealth Caucus along with my colleague, Ms. Matsui, I am delighted that we are taking a close look at this. I represent a very rural district, as you know, and telehealth plays such an important part of healthcare delivery in rural parts of our country. In fact, you know, it was about this time last year, as COVID began to spread and the shutdowns took hold, that telehealth began playing such a key role in protecting vulnerable patients and helping to slow a run on our overburdened medical system.

I was proud to fight for the emergency telehealth waivers that gave providers additional tools to make sure millions of Americans still receive and are receiving today the healthcare they needed. But this emergency will end, thank God. But many of these temporary waivers will end with it. And in my view, we should make this progress permanent to prevent a telehealth cliff, which would reverse the gains that we have made, and deny patients the telehealth services that they have grown to appreciate and rely upon. I have legislation that will do just that, and I look forward to working with my colleagues this Congress to make responsible, permanent changes.

So first, to Dr. Mehrotra, as we have heard today, obviously, telehealth isn't appropriate for every type of ailment or doctor visit, but it is uniquely positioned to make a huge difference in many others. One of those is in accessing mental health treatment. In a rural Appalachian district like mine, specialists such as counselors and psychiatrists could be perhaps hours away, and treatment can be out of reach. Telehealth could be a lifeline to someone headed down the path to a mental health crisis, and with prompt intervention a possible emergency room visit or worse could possibly be avoided.

So, Dr. Mehrotra, in your testimony you mentioned that telehealth can be used to prevent more costly care down the road. Can you outline why, in your view, it is so important to address issues early?

And can you provide some more examples on how telehealth could be used to achieve this?

Dr. MEHROTRA. Representative Johnson, thank you so much, and I just do want to emphasize what a key role telemedicine has played in rural communities. In some of our work prior to the pandemic we found that, in some rural communities, 30 to 40 percent of the visits for patients with serious mental illness were provided via telemedicine. This is, again, in the Medicare population before the pandemic. And certainly within the pandemic that rate has increased dramatically.

Though I will emphasize what Representative Craig—she cited one of our papers that, unfortunately, during the pandemic, rural patients, unfortunately, are using telemedicine at a lower rate than people in urban areas. So it has really flipped.

But your question, Representative Johnson, was more about how we can address, where we can address—if we can intervene early, how can we prevent downstream issues from coming on. And one area that I think is very promising, and I think Representative Eshoo had mentioned this previously, was in skilled nursing facilities, where we see that, if we can provide telemedicine coverage for after-hours coverage as well, it allows patients to be treated within the skilled nursing facility and not be transferred out to the local emergency department and be hospitalized.

And so it is helpful for people to stay within the facility, and it also saves money. So that is a really great example of where it can be quite cost effective.

Mr. JOHNSON. Well, good. Well, good. Well, your point about rural Americans being some of the lowest volume of telehealth

users, I think there is a really good reason for that, and that is why I want to go to Mr. Riccardi next.

If Americans don't have reliable broadband internet, our debate over payment models, state licensure, and permitted services won't be of any help to people that live in rural areas, low-income individuals who would benefit the most from telehealth services. So I agree with your testimony that closing the digital divide is essential.

So, as policymakers, why is it so important, as we consider permanent telehealth policy changes, that we also keep working to build adequate broadband infrastructure, especially in the midst of a global pandemic like this, when school work and healthcare have moved online?

Mr. RICCARDI. Thank you, Congressman Johnson. I think currently, as we consider expanding the Medicare telehealth benefit, that we also have to invest in the infrastructure to ensure that all communities have access to broadband and the technologies that they can use to receive care from home.

So, as we consider all of this, we—to revisit a point I shared earlier, I think it is important that we have a glide path in place to ensure that there is no disruption in care once this public health emergency ends. And, as we consider expanding the benefit, that we consider people living in the rural environment who have benefited from telehealth for many years but still lack the essential connectivity that is needed to maximize the capability of receiving care, and then also consider, you know, urban areas and, in particular, the necessity for beneficiaries in rural environments and in cities to receive care from home, as a supplement to in-person care.

So I think there is quite a bit of investment that needs to be made, both in the—in technology and then also in the expansion of the benefit.

Mr. JOHNSON. Well, thank you. Madam Chairwoman, thank you for the indulgence in letting that answer run a little over. Thanks for having me.

Ms. ESHOO. Oh, absolutely. Well, if we can go all day, what is a few more minutes here or there, right?

I would just add to this that, in the American Rescue Act, there is literally billions of dollars directed to build out broadband in our country. So everyone should know that. I mean, whether you support the whole bill or not, there is significant funding in it. And, of course, it is COVID-related. So I just wanted to add that.

So thank you, Mr. Johnson.

A wonderful new member of our committee, the gentlewoman from Texas, Mrs. Fletcher, you are recognized for 5 minutes for your questions.

Mrs. FLETCHER. Thank you, Chairwoman Eshoo, and thanks to you and Ranking Member Guthrie for holding this hearing on telehealth today. Thank you to all of the witnesses for sharing your insights, answering our questions.

As we have discussed throughout the day, the COVID–19 pandemic has drastically changed the way that we receive care. And I agree with my colleagues that telehealth is a silver lining of this experience. Even before the pandemic, providers in my community

were telling me how they were using and hoped to expand telehealth. And we have seen that in my district over the last year.

I want to touch on two issues in the time that I have.

First, another somewhat new area, and I believe it is following up on the pediatric issues that Dr. Schrier raised, and the issues that Ms. Craig raised. I heard from my constituents that the need for pediatric behavioral health is both enormous and growing. COVID has increased suicide rates, has created isolation from peers and access to adults like teachers and coaches and pediatricians who often help spot issues or provide help, and that telemedicine has really kept the lights on for mental health programs. So my constituents working in this area tell me that they have converted their evidence-based treatments to things that work for telemedicine.

Dr. Mahoney, I appreciated that in your written testimony you noted the importance of applying virtual care in all areas, including physical therapy and speech language pathology, and occupational therapy, which are very important in my district, as well, and something that I worked on at the beginning of the pandemic. These have been critical for my constituents. Can you speak a little bit to these behavioral health issues from your perspective, especially pediatric behavioral health issues?

And, while I understand it is a very complicated issue, the need or the possibility for reimbursement beyond Medicaid for behavioral health, telemedicine.

Dr. MAHONEY. Great. Well, thank you, Congresswoman Fletcher, for the excellent question and the attention to this important issue, particularly during this pandemic, when children are experiencing more isolation and often are overlooked and aren't able to get the most evidence-based treatments for their conditions.

And so what I would say related to reimbursement, this is primarily a question about Medicaid law, and sort of outside of, you know, my expertise. And I am happy to follow up in writing with a response.

But, in general, what I will say is that having the interstate restrictions waived has been beneficial in providing access to subspecialty services across State lines in order to address this demand for behavioral health services among our pediatric patients.

Mrs. FLETCHER. Thank you so much for that. And, on a slightly different topic, although it certainly applies to pediatric patients, as well, but, you know, even without the challenges of COVID–19, for people with disabilities or medical complexities, just getting to the doctor can be extremely burdensome on both the patient and the caregiver. And we have certainly heard about some of those challenges earlier today. I have heard a lot of stories from my constituents about how telehealth has really helped ease some of those burdens. Just the other day, I was on the phone with a constituent who has epilepsy and can't drive herself to the doctor, has limited access to transportation, and basically just lost her reliable transportation.

So, Mr. Riccardi, are there particular issues that we should be thinking about to ensure that more people with disabilities or complex medical conditions are able to access these services?

Mr. RICCARDI. Yes. And, you know, fortunately, the pandemic has allowed more people to access these services. And from, you know, our help line and our clients, we do see lack of transportation or access to facilities that meet ADA compliance as an issue.

So, as we consider moving forward with telehealth, we want to make sure that in-person facilities still are meeting these requirements and telehealth does not become the barrier for people with disabilities that may need followup care, in-person care.

And, as we know, people with chronic conditions have been able to receive services through the pandemic, e-visits, and others that we would like to see moving forward. But we must ensure that access to in-person care is both accessible and available.

Mrs. FLETCHER. Thank you so much, Mr. Riccardi. Thanks to all of you for your really insightful testimony today.

And Madam Chairwoman, thank you again for holding this hearing. I yield back.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure now to recognize another one of our wonderful Members that is waiving on today, the gentleman from Indiana, Mr. Pence.

You are recognized for 5 minutes for your questions.

Mr. PENCE. Well, thank you, Chair Eshoo. I haven't been called wonderful for quite some time. And thank you, Ranking Member Guthrie, for holding this hearing. And thank you to the witnesses for appearing before us today to discuss the advantages of telehealth technologies during the COVID–19 pandemic and beyond.

In rural districts like my Indiana 6th district, telehealth expansion during the pandemic has been a game changer. Countless Hoosiers have benefited from the convenience of services that remotely connect patients to doctors, specialists, and other healthcare professionals, all from the comfort of their own home. Throughout the pandemic, telehealth proved that it can provide high-quality, patient-centered care that in many instances mirrors the type of care received in person.

Under President Trump's leadership, flexibility in telehealth services allowed physicians to stretch their resources to meet the diverse needs of disparate communities, quite often 2 hours away from healthcare, as mentioned earlier in the hearing today.

In Indiana's 6th district, two hospital systems received funding under the FCC's COVID–19 telehealth program to service patients' needs with innovative methods of care. Hancock Regional Hospital in Greenfield used these grants to develop a portable camera system for COVID–19-infected patients to connect with infectious disease experts located at neighboring hospital systems.

Beyond the pandemic, the telehealth services will play a key role in addressing barriers to care for rural patients, especially those that suffer from mobility issues or patients with chronic conditions. It is important to recognize, however, that these services are rendered useless for Hoosiers and all Americans that sit on the wrong side of the digital divide, which covers a large portion of my district. Innovative models of care will not overcome inadequate internet connections.

Further, as this committee develops solutions to the future development of telehealth technologies, we must remain cognizant of the

challenges of wasteful spending and fraudulent claims that will strain an already bloated healthcare system.

Dr. Mehrotra, I understand that there are certain conditions such as movement disorders which require in-person interactions to properly diagnose and treat. In your testimony, you also mentioned the limitation of telemedicine visits for things like ear infections for infants. This is especially difficult for patients in rural America with limited access to resources. Doctor, can you expand more on how we could blend telehealth services into traditional care to better impact rural America and patients with chronic healthcare conditions?

Dr. MEHROTRA. Well, thank you very much for the question, Representative Pence. And I might highlight something before I turn to your question directly. I do want to emphasize something that you brought up earlier in your testimony, when you discussed the health systems in your area using telemedicine.

We are also seeing a lot of, in rural communities, telemedicine used in emergency departments to try to facilitate specialty care being provided within those communities. And the one thing I wanted to emphasize there that I am concerned about is, while we have evidence that that telemedicine used in emergency departments is effective, the smallest and most rural hospitals are the least likely to have that technology. And so it is a real barrier there. So how do we make sure that those hospitals have that technology?

In regards to your question more directly related to how do we incorporate telemedicine care into rural communities, I think one of the points that we made earlier in the conversation is how do we allow patients in rural communities to access the care from anywhere else in the country.

And I think we heard a story of how, in many cases, patients in rural communities don't—it is not someone within the State of Indiana, for example, but is in many States away. And so we talk a lot about licensure, and being such a critical reform to try to allow patients in rural communities to access the care that they need.

Mr. PENCE. OK, thank you.

And thank you for letting me come on, Madam Chair. I yield back.

Ms. ESHOO. The gentleman yields back.

You are always welcome at the subcommittee.

And now, last but not least, the gentleman from Arizona, Mr. O'Halleran, who is also waiving on today.

I do believe you are the last one.

And thank you to the witnesses for this long hearing. But Mr. O'Halleran is worth hearing from, and then we will have a few closing business things to do.

Mr. O'Halleran, you have 5 minutes to question.

Mr. O'HALLERAN. Well, thank you, Madam Chair, for letting me waive on. I always appreciate being last, if I can speak, so I appreciate that very much.

You know, this committee is made up of individuals across the whole spectrum of political thought, but they all care about one thing, that is the health of the citizens of our Nation.

The COVID–19 pandemic has finally forced Congress—and I mean forced us—to look at HHS and CMS to rapidly address some of the issues regarding telehealth.

One of the most significant issues in administering telehealth in rural America is the lack of specialists and, for that matter, just plain lack of doctors, lack of nurses, lack of health professionals that we need.

Nothing I am going to say is going to be—and talk about—is new to any of you. It is just, why is it still an issue in our country, this great country, decade after decade after decade?

It shouldn't be this way. Our citizens are not expendable. We are all—should be treated equally in healthcare also. And we have to make these temporary changes, those that are adaptable, permanent.

My district—why I am so passionate about this is that my district is larger than the State of Illinois. It is 58,000 square miles. And so we have got a little bit of room there. And I have the same amount, plus or minus, of any other congressperson here.

I have been working on telehealth issues since I was in the legislature 20 years ago. And changes have gone in the right direction, but not fast.

I have 12 Tribes in the district, and they include some of the largest Tribal lands in the Nation: the Navajo, the Hopi, the White Mountain Apache, some in the San Carlos. These are Tribes with larger land masses than many of the States in this country.

I go to different areas with Meals on Wheels to make sure I get out there and talk—and actually talk to people, not just deliver the food, but see the conditions they live in, talk to them about what their issues are. It always gets back to healthcare, and it always gets back to not only affordability but the ability to even get care in a way that they can get to the doctor that is even nearby. That is wrong. We have to do something differently about that, and telemedicine is only a piece of that puzzle.

The disparities even in urban communities is a problem in this country, and we have to address those issues.

The CMS issues that are critical to being able to get reimbursements at the appropriate level are critical in this process.

Rural doctors. I mean, I just watched a caravan going out of rural America, not coming into rural America, and we have to do that. That is critical, to be able to address the issues that we just got done talking about. How do we tell somebody on a telemedicine thing to come on down, come on down, we will see you down at the VA, or we will see you down at the center, down in—or whatever, and it is a 5-hour trip one way and they can't afford to stay at a hospital. They need healthcare, they need it now, they need to talk to that specialist. If it is not a physical examination, then to be able to go over their medications and stuff. And that is not always available. I can't tell you how many homes I am in where there is no such thing as a computer in those homes.

And the need for additional technology, we shouldn't be—broadband is something we all want to work on, but we can't work out to—and thinking about it today. We have to think about it tomorrow, where the technology is going, and have the capacity and speed in which to do that.

And so I just—I want to end there with my comments, but I do have a question for—let's see where it is at—Dr. Resneck, and I will get to the short end of it.

Without access to high-speed broadband, are there certain specialists who may be difficult to see, treatments that may be more difficult to obtain because of these—Americans lack high speed broadband?

And what is the future with broadband, as far as bringing care to people and us being able to adapt to it in the appropriate way?

Dr. RESNECK. Thank you for all of your comments. You brought up a lot of outstanding issues, Congressman.

And yes, but there is not just a specialty. I mean, there are certain things that require more bandwidth than others. But I would say all of us and all of our patients need the option to be able to communicate with us electronically, and that requires broadband access.

But I am optimistic. I am optimistic that you all are going to help solve the Medicare rules problem that we will be facing after the pandemic. And I am optimistic that, as a result, for rural populations like yours, telehealth will be a big part of the answer so that people's life expectancies and their health are not so heavily determined by the ZIP code that they live in, by their race, ethnicity. I think we are going to make big progress, and I think telehealth is going to be a part of it. And I agree, we need broadband to be part of it too.

Mr. O'HALLERAN. So thank you very much.

And, Madam Chair, I thank you for the time over which you allowed me to go. Thank you.

Ms. ESHOO. You waited a long time to speak. So, as I said earlier to another Member, a couple of minutes here, a couple of minutes there—a lot of chairmen have cut me off in the middle of a sentence over 28 years, so I find myself being generous as a result of that.

And we have one more Member to recognize. We are glad to see him. And he is the gentleman from Maryland, Mr. Sarbanes. I—he has been probably on the floor the better part of today.

So we are glad you made it to our subcommittee hearing, and you are recognized for your 5 minutes of questions.

Mr. SARBANES. Thanks very much, Madam Chair. I appreciate it. And I appreciate you holding this very important hearing.

We have been hearing from many constituents and provider groups in my district—and I know this is the case for my colleagues—about how much of a benefit telehealth can offer, particularly during this terrible pandemic that we are facing. It allows continued access to medical care for patients while protecting the health of both the patients and the medical staff that are serving them. So it makes eminent sense.

We know that we took steps to greatly expand telehealth under the CARES Act, which now allows federally qualified health centers and rural health clinics to utilize those services under Medicare. And that is the case across the country.

But in Maryland, there's places like school-based health centers that still can't use telehealth to access their student populations. And we know that school-based health centers provide high-qual-

ity, comprehensive primary healthcare, mental health services, preventive care, social services, and youth development to primarily low-income children and adolescents across the Nation. And they play a critical role in helping to reach underserved populations and to achieve health equity.

I will note that the Maryland State Senate actually recently passed a bill that would allow school-based health centers to provide their services via telehealth. In Congress I think we should be looking at similar kinds of things to make sure that that opportunity is available.

Dr. Resneck, how has the experience in telehealth services helped doctors and medical staff reach younger patients, particularly underserved populations? And what opportunities do you see to broaden access that can benefit those populations?

Dr. RESNECK. Yes, I have seen this improvement at both ends of the spectrum. It is younger patients, as well. We have a lot of pediatric dermatologists on our team here, and you know, the issue is getting them into the office. Again, it doubles up. You have got them out of school, you have got a parent who has to potentially miss work. You have got transportation issues to get into the clinic. All those things are still true for kids, and sometimes—and in some instances are actually multiplied for kids.

So the other thing is just in terms of social distancing with COVID. Sometimes in pediatric visits we have got a kid, family member, medical student, multiple people in the room. It makes social distancing even more difficult. So very important that those in-person visits still be available to kids, when they are appropriate, and very important to have that telehealth tool as an option, as well.

Mr. SARBANES. Thanks very much.

Dr. Mehrotra——

Dr. MAHONEY. I am sorry, Congressman Sarbanes, can I just add a comment about school-based——

Mr. SARBANES. Yes, sure.

Dr. MAHONEY. OK, thank you. So, yes, I just wanted to, you know, just amplify that point, that school-based health centers have the potential to significantly improve telehealth access to children, because it helps us overcome this broadband device issue, whereas some children would not be able to have access to telehealth, and in the school-based systems they would have access.

And so we have been working at Stanford with schools for one-off family needs. But it would be tremendously helpful to be able to expand that, of course, as a Medicaid issue. But I just wanted to add that comment. Thank you.

Mr. SARBANES. No, that is an extremely valuable perspective to offer.

I have got about a minute left. Dr. Mehrotra, maybe you could just—and this may have been covered already, or talked about, but give us your thoughts on what telehealth is going to look like on the other side of the pandemic. Because, obviously, the radical change here and expansion of it in the midst of the pandemic, I think, is probably creating a new foundational level of the access to it postpandemic. So can you just give us some quick thoughts on that?

Dr. MEHROTRA. Yes. Well, I couldn't resist, but I will just make a very quick comment on the school-based health centers, that we also see that it allows teachers to get involved with things like attention deficit disorder. So it is really another value, a key person in a child's life.

But, in terms of postpandemic, one of the ideas that has come up and I think maybe bears emphasizing in terms of where telehealth is going is that we are seeing new models of care which really push our boundaries on what is a visit. And what I mean by that is such as these tele-endocrinology providers, where they have continuous glucose monitoring 24 hours a day, 7 days a week, and they are sending messages to patients several times a day—"Adjust your insulin. How are you doing on your diet?"—and I think these new models of care, which kind of come under remote patient monitoring, are where we are headed post the pandemic, but also really complicate how does the Medicare program or any other payer pay for a visit.

Mr. SARBANES. Thank you.

We have got our work cut out for us, Madam Chair. I yield back.

Ms. ESHOO. The gentleman yields back.

Well, we don't have any other Members at this point that are coming in to speak.

I just wanted to give the exact amount for broadband in the American Rescue Act. It is $7 billion, with a B. That is going to go a long way, because, regardless of what side of the aisle or what part of the country, Members have spoken over and over and over again the need for broadband, because that is the platform that telehealth really rests on. If we don't have that, there isn't any telehealth.

I want to thank each one of the witnesses. You have been extraordinary. I think this is one of the best hearings we have ever had. And I think one of the reasons for that is that each one of you is superb. But you also spoke very directly to the American people. Whatever question members asked, you actually answered the questions. And that is so welcome. So for 4½ hours, you have met with and answered the questions of 36 Members of Congress. You saw firsthand that each and every Member really cares very deeply about this issue and that it is thoroughly bipartisan.

So that gives me great hope, together with each one of you being such a great source of, you know, of not only professional advice, but being such a great source of intellect for us. And we will continue drawing from you. I would like to see one bill, one bill that is comprehensive, and we will keep working with you so that the bill that we come up with really speaks to not only this moment in time but that it is so durable that it will really speak to the future beyond, God willing, this pandemic.

So I can't thank the witnesses enough. Dr. Mahoney, Dr. Mehrotra, Elizabeth Mitchell, Dr. Resneck, and Frederic Riccardi, you have just been outstanding.

Now I would like to make a unanimous consent request to enter into the record documents. And I want to ask my friend, the ranking member, Mr. Guthrie, if you would consent to my request that we place these in the record. There are 50. And if you would consent, then you don't have to listen to me reading 50——

Mr. GUTHRIE. You have my—I consent. I consent——

Ms. ESHOO. They are all important, but——

Mr. GUTHRIE. You have my consent.

Ms. ESHOO [continuing]. Thank you very much. Thank you.

[The information appears at the conclusion of the hearing.]

Ms. ESHOO. And so these will all be made part of the record. Any of the organizations or individuals who are listening in, thank you for submitting something for the record.

So, with that, I thank the ranking member too. Four and a half hours, it is a long time. But you know what? I think every minute was worth it. And I hope that you all feel that way, as well. If we can get this done and done well, we will have made a major contribution with your extraordinary help and in our day and our time for the American people.

So, with that, we will adjourn the subcommittee hearing for today, and everyone stay well. We need you. Thank you.

[Whereupon, at 2:56 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Employers on Telehealth: Government Standing in the Way

Remove antiquated, counterproductive rules to unleash real markets, better care, and greater coverage via telemedicine

Statement for the Record by
The ERISA Industry Committee (ERIC) to the
U.S. House of Representatives
Committee on Energy & Commerce (E&C), Subcommittee on Health

Hearing:

"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

March 2, 2021

Introduction and About The ERISA Industry Committee

Chairman Pallone, Ranking Member McMorris Rodgers, and members of the Committee, thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled, "*The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care*." Our key finding is that, while telehealth is one of the only areas in health care with a vibrant, functioning market addressing physical and mental health needs, that market is severely curtailed by government rules, and some of the special interest proposals in Congress would go in the exact wrong direction. We have included our top three recommendations to improve telehealth for private-sector workers and their families.

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. ERIC's member companies voluntarily provide benefits that cover millions of active and retired workers and their families across the country. With member companies that are leaders in every sector of the economy, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA's protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

You are likely to engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

ERIC's member companies have been pioneers in offering robust telehealth benefits. Telehealth enables our beneficiaries to obtain the care they need, when and where they need it, affordably and conveniently. It reduces the need to leave home or work and risk infection at a physician's office, provides a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages, especially related to mental health, and improve choice and competition in health care. Nearly every ERIC member company offers comprehensive telehealth benefits and did so long before the COVID pandemic. As in most aspects of health insurance and value-driven plan design, self-insured employers have been the early adopters and drivers of telehealth expansion. With the onset of the pandemic, ERIC's member companies led the way in rolling out telehealth improvements – held back only by various federal and state government barriers.

**Federal Actions Greatly Improve Telehealth for Medicare Beneficiaries…
and Leave the Private Sector Behind**

Early on in the pandemic, the Administration and Congress quickly realized that unnecessary barriers to telehealth care would be a significant problem for Medicare beneficiaries. Many of those individuals were quarantined or in areas undergoing lockdowns. Many were in different states and regions that were experiencing peaks in hospital and provider capacity. And Medicare's own coverage of telehealth was nowhere near broad enough to replace much of the care that would otherwise be foregone due to medical facilities being closed to non-COVID patients.

The Administration and Congress acted quickly and decisively:

- Medicare promptly eliminated state licensure barriers, allowing a willing and qualified provider to see a willing Medicare patient via telehealth, without regard to their locations;
- Medicare promptly eliminated state telehealth barriers, such as requirements that patients travel to specific originating sites before they can access telehealth, limitations related to modality (video-only requirements, etc.), requirements that the provider and patient have a pre-existing relationship, and more; and
- Medicare expanded coverage to include more services for more patients, covered via telehealth.

These changes massively improved telehealth benefits for Medicare beneficiaries, instantly unleashing telehealth's vast potential to fill the voids created by the pandemic and its response – and paving the way for permanent improvement. In fact, in a December 4, 2020 letter, 49 Congressional leaders called for making these changes permanent. While ERIC members are primarily outside of the Medicare system, we support making these Medicare improvements permanent. Medicare's embrace of telehealth is a boon to private sector patients, because it advances the creation of infrastructure, the adoption of telehealth by more providers, and provides proof that telehealth expansion can produce better access to care and savings.

Unfortunately, very few improvements have been made for patients in the private sector not covered by Medicare, despite employer efforts to expand and improve telehealth. For private-sector patients:

Care is still limited in many states only to a patient and provider both physically located in that state. Many states have failed to join interstate medical licensing compacts that provide reciprocity for mental health and other medical providers in other states, expanding the network of available providers for state beneficiaries to access. Congress waived these requirements for Medicare and should do the same for private sector beneficiaries or otherwise effectuate interstate licensing. While some states have signed limited interstate reciprocity compacts, to recognize limited practice by limited types of providers, many have provided little or no licensure relief. Perhaps most troubling, the number of states that have enacted temporary licensure relief is actually on a downward trend, as the COVID pandemic begins to subside and states return to their previous policies.

Restrictive licensure rules help some providers by essentially outlawing competition from out-of-state, but it hinders other providers from expanding their practice. The failure to recognize interstate medical licensure reciprocity for telehealth means that for many patients, the state government has banned them from logging on to their computer or smartphone and connecting with a readily available and qualified provider.

Many states still impose unnecessary barriers to the use of telemedicine. These barriers can range from requiring that a patient travel to a specific telehealth site before they can connect to a provider, limiting telehealth to specific technologies (for instance, requiring two-way video, which may be out of reach by those in rural or other areas without broadband access or the sophistication to work it, outlawing the use of "portals" and store-and-forward communications particularly helpful to identify skin conditions, pink eye, etc.), mandating that a patient can only do a telehealth visit with a doctor they already have a relationship with, and other barriers. While these barriers may be imposed under the guise of setting a standard of care or protecting patients, these requirements really serve to stymie telehealth, driving more care to (more expensive) in-person settings and preventing wider telehealth adoption.

These restrictions also have significant equity impact, creating barriers that disproportionately affect low-income populations and persons of color. At the same time, they serve to protect profits for high-income professions.

Rules imposed by the federal government prevent employers from offering telehealth to many beneficiaries. Employers cannot offer telehealth as an employee benefit, separate from health coverage, because telehealth benefits are deemed to be "a plan" for the purposes of the Affordable Care Act (ACA) rules. This determination requires telehealth benefits to be paired with a full medical benefit that meets all of the different ACA requirements – 1st-dollar coverage of vaccines, essential health benefits and annual limit rules, and much more. Because telehealth is, by definition, limited and conducted remotely, it simply cannot meet all of the ACA requirements on its own. In fact, employers often use a separate vendor to design and administer their telehealth benefits, rather than the insurance company or third-party administrator that operates their full medical plan. The result is that telehealth cannot be offered as a standalone to anyone not enrolled in the full medical plan, which effectively bans employers from extending telehealth to all populations, including:

- Full-time employees who are not enrolled in the medical plan, or employees' family members, if the employee is on a self-only plan;
- Part-time employees ineligible for the medical benefit;
- Seasonal, agricultural, or other temporary workers;
- Interns, trainees, and the like; and,
- New employees on a waiting period for the full medical plan, among others.

ERIC notes that this is a serious anomaly – perhaps the first time in living memory that beneficiaries of government programs have more access, more flexibility, and in some ways, better benefits than private sector workers on employer-sponsored plans. Employers are generally the pioneers in health benefits, experimenting with and leading the way in driving value, innovation, quality, and flexibility for patients. ***Now, because of government barriers, private sector workers are being left behind.***

On June 23rd, 2020, the Department of Labor issued a Frequently Asked Question (FAQ Part 43) that for the first time, allowed employers to expand standalone telehealth offerings, but with two key debilitating restrictions:

(1) Standalone telehealth may ***only*** be offered to individuals ***ineligible for the full medical/surgical benefit***; and

(2) Standalone telehealth may be offered to these individuals ***only until the end of the public health emergency***.

While this FAQ was a step in the right direction, it unfortunately leaves a number of potential beneficiary cohorts behind (again, younger workers and those of less economic means are hardest hit), while the temporary nature served as a significant disincentive for large employers to implement a major benefit change. **It is critical Congress make permanent the allowance to offer standalone telehealth benefits, and expand the offering to *unenrolled* individuals, in addition to just those who are *ineligible*.**

We will note one considerable improvement in telehealth that Congress has made for private sector workers: individuals enrolled in a high-deductible health plan (HDHP) with a health savings account (HSA) can now benefit from 1st-dollar coverage of telehealth, thanks to the enactment of the "Telehealth Expansion Act" (S. 3539) by Senator Steve Daines (R-MT), which was passed into law as part of the CARES Act (H.R. 748). Unfortunately, this telehealth improvement is time-limited and set to expire at the end of 2021. **We urge Congress to make 1st-dollar coverage of telehealth permanent so that workers in these plans can receive the care they need.**

Key Steps the E&C Committee Should Consider to Improve Telehealth

The solutions to many of these problems are within the E&C Committee's jurisdiction, and employers look forward to continuing to provide technical assistance to Congress to implement solutions. We urge the Committee to advance provisions to address each of these barriers to care for private sector workers and put them on equal footing with Medicare beneficiaries.

First, Congress should pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (H.R. 708) and enable providers to practice telehealth across state lines during the COVID-19 pandemic. Telehealth use has drastically increased over the past year, and some state licensing restrictions continue to disrupt patients' care. The TREAT Act would provide temporary state licensing reciprocity for all licensed and certified practitioners or professionals (those who treat physical and mental health conditions) in all states for all types of services (in-person and telehealth) during the COVID-19 Public Health Emergency. A provider who has achieved a medical license in their own state should be permitted to practice on the internet, without states blocking them from seeing patients – and likewise, a patient who goes online to see a doctor should not be prevented by state rules from seeing a qualified provider who is licensed in another state. States should retain their rights to determine whether providers licensed in that state will be qualified to write prescriptions or otherwise develop a scope of practice. However, if a provider in another state has been deemed qualified, a state should not be permitted to prevent patients from seeing that provider or prevent the provider from operating to the fullest extent of their license in that interaction. For example, not allowing a qualified provider to prescribe medication during a medical visit or discuss treatment options during a mental health visit.

Immediate action should be taken to ensure that patients who use telehealth for physical and mental health services will have the best chance of finding a provider ready and willing to see them on the other end during the public health emergency. Mental health care providers prior to the pandemic were difficult to access, especially for those not living in urban cities. More than sixty percent of rural Americans live in mental health professional shortage areas, and the need for care has only been exacerbated during the COVID-19 pandemic. Congress' immediate action will enable more competition and access in telehealth, creating incentives for providers to improve quality and affordable access for patients. At a time when 40 million Americans have lost their jobs, relief for patients is sorely needed in offering mental health care services through telehealth.

In the longer term, ***we urge Congress to enact a permanent solution to interstate licensure***. While this will require addressing some thorny questions, we have seen significant leadership in the past with respect to the issue. For instance, in a previous Congress, Chairman Pallone introduced the TELE-MED Act to permanently allow interstate practice for Medicare providers. Congress previously fixed this issue in the realm of sports medicine as well. While there are different possible paths forward (national reciprocity, a national license, one comprehensive interstate compact with financial incentives for states), employers urge Congress to work through this challenge and come to consensus on a solution.

Second, Congress should establish a simple set of federal standards for telehealth, eliminating state barriers. We can think of no better example of interstate commerce than a willing doctor and willing patient connecting electronically via the internet to do a telehealth visit. While it is entirely appropriate for a state to place standards to regulate the practice of medicine at brick-and-mortar medical facilities within the state's geographic boundaries, it makes little sense to have 50 different rules for telehealth (practiced remotely on the internet or via phone) depending on where a provider or patient may be located at any given moment.

Congress can also develop a set of rules that protect patients while maximizing flexibility and care, rather than some of the current protectionist rules that serve to block patients from care on the state level. The new set of rules should:

- Allow telehealth to establish a patient-provider relationship through an initial telehealth visit;
- Apply the same medical standard of care used for in-person to telehealth visits;
- Ensure that reimbursement is privately negotiated between providers and payers;
- Encourage interstate practice among providers
- Promote continuity of care by encouraging telehealth providers to coordinate with a patient's primary care provider;
- Implement "technology-neutral" rules for telehealth, to "future-proof" rules for advances in technology and best practices, and eliminate discrimination for patients who may not have access to broadband internet;
- Eliminate all "originating site" requirements that arbitrarily limit patient access to telehealth;
- Preserve the same informed consent requirements for patients in telehealth that apply in person; and
- Ensure that telehealth providers may prescribe medication to patients with reasonable limits.

This simple, streamlined set of rules will provide clarity to providers and maximize access for patients.

Third, Congress should designate standalone telehealth as an "excepted benefit" so that it can be offered to more patients. This is the way Congress treats other "add-on" benefits like vision, dental, long-term care, cancer-only plans, hospital indemnity insurance, and other benefits that are health-related but do not constitute a full medical plan. It would be a simple change by adding the word "telehealth" into the appropriate sections of the Health Information Portability and Accountability Act (HIPAA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC).

Doing so would not affect an employer's responsibility to offer minimum essential coverage to employees, nor would it weaken an individual's responsibility to enroll in such. Employers or insurers could not swap out telehealth, which is limited in scope and closer to a supplement than a full medical plan, for a full medical benefit. It would simply open up employers' ability to offer telehealth benefits to millions of patients who currently are not allowed – by Congress – to access those benefits. There is precedent for Congress expanding the definition of excepted benefits (e.g., Congress previously acted to allow "limited duration long term care" benefits to be offered outside a medical plan).

In a recent survey, more than 25 percent of ERIC member companies stated that they would expand telehealth offerings if Congress permitted it to be offered as a standalone benefit. This represents billions of dollars in private sector money that is currently being left on the table, and millions of Americans who could have access to telehealth coverage and care, if only the government would get out of the way. Many ERIC member companies are currently taking advantage of the DOL FAQ allowing limited telehealth expansion, but action by Congress could greatly increase these numbers, and thus, greatly increase patients' access to care.

Counterproductive, Protectionist, Anti-Market Proposals:
Worse Than Doing Nothing

Meanwhile, some stakeholders are asking Congress to implement telehealth changes that would go in the exact opposite direction, eliminating competitive markets, promoting low-value care, and reducing the potential for telehealth to be transformational for the medical system.

For instance, the "*Health Care at Home Act*" would mandate ERISA health plans to cover telehealth for any service that is covered in person, as well as mandate that telehealth services be reimbursed at the same amount as in-person services. Both of these changes fail to expand and improve telehealth and instead would uproot the blossoming market.

Large employers that offer health coverage through ERISA plans make decisions on services to cover based on clinical guidelines, evidence, and best practices. We learn from experience, advice from medical professional societies, bodies that evaluate quality and efficiency in health care, and other sources, and then use this information to develop benefits that drive the most value for our beneficiaries. The prospect of government imposition of a sweeping coverage mandate within ERISA plans would be an extreme break from precedent, not to mention a counterproductive endeavor that would inject more unproven and potentially low-value care into employer-sponsored coverage. This, in turn, would reduce the quality of coverage, while increasing costs for participants. It should be the responsibility of ERISA plan sponsors, not the government, to determine what care is appropriate to cover via telehealth settings.

Under current law, providers are free to negotiate telemedicine rates with payers – which has given rise to a thriving market in which competition drives cost efficiency, value, quality, and innovation. So, it should come as no surprise that certain provider groups are eager to destroy this market and instead set reimbursement by government fiat. It is wholly inappropriate and unprecedented for the federal government to mandate payment rates between two private parties.

Further, telehealth is cheaper than in-person care. Telehealth enables providers to treat more patients more efficiently, with less overhead cost, less staff needed, and fewer expenses associated with operating brick-and-mortar retail health settings. This has enabled telehealth providers to offer more competitive rates than in-person, which has been in no small part responsible for the telehealth renaissance. This has caused many employers to adopt and offer telehealth benefits long before the COVID emergency and driven the continuing exploration and innovation that serves to produce ongoing improvements for patients. Losing this successful competitive market would be a significant setback for patients and employers, and ultimately for up-and-coming providers who otherwise could cultivate opportunities in the telehealth space.

Conclusion

Thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to working with Congress to expand and improve telehealth for millions of patients in the private sector, and to defeat proposals that would impose government mandates that make the situation worse, not better. We look forward to working with you to develop and perfect telehealth proposals that can be passed in Congress and signed into law by President Biden.

BLUE PERSPECTIVE
MARCH 2021

BlueCross BlueShield Association

EXPANDING ACCESS TO CARE THROUGH TELEHEALTH DURING COVID-19 AND BEYOND

The Blue Cross Blue Shield Association (BCBSA) strongly supports the use of innovative technologies, including telehealth, to expand consumer access to care when and where they need it. Blue Cross and Blue Shield (BCBS) companies are leading the effort to realize the promise of telehealth to improve health care access, reduce costs and promote positive health outcomes.

KEY FACTS

SINCE MARCH 2020, BCBS COMPANIES have expanded access and coverage for telehealth.

To date, BCBS companies have **COLLECTIVELY COMMITTED OVER $7 BILLION TO FIGHT THE COVID-19 PANDEMIC.**

BCBSA RECOMMENDS

As policymakers consider new laws and regulations around telehealth, BCBSA recommends a thoughtful approach to permanent telehealth expansion with a focus on flexibility in coverage to provide the care needs of each community, while enhancing trust and consumer protection against fraud and abuse through HIPAA-aligned privacy protections. To achieve these goals, we recommend that policymakers incorporate the following set of principles as a guiding framework:

1. ENSURE ACCESS AND EFFICIENCY

Improved access to care for patients and increased efficiency for providers and health plans should be underlying goals of all telehealth policies. Plans should be empowered — not mandated — to use technologies like telehealth to expand access to their members. We support efforts by state and federal agencies to remove arbitrary restrictions that dictate how, when and where a provider can treat patients, including geographic and originating site requirements which are not evidence-based or have no impact on quality of care. We also support increased investment in broadband and telehealth infrastructure to connect rural and underserved communities.

2. PROVIDE FLEXIBILITY

Telehealth and other health care policies should strive for maximum flexibility and cost efficiency and, therefore, should not impose coverage or payment mandates. While some health plans have provided payment at parity with in-person visits during the COVID-19 emergency to support health care providers, we should leverage technology to drive cost efficiencies (i.e., less overhead for office space, staff, time, etc.) once the public health emergency is lifted. Competition to provide better quality and more efficient care through the use of telehealth should be encouraged to help reduce costs.

3. MAKE CONSUMER PROTECTION AND TRUST PARAMOUNT

Consumer protection must be paramount to enhance quality and patient safety while expanding telehealth. The regulatory framework for telehealth must assure HIPAA-aligned privacy protections and provide guardrails against fraud and abuse. This will facilitate trust and open communications between the provider and the patient receiving care.

The Blue Cross Blue Shield Association is a national federation of 36 independent, community-based and locally-operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one-in-three Americans. To learn more about how BCBSA is advocating to improve healthcare for all Americans, please visit www.bcbsprogresshealth.com.

ISSUED ON 3/2021

BCBSPROGRESSHEALTH.com
FOLLOW US | @BCBSProgress

March 1, 2021

The Honorable Anna Eshoo
Chair
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Eshoo, Ranking Member Guthrie, and Members of the Subcommittee on Health:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona for over 35 years. I would like to thank the Subcommittee on Health for convening a hearing on Tuesday, March 2, 2021 on "The Future of Telehealth: How COVID-19 is Changing The Delivery of Virtual Care." I appreciate this opportunity to provide my perspective, as a health care practitioner and policy analyst, to assist this panel in its assessment of existing policies regarding virtual care, with the goal of improving readiness as well as access to health care before, during, and after the next public health emergency.

The social distancing measures required to address the COVID-19 pandemic led to a newfound appreciation for the use of telemedicine, a technological advance that has been available for several decades.[1] Teleradiology, for example, which taps the skills of the world's experts in diagnostic imaging, has been in use since the beginning of this century.[2] Yet telehealth has only begun to receive the attention it deserves with the advent of the COVID-19 pandemic.

As emergency measures, most states' governors temporarily suspended the requirement that telehealth services can only be provided by practitioners licensed by their states. As a public health emergency measure, the Centers for Medicare and Medicaid Services, for the first time, began paying providers for telehealth services even if they were provided by practitioners licensed by states outside of the state in which the beneficiaries received care. CMS expanded on the list of telehealth services covered and made the policy permanent in December 2020.[3]

Last week Senator Brian Schatz (D-HI), Senator Jeanne Shaheen (D-NH), and Senator Tim Scott (R-SC) re-introduced the *Telehealth Modernization Act*, which would codify and expand telehealth coverage for seniors in the Medicare program.[4] While this is a step in the right direction, it doesn't address the major obstacle blocking all patients—Medicare and non-Medicare—from this great technological advance in 21st Century medicine: state licensing laws prohibit patients from receiving care from health care practitioners licensed out of state. While many states have temporarily suspended these laws for the duration of the public health emergency, the barriers will return to their status quo ante position when the emergency ends.[5]

A return to the status quo ante means a person can travel from, say, Phoenix, Arizona to Los Angeles, California to consult with and receive care from a renowned expert in some unique medical condition, but cannot do telehealth follow up visits with that practitioner unless that practitioner obtains a license in Arizona. In other words, a patient may travel to a doctor, but the doctor may not travel to the patient. *The fact that Medicare would pay the doctor for the out-of-state services does not help matters if the doctor is not allowed to provide the services.*

To the extent consistent with its authority to tear down barriers to interstate commerce under Article 1, Section 8 of the Constitution, Congress should define the "locus of care" as the state in which the practitioner is located as opposed to the state in which the consumer of the service resides. While states have constitutional authority to regulate the practice of medicine for residents within their borders, crossing state lines to provide telemedicine or short-term in-person care can reasonably be classified as interstate commerce.[6]

This change would increase access to care and allow patients to utilize expertise that may exist in areas of the country otherwise beyond their reach. It would also remove the protection from out-of-state competitors that health care providers otherwise enjoy. The increased competition would redound to the benefit of patients.

Congress can and should also apply this definition of the "locus of care" to practitioners licensed in one state who provide short-term in-person care in a state where they do not have a permanent location. Examples of providers to whom such an act would apply include those who usually work through agencies to provide care during short, temporary stints in medically underserved areas, those located very close to the border of a neighboring state, and out-of-state experts in rare and specialized medical conditions brought in to consult and help manage a fragile patient unstable for transfer. These examples are analogous to telemedicine practice.

Possessing an out-of-state license would not automatically enable a health care provider to practice at any health care facility within a new state. Health care facilities perform their own due diligence in vetting and credentialing health care staff applicants. The same vetting process could just as easily be performed on an applicant for staff privileges who is licensed in another state. That happens now when a provider relocates from another state after obtaining a license in the new state.

Defining the locus of care as the state in which a health care practitioner is licensed would make it easier for *locum tenens* ("fill in") providers and out-of-state specialists to provide itinerant temporary health services to remote and underserved communities, free from the burden of licensing applications and fees in the several states where these communities reside. In the event that a practitioner establishes an office within a state, the practitioner would then become subject to applicable state-based practitioner licensing laws.

Some states are not waiting for Congress to act. Arizona is currently considering legislation that would make it the first state to allow its patients to receive telehealth services from health care practitioners licensed in any of the other states and the District of Columbia.[7]

They would be subject to the laws governing the health care professions of the state of Arizona, as well as review and disciplinary action by the relevant professional licensing boards of the state of Arizona. Liability cases would be heard in Arizona courts and would be subject to Arizona liability law. In announcing his support of the legislation, Arizona Governor Doug Ducey stated:

> *A person who is visiting a family here or spends the winter here should be able to reach their doctor in their home state by telemedicine. A family in Mohave County who utilizes a hospital in Las Vegas, Nevada should be able to get follow up care via telemedicine. Today, someone who has the means to travel to a consultation with a specialist in another state can do so. Specialty doctors should not only be accessible via an expensive flight and hotel stay. If a specialty provider is willing to do a consult via telehealth, Arizona patients should have easy access to those services without unnecessary travel expenses and Arizona is going to lead the way.* ***If it's safe and it works during a pandemic, we should embrace it when we're not in an emergency as well.*** (Emphasis added.)[8]

While actions by the states to break down the barriers to telehealth are laudable, a state-by-state approach will take a great deal of time. And telehealth technology is ready to bring to patients now. Until state licensing obstacles are removed, the growth of this wonderful technology will remain stunted. And patients—not health care providers—will be the biggest losers.

Congress can act now to remove those barriers by exercising its constitutionally authorized powers to regulate commerce "among the several states" and define the "locus of care" as the state in which the practitioner is licensed.

Respectfully submitted,

Jeffrey A. Singer, MD, FACS
Senior Fellow
Department of Health Policy Studies
Cato Institute

[1] https://www.ncbi.nlm.nih.gov/books/NBK45445/
[2] https://www.cnn.com/2004/HEALTH/05/10/tele.health.final/index.html
[3] https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment
[4] https://www.scott.senate.gov/media-center/press-releases/scott-schatz-shaheen-introduce-bipartisan-legislation-to-increase-access-to-telehealth-in-the-midst-of-the-pandemic
[5] https://www.cato.org/publications/pandemics-policy/reform-regulation-health-care-providers
[6] https://www.cato.org/publications/policy-analysis/liberating-telemedicine-options-eliminate-state-licensing-roadblock
[7] https://www.azleg.gov/legtext/55leg/1r/bills/hb2454p.htm
[8] https://azgovernor.gov/sites/default/files/2021_resilient_book.pdf

March 2, 2021

The Honorable Anna G. Eshoo
Chairwoman
House Committee on Energy and Commerce
Subcommittee on Health
Washington, District of Columbia 20515

The Honorable Brett Guthrie
Republican Leader
House Committee on Energy and Commerce
Subcommittee on Health
Washington, District of Columbia 20515

Dear Members of the Subcommittee:

We applaud you for examining federal policies around live audio and video healthcare visits with today's hearing, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." We appreciate this opportunity to weigh in on this important inquiry as the 117th Congress commences.

ACT | The App Association's Connected Health Initiative (CHI) represents a broad consensus of healthcare and technology leaders seeking a policy environment that encourages the use of connected health innovations. We seek essential policy changes that will help all Americans benefit from an information and communications technology-enabled American healthcare system. For more information, see www.connectedhi.com.

We share each of the goals expressed by several members of the Subcommittee to ensure telehealth services remain accessible after the public health emergency (PHE) expires and look forward to working with each of your offices to share solutions, consistent with the approach described in our previous testimony before the House Committee on Energy and Commerce and the Senate Health, Education, Labor, and Pensions Committee.[1] Connected health services drive value for patients, caregivers, and taxpayers and are essential tools to improve healthcare for all Americans, while reducing rising healthcare costs. We appreciate your consideration our views and look forward to collaborating on this vital issue.

The exceedingly broad restrictions on Medicare's coverage of telehealth services, found in Sec. 1834(m) of the Social Security Act, effectively bar coverage for telehealth services except for a small fraction of Medicare beneficiaries. Except in pilot demonstration programs in Hawai'i and Alaska, 1834(m) prevents Medicare reimbursement for the use of telehealth unless the patient is at a qualified originating site (which excludes their homes) and located in either a "rural health professional shortage area" or in a county that is outside of a Metropolitan Statistical Area (MSA).[2]

---

[1] Testimony of Morgan Reed, Executive Director, The Connected Health Initiative, Hearing on "Health Care in Rural America: Examining Experience and Costs," Senate Committee on Health, Education, Labor, and Pensions (HELP), Subcommittee on Primary Health and Retirement Security (Sept. 25, 2018), *available at* http://actonline.org/wp-content/uploads/2018-09-13-Testimony-CHI-House-EC-Health-Sub.pdf; Testimony of Morgan Reed, Executive Director, The Connected Health Initiative, Hearing on "Examining Barriers to Expanding Innovative, Value-Based Care in Medicare," House Committee on Energy and Commerce, Subcommittee on Health (Sept. 13, 2018), *available at* http://actonline.org/wp-content/uploads/2018-09-13-Testimony-CHI-House-EC-Health-Sub.pdf.

[2] 42 U.S.C. 1395m(m)(4)(C).

These restrictions pose a serious barrier to the adoption of live voice and video interaction between caregivers and patients. Out of approximately $800 billion the federal government spends on Medicare each year, physicians billed just $29 million or so over the last year for which this data is available.[3] Where patients with private insurance can generally interact with their caregivers over live voice and video, Medicare patients are usually unable to exercise that option outside the PHE. Medicare patients must visit their physicians in person even when video or voice communication would be more cost-effective, safer, or otherwise better for the patient than incurring the time and resource costs necessary to travel to the office physically and linger in the waiting room.

Although the temporary general waiver of these restrictions was a welcome development during the COVID-19 pandemic, we strongly urge you to consider permanent statutory changes that negate the need for a waiver. To that end, we urge this Subcommittee to consider the Telehealth Modernization Act (H.R. 8727, 116th / S. 368, 117th), which would minimize the various restrictions on "qualified originating site" to "any site at which the eligible telehealth individual is located at the time the service is furnished."[4] We also note that the bill would provide more flexibility for the Centers for Medicare and Medicaid Services (CMS) to enable more practitioner categories to provide telehealth services and retain the eligible telehealth services it added during the pandemic[5] after the PHE expires (sections 2(b) and 2(c) respectively).

The statute should no longer exclude critical patient populations, and we should also endeavor to future-proof the statute. Accordingly, the Telehealth Modernization Act does not *require* Medicare to cover telehealth services in a broader range of clinical circumstances. Instead, it would remove the statutory restrictions put in place when video calls were impossible except in extremely limited circumstances, including when the patient was at another healthcare facility with the proper infrastructure. Technological capabilities surpassed the law by leaps and bounds in this case, as smart devices can facilitate telehealth visits no matter the location of the patient so long as there is a stable broadband connection. The expanding distribution of smart devices across demographics and geographic areas leaves these geographic and physical constraints on coverage woefully out of date.

Telehealth services can help address inequities by providing a means to access care regardless of where the patient lives or is located when seeking healthcare services. The current statute's narrow allowance for telehealth coverage only for certain rural patients with access to a physician's office arbitrarily deems those patients worthy of coverage while leaving urban and suburban populations uncovered. With smartphone ownership and use approximately the same at about 80 percent for Black, white, and Hispanic populations,[6] excluding all patients from coverage except those in a narrow set of locations exacerbates inequitable access to care.

---

[3] *See* Eric Wicklund, "Medicare Spending on Telehealth Increases, But Barriers Remain," MHEALTH INTELLIGENCE (Aug. 28, 2017), *available at* https://mhealthintelligence.com/news/medicare-spending-on-telehealth-increases-but-barriers-remain.

[4] The Telehealth Modernization Act (S. 4375 / H.R. 8727, 116th Cong.) Sec. 2.

[5] *See* Press Release, "Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients," U.S. Dept. of Human Svcs. (Dec. 1, 2020), *available at* https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.

[6] Andrew Perrin and Erica Turner, "Smartphones help blacks, Hispanics bridge some – but not all – digital gaps with whites," FACTANK, PEW RESEARCH CTR. (Aug. 20, 2019), *available at*

Program integrity questions fail to justify the current restrictions on Medicare coverage of telehealth services.[7] CMS has all the same tools and authorities to combat program integrity issues for services provided via telehealth that it possesses for the other modalities through which care is delivered. Technologies that broadly enable live audio and video interactions are not a new service presenting new program integrity questions, they are a modality. Moreover, telehealth visits have an auditable digital footprint, which *does* help with fraud detection. And barring almost all originating site locations based on geography, as current law does, provides no discernible advantage from a fraud and abuse standpoint—except that almost no otherwise eligible beneficiaries could receive coverage. Finally, enabling coverage regardless of the location of a patient with mobile connectivity is key to ensuring access to telehealth services for patients who lack access to broadband at home, homeless populations who need access to remote care, and those who are unable to conduct a visit from their homes for any reason. Accordingly, a complete approach to addressing telehealth access for these populations should also include federal support for broadband infrastructure deployment and adoption. We applaud your leadership in addressing the digital divide, as it is a key component to addressing inequities in healthcare access as well.

We appreciate that this Subcommittee is focusing on the impacts of telehealth services during the pandemic and how federal healthcare laws can better empower providers, innovators, patients, and consumers to control costs and expand access to quality care. Tech-driven tools play a vital role in the improvement in quality and cost-effectiveness of healthcare, and that role has only broadened during the pandemic. Ensuring that CMS, Congress, and other federal agencies create a legal landscape that supports—rather than hinders—the use of and access to these tools is, therefore, of utmost importance.

Sincerely,

Graham Dufault
Connected Health Initiative

---

https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/.

[7] *See* Appendix for more background on Program Integrity concerns and removing restrictions on telehealth coverage.

The Connected Health Initiative (CHI), an initiative of ACT | The App Association, is the leading multistakeholder group spanning the connected health ecosystem seeking to effect policy changes that encourage the responsible use of digital health innovations throughout the continuum of care, supporting an environment in which patients and consumers can see improvements in their health. CHI is driven by the its Steering Committee, which consists of the American Medical Association, Apple, Boston Children's Hospital, Cambia Health Solutions, Dogtown Media, George Washington University Hospital, Intel Corporation, Kaia Health, Microsoft, Noom Inc., Novo Nordisk, The Omega Concern, Otsuka Pharmaceutical, Podimetrics, Rimidi, Roche, United Health Group, the University of California-Davis, the University of Mississippi Medical Center (UMMC) Center for Telehealth, the University of New Orleans, and the University of Virginia Center for Telehealth.

For more information, see www.connectedhi.com.

Appendix

Telehealth and Program Integrity

Millions of Americans turned to live audio and video visits with healthcare providers during the COVID-19 pandemic, and Congress needs to make decisions that will permanently affect how Americans, in particular Medicare patients, may access these telehealth services on a permanent basis. Live audio and video interactions are an increasingly important part of healthcare services for every demographic in a broadening set of care scenarios. However, although the U.S. Department of Health and Human Services (HHS) has existing mechanisms in place to address overutilization, fraud, waste, and abuse, policymakers rightfully seek to better understand how removing statutory barriers to telehealth coverage might impact the fiscal stability of Medicare. We believe removal of those statutory barriers is the most fiscally responsible course of action for a number of reasons.

In terms of program integrity, it is important to note that nearly all recent U.S. Department of Justice (DOJ) actions are related to telemarketers—or physicians using technology—to unnecessarily prescribe durable medical equipment (DME), genetic testing, pharmaceuticals, or other medical equipment. Historically, improper billing of Medicare for telehealth services is low and is similar to improper billing of face-to-face care.

- Analysis of Medicare telehealth services claims data from the PHE indicates that **fears of overutilization are overstated**:
  - An analysis of Medicare fee-for-service (FFS) claims data indicates that new patient office visits conducted via telehealth **accounted for just 3.6 percent** of all FFS Medicare telehealth spending when the pandemic first shocked the U.S. healthcare system—and when 1834(m) restrictions were first generally waived—between March 16 and June 30 of 2020.
  - Accordingly, claims data also indicate that after an initial spike, telehealth usage **has subsided as a percentage of ambulatory visits and is flattening out** as the pandemic wears on.
    - *Findings based on claims data **weigh heavily against predictions of dramatic uptake** by new Medicare telehealth users exerting uncontrollable fiscal pressure on the Medicare system.*
- HHS already has strong mechanisms to deal with various kinds of Program Integrity (PI) concerns with Medicare telehealth services:
  - Improper Billing:
    - Audit records from HHS' Office of Inspector General (OIG) 2018 report evaluating telehealth payments prior to the public health emergency (PHE) suggest that the primary source (**over 63 percent**) of improper telehealth payments were from Medicare beneficiaries being outside the statutory geographic limits set in Section 1834(m).
    - From this data, OIG determined that improper payments for telehealth services were at least **partially the result of claim forms omitting a**

designated field for originating-site location and practitioners being unaware of various telehealth requirements.
        - *If statutory geographic restrictions are lifted, the data here suggest that the bulk of improper payments for telehealth services are:*
            - *Unlikely to expand with increased access to telehealth services; and*
            - *Unlikely to be addressed by continuing geographic restrictions on coverage, or by imposing an in-person requirement, which would more likely cause the billing friction leading to improper payments to persist.*
        - OIG proposed a number of measures to prevent future improper billing events involving telehealth services and HHS is implementing those now.
    - Kickbacks and Other Illegal Arrangements:
        - DOJ ramped up enforcement of the Anti-kickback Statute and Stark Law, and OIG expects to release a report this year on "Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks." In one recurrent fraud scheme, fraudsters contact target patients via telephone, pay kickbacks to providers to write unnecessary prescriptions for durable medical equipment (DME), and then send the equipment to target patients while billing Medicare.
            - DOJ and HHS OIG have the tools they need—including partnership with the U.S. Postal Service—to detect these schemes and stop them.
- In addition to all Medicare coverage and payment and fraud and abuse authorities applying to telehealth services just as they do any other Medicare covered service, the existing Medicare claims process allows the Centers for Medicare and Medicaid Services (CMS) to effectively track and audit all telehealth services billed to Medicare via a specific modifier code (Modifier 95). The Modifier 95 describes "synchronous telemedicine services rendered via a real time interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. The Modifier 95, along with listing the Place of Service (POS) equal to what it would have been for the in-person service, is also applicable for telemedicine services rendered during the COVID-19 Public Health Emergency. The requirement to code with the Modifier 95 enables CMS to properly track and audit telemedicine services and is a powerful tool for rooting out fraud, waste, and abuse.
- Telehealth can help reduce long-term costs by enabling caregivers better access to patients to employ preventive measures and avoid costly escalation events:
    - This compendium of research includes a variety of studies confirming that responsible use of telehealth services facilitates cost-effective care.
    - The University of Virginia's (UVA's) care coordination and remote patient monitoring program, which relies on telehealth visits among other digital health tools, reduced hospital readmissions by 40 percent, regardless of payer, since it began in 2012.
        - *Hospital readmissions impose outsized costs—about $26 billion annually—on the Medicare system, and reducing them through the use of telehealth is a smart investment.*

Statement for the Record
House Committee on Energy and Commerce
Subcommittee on Health
Comments Regarding the Future of Telehealth
February 25, 2021

The Cystic Fibrosis Foundation writes to the House Energy and Commerce Committee recommending the following policy considerations when drafting telehealth legislation. Telehealth has long been an important care delivery method for improving access in underserved communities, particularly in rural areas and areas with physician shortages. Telehealth also helps ensure access to care when in-person visits are not a safe or feasible option, which has been critical during the COVID-19 pandemic. The CF Foundation commends the committee for identifying telehealth as a key element of care and appreciates the opportunity to provide written comment.

Individuals with CF receive multidisciplinary, specialized care at accredited CF care centers and sometimes get care at outside their state of residence. During this time of COVID-19, individuals with CF are particularly conscientious about potential exposure to the virus and therefore rely heavily on access to telehealth services. The CF Foundation urges this committee to pass legislation that would increase access to essential telehealth services in the following areas.

Temporary Licensing Reciprocity
For those who rely on out-of-state care centers to help manage their CF, clinician licensure reciprocity is an important tool to make remote care accessible. The *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* would enable temporary licensing reciprocity for all licensed and certified practitioners in all states for all types of services for the duration of the COVID-19 public health emergency (PHE). While many states have adjusted their licensure requirements to enable greater flexibility of care and telehealth access for patients who live in a different state from their providers, the variability from state-to-state results in some individuals with CF still struggling to maintain continuous care with their established care team. We advise this committee to pass legislation that would ease patient access to telehealth services through temporary clinician licensure reciprocity.

Geographic Restrictions
As we look beyond this PHE, originating site and geographic restrictions should be permanently eliminated to ensure that patients are not required to travel to specific locations to access telehealth services unless special equipment is necessary for an examination by a remote provider. Before the COVID-19 pandemic, Medicare rules largely limited use of a patient's home as the originating site to those living in rural areas or with a specific condition. The drastic increase in telehealth usage during the PHE has shown the futility of geographic restrictions and it is appropriate and safe for patients to receive care from their homes. We recommend this committee pass legislation permanently removing originating site and geographic requirements.

CYSTIC FIBROSIS FOUNDATION
NATIONAL OFFICE

4550 MONTGOMERY AVE.
SUITE 1100N
BETHESDA, MD 20814

TEL: 800.FIGHT.CF
FAX: 301.951.6378

WEB: WWW.CFF.ORG

Audio-only Visits
At the beginning of the PHE, the Centers for Medicare and Medicaid Services (CMS) established a temporary coverage policy for audio-only telephone visits, ensuring patients without access to the internet or video platform are still able to receive needed care while avoiding potential exposure to coronavirus. This flexibility is particularly important for rural and low-income populations who are more likely to have limited or no access to the internet or insufficient broadband to support video conferencing.

While audio-only visits are not a suitable for all health care services and not a substitute for in-person care, there are a number of aspects of a regular CF visit that can be conducted through the phone. For instance, clinicians can easily review medical history, current medications, and symptoms, and adjust a patient's care plan. CF patients and care teams can also review data from home spirometers to track trends in lung function. For CF providers, listening to a patient's cough can also provide actionable information about potential exacerbations. CMS has taken steps to continue expanding audio-only coverage in Medicare and we encourage this committee to work with the agency to make audio-only visits a permanent benefit as appropriate.

Expanding Eligible Practitioners
The CF clinical care team includes physicians, nurses, dietitians, social workers, and respiratory therapists – each of whom plays a unique role in managing CF care. Such access to all members of the care team could help patients better maintain and manage their care, leading to more consistent and better outcomes. We ask the committee to work with CMS to continue evaluating and expanding providers eligible to deliver telehealth services.

***

The CF Foundation appreciates the work of the Energy and Commerce Committee to advance telehealth as a priority during the COVID-19 pandemic and beyond this PHE. We ask the committee to take the above policies into consideration when drafting legislation. Thank you for the opportunity to comment.

CYSTIC FIBROSIS FOUNDATION
NATIONAL OFFICE

4550 MONTGOMERY AVE.
SUITE 1100N
BETHESDA, MD 20814

TEL: 800.FIGHT.CF
FAX: 301.951.6378

WEB: WWW.CFF.ORG

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

Subcommittee on Health

of the

Committee on Energy and Commerce

of the

U.S. House of Representatives

"The Future of Telehealth: COVID-19 is Changing the Delivery of Virtual Care"

March 2, 2021

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 AHA appreciates the opportunity to submit for the record our comments regarding the importance of the future of telehealth. During the COVID-19 pandemic, telehealth has provided a critical way for patients to continue to access needed care. We greatly appreciate the flexibilities implemented during the public health emergency, as they have allowed hospitals and health systems to care for patients in the safety of their own homes.

The increased use of telehealth since the start of the public health emergency (PHE) is producing high-quality outcomes for patients, closing longstanding workforce gaps and those that arose as a result of an overwhelmed, hardworking provider workforce, and protecting access for patients too vulnerable to risk infection. This shift in care delivery could outlast the PHE if the appropriate statutory and regulatory framework is

established. We urge Congress to consider how to ensure these flexibilities remain for patients and health care providers beyond the PHE.

DELIVERY OF TELEHEALTH ACROSS THE NATION

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.

- **Increased Access to Specialists:** One example of the impact made by these flexibilities comes from a hospital member who 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 member 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 very 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, including the 97% of patients who remained at home and whose anxiety about this novel disease was very well-managed due to regular connection with a provider. 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 member is now expanding its virtual hospital beyond COVID-19 care to assist those with chronic conditions.

- **Improved Outcomes:** Many other AHA members also indicated they observed greatly improved health outcomes for patients who no longer cancelled 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 – and in the years prior – the AHA strongly urges Congress to consider the elimination of the 1834(m) geographic and originating site restrictions, which would allow all patients to receive telehealth services in their homes, residential facilities and other locations. Without this change, much of the progress that has been made over the past months to significantly increase patient access to care will disappear, since the status quo limits telehealth to rural areas of the country and requires patients to be at certain types of facilities to receive care. The PHE clearly demonstrated the need for access to telehealth in non-rural areas including in the safety of patients' homes, and the importance of being able to reach patients who are completely removed from the health care system, such as homeless individuals in shelters.

While telehealth has great potential to increase access to care, any expansion of telehealth should be implemented with the explicit goal of addressing health equity and reducing health disparities, as challenges remain for the nation's minority communities. As such, telehealth should be employed with supporting policies, such as access to broadband and end-user devices, to reach underserved populations.

COVERAGE AND REIMBURSEMENT FOR AUDIO-ONLY SERVICES

One of the flexibilities allowed during the PHE is Medicare coverage and payment for audio-only services. During the PHE, CMS used waiver authority to establish separate payment for audio-only evaluation and management (E/M) services and temporarily waived the requirement that telehealth services be provided by two-way, audio/video communication technology, so as to add the audio-only E/M services to the Medicare telehealth list of services and permit other services on the list to be delivered via audio-only connection.

The AHA strongly supports coverage and reimbursement for audio-only services and encourages Congress to continue this flexibility for health care providers. This flexibility has enabled hospitals and health systems to maintain access to care for numerous patients who do not have access to broadband or video conferencing technology. It also has protected the continuity of care when a video connection fails. In those situations, if a provider and patient are connected via audio/video technology, and their video connection fails, they can default to an audio-only visit and pick up right where they left off. In addition, audio-only behavioral health services have become extremely popular with patients who are more comfortable without face-to-face visits.

LICENSURE

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. Every state and territory has laws in place that govern the practice of medicine. These laws require a person practicing medicine to obtain a full and unrestricted license authorizing that person to engage in the practice of medicine within that state or territory. **The AHA has supported the Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168 and H.R. 708) that would allow for the temporary reciprocity for treatment by medical professionals licensed in one state to patients in other states.** The legislation is limited in duration to the COVID-19 pandemic and only allows a health care professional to practice within their licensed scope of practice. It does not allow a health care professional to issue a prescription for a controlled substance without proper registration and in compliance with applicable regulations.

This legislation would provide flexibility for health care workers to cross state lines physically and virtually to provide care during the COVID-19 pandemic. We need as many of our health care providers as possible to provide care, regardless of their location.

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

EXPANDING THE TYPES OF PROVIDERS ELIGIBLE TO DELIVER TELEHEALTH

The COVID-19 pandemic has had an unprecedented impact on the front line workers who have tirelessly provided care during this crisis. Policies that increase the types of health care facilities and providers that can offer telehealth care will benefit both patients and providers. Medicare provides reimbursement to both an originating and distant site for telehealth services. The originating site is the location of the patient receiving the telehealth service, while the distant site is the location of the health care provider providing the telehealth service. Specifically, 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 expanding the types of providers that can deliver and bill for telehealth services to include, among others, physical therapists, occupational therapists and speech-language pathologists.

CONCLUSION

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.

March 1, 2021

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
Washington, D.C.

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
Washington, D.C.

Dear Chairwoman Eshoo and Ranking Member Guthrie,

On behalf of the American Academy of Family Physicians (AAFP), representing more than 136,700 family physicians and medical students across the nation, I write to thank you for hosting the hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." Family physicians have rapidly changed the way they practice to meet the needs of their patients during the COVID-19 pandemic. About 70 percent also report that they plan to continue providing more telehealth services in the future. However, legislative changes are needed to permanently improve equitable access to high-quality telehealth services, such as those provided by primary care physicians within a patient's medical home.

Telehealth can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, continuous care. Telehealth services have allowed patients and families to maintain access to their usual source of primary care, ensuring care continuity during the pandemic and will continue to be critical as our nation recovers from the COVID-19 pandemic. Given these benefits, patients and physicians alike have indicated that current telehealth flexibilities should continue beyond the public health emergency. Congress must act to extend Medicare telehealth flexibilities and ensure telehealth is permanently recognized across payers as a valuable modality of providing primary care services.

Telehealth benefit expansions must increase access to care and promote high-quality, comprehensive, continuous care. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care and expand access to care for under resourced communities. As outlined in our Joint Principles for Telehealth Policy, in partnership with the American Academy of Pediatrics and the American College of Physicians, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. Expanding telehealth services in isolation without any regard for previous physician-patient relationship, medical history, or the eventual need for a follow-up hands-on physical examination can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care.[i,ii] In fact, a recent nationwide survey found that most patients prefer to see their usual physician through a telehealth

STRONG MEDICINE FOR AMERICA

President
Ada Stewart, MD
Columbia, SC

President-elect
Sterling Ransone, MD
Deltaville, VA

Board Chair
Gary LeRoy, MD
Dayton, OH

Speaker
Alan Schwartzstein, MD
Oregon, WI

Vice Speaker
Russell Kohl, MD
Stilwell, KS

Executive Vice President
R. Shawn Martin
Leawood, KS

Directors
James Ellzy, MD, *Washington, DC*
Dennis Gingrich, MD, *Hershey, PA*
Tochi Iroku-Malize, MD, *Bay Shore, NY*
Andrew Carroll, MD, *Chandler, AZ*
Steven Furr, MD, *Jackson, AL*
Margot Savoy, MD, *Media, PA*
Jennifer Brull, MD, *Plainville, KS*
Mary Campagnolo, MD, *Borderntown, NJ*
Todd Shaffer, MD, *Lee's Summit, MO*
Danielle Carter, MD (New Physician Member), *Jacksonville, FL*
Anna Askari, MD (Resident Member), *Palm Desert, CA*
Cynthia Ciccotelli (Student Member), *Yardley, PA*

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

visit, felt it was important to have an established relationship with the clinician providing telehealth services, and felt it was important for the clinician to have access to their full medical record.[iii]

The AAFP is supportive of broadly expanding access to telehealth services. However, we recognize that the subcommittee may have ongoing concerns with waste, fraud, and abuse and may be interested in policy solutions. In addition to promoting the use of telehealth within the medical home, we also recommend relying on existing Medicare policies to minimize the administrative burden imposed on physician practices. For example, Medicare defines an established patient as one that has received professional services from a clinician in the same practice and of the same medical specialty within the last three years.[iv] This definition should be repurposed in new telehealth policies, instead of creating a new definition for an established patient that could conflict with current coding guidelines.

Congress should permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access care at home. The COVID-19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

Require Medicare to cover audio-only Evaluation and Management (E/M) services beyond the public health emergency. Coverage of audio-only E/M services is vital for ensuring equitable access to telehealth services for patients who may lack broadband access or be uncomfortable with video visits. In September, after using telehealth for several months due to the pandemic, more than 80 percent of family physicians responded to an AAFP survey indicating they were using phone calls to provide telehealth services. Together with ongoing reports from physicians that phone calls are vital to ensuring access for many patients, this survey data indicates that phone calls are more accessible for many patients than video visits. This may be particularly true for Medicare beneficiaries. According to the Pew Research Center, 91 percent of patients over the age of 65 own a cell phone; but only about 53 percent of these devices are smartphones with video capability.[v]

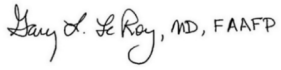
Congress should work to standardize coverage and payment of telehealth services across payers, including by requiring they cover telehealth services provided by any in-network provider and prohibiting policies that only cover telehealth services provided by separately contracted virtual-only vendors. As previously mentioned, evidence clearly indicates that patients prefer to receive telehealth services from their usual source of care. Existing benefit structures do not reflect this preference, or the importance of continuous primary care.

Payment models should support the patients' ability to choose their preferred modality of care (i.e., audio-video or audio-only) and ensure appropriate payment for care provided. For example, E/M services require the same level of physician work regardless of the modality of care. Family physicians report that there are unique costs associated with implementing telehealth in their practices and altering clinical workflows to ensure successful telehealth visits. Payment for telehealth services must appropriately account for these costs.

Permanently ensure beneficiaries can access telehealth services provided by Federally-qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). FQHCs and RHCs serve as the primary source of care for millions of low-income and underserved patients across the country. In order to promote care continuity and ensure beneficiaries have access to affordable, comprehensive care, Medicare should permanently cover telehealth services provided by these health centers. Medicare and Medicaid payment methodologies should also be modified to provide appropriate and timely payment to community health centers for telehealth services.

Thank you for the opportunity to provide written testimony for the hearing. The AAFP stands ready to work with you to improve equitable access to high-quality telehealth services. Should you have any questions, please contact Erica Cischke, Senior Manager of Legislative and Regulatory Affairs, at ecischke@aafp.org.

Sincerely,



Gary L. LeRoy, MD, FAAFP
Board Chair
American Academy of Family Physicians

---

[i] Shi, Zhuo et al. "Quality Of Care For Acute Respiratory Infections During Direct-To-Consumer Telemedicine Visits For Adults." Health affairs (Project Hope) vol. 37,12 (2018): 2014-2023. doi:10.1377/hlthaff.2018.05091
[ii] 4 Sprecher, Eli, and Jonathan A. Finkelstein. "Telemedicine and Antibiotic Use: One Click Forward or Two Steps Back?" American Academy of Pediatrics, American Academy of Pediatrics, 1 Sept. 2019, pediatrics.aappublications.org/content/144/3/e20191585.
[iii] Welch, B. M., Harvey, J., O'Connell, N. S., & Mcelligott, J. T. (2017). Patient preferences for direct-to-consumer telemedicine services: A nationwide survey. *BMC Health Services Research, 17*(1). doi:10.1186/s12913-017-2744 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5704580/
[iv] CMS Manual System Notification. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1231OTN.pdf
[v] Pew Research Center. Mobile Fact Sheet. Jun 2019. Available at: https://www.pewresearch.org/internet/fact-sheet/mobile/

Statement by the Association of American Medical Colleges on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
Submitted for the Record to the
Energy and Commerce Subcommittee on Health
United States House of Representatives
March 2, 2021

The AAMC (Association of American Medical Colleges) thanks the Energy and Commerce Subcommittee on Health for convening the March 2 hearing, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care" and for the opportunity to provide written comments for inclusion in the record.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC appreciates the work that Congress and the Centers for Medicare and Medicaid Services (CMS) have done to provide important flexibilities around telehealth during the COVID-19 pandemic. The AAMC strongly supports the telehealth waivers and regulatory changes established by Congress and CMS in response to the public health emergency (PHE) that have facilitated the widespread use of telehealth and other communication technology-based services. We support additional efforts by Congress to ensure that Medicare beneficiaries and other patients can continue to have access to telehealth services beyond the pandemic.

Telehealth Helps Expand Access to Care for Patients and Providers

Teaching hospitals, faculty physicians, and other providers have responded to the PHE and the waivers and flexibilities provided by Congress by rapidly implementing telehealth in their settings and practices in order to provide continued access to medical care for their patients. Physicians have been able to monitor non-critically ill COVID-19 positive patients, follow-up on patients with chronic disease who can be cared for without risking a visit to the hospital or clinic, and provide care for many Medicare beneficiaries and other patients without imposing the burden of travel.

Data from the Clinical Practice Solutions Center (CPSC),[1] which contains claims data from 90 physician faculty practices, shows that in March and April 2020, faculty practices on average

[1] The Clinical Practice Solutions Center (CPSC), owned by the Association of American Medical Colleges and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.

were providing approximately 50% of their ambulatory visits via telehealth, a dramatic increase from the use of telehealth prior to the pandemic. This is consistent with reports from CMS regarding telehealth services provided to Medicare beneficiaries during that time frame.[2]

The use of telehealth provides many benefits to patients, especially during the PHE. It expands care for the frail or elderly, for whom travel to a provider or facility is risky or difficult even when there is no pandemic. Physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital admissions. Telehealth also protects patients from exposure to infectious diseases, including COVID-19 and the seasonal flu. The use of telehealth enables specialists, such as pediatric specialists and critical care physicians, to bring their skills to rural areas and other areas that may not have subspecialty care in their communities. Immediate availability of a pediatric infectious disease specialist or a stroke critical care physician via telehealth can be life saving for those in remote, rural, or small size communities.

At the same time, it must be recognized that the development of telehealth capabilities has required investing significant resources in technology, training, and infrastructure. The flexibilities provided by Congress for telehealth coverage and payment have enabled teaching hospitals, teaching physicians, other health care providers, and their patients to experience the benefits of telehealth. Analyses of surveys of more than 30,000 patients conducted by Press Ganey for services in March and April 2020 show that patients feel overwhelmingly positive about their virtual interactions with health care providers.[3] Beyond aiding with the COVID-19 response, telehealth offers the long-term promise of expanding quality health care in the future, particularly to individuals with limited access to services, individuals with disabilities, and elderly patients who have difficulty traveling.

We recognize that due to statutory limitations, most of the current flexibilities are in place only during the PHE. However, it is imperative that the progress that has been made since March 2020 continue when the PHE ends. **We urge Congress to make legislative changes that will allow the current changes to be made permanent while ensuring that reimbursement remains at a level that will support the infrastructure needed to continue to provide telehealth services at a level far above that of the pre-pandemic world.**

Specifically, the AAMC recommends the following:

Congress Should Remove Patient Location Restrictions and Rural Site Requirements

The AAMC strongly supports changes made by Congress that waived patient location restrictions that applied to telehealth service during the PHE. These changes have enabled CMS to pay for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home, during the PHE.

---

[2] Health Affairs, Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. July 15, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/

[3] Press Ganey, The Rapid Transition to Telemedicine: Insights and Early Trends. May 19, 2020. https://www.pressganey.com/resources/white-papers/the-rapid-transition-to-telemedicine-insights-and-early-trends?s=White_Paper-PR

This has allowed patients to remain in their home, reducing their exposure to COVID-19 and reducing the risk of exposing another patient or their physician to COVID-19. It also means that patients who find travel to an in-person appointment challenging can receive care that may be particularly important, especially for patients with chronic conditions or disabilities who need regular monitoring. The AAMC encourages Congress to remove the rural site requirements and allow the home to be an originating site.

Providers Should be Paid the Same Amount for Telehealth Services as Services Delivered In-Person

The AAMC strongly recommends that providers be paid the same for furnishing telehealth services as services delivered in person. Faculty practice plan leaders have highlighted significant infrastructure costs to fully integrate their electronic health record systems with HIPAA-compliant telehealth programs. Physicians employ medical assistants, nurses, and other staff to engage patients during telehealth visits and to coordinate care, regardless of whether the services are furnished in person or via telehealth.

We recommend Congress provide a facility fee under the outpatient prospective payment system for telehealth services provided by physicians that would have been provided in the provider-based entity. Similar to the physician office-based setting, the provider-based entity will continue to employ nurses, medical assistants, and other staff to engage patients during telehealth visits or to coordinate pre-or-post visit care. The provider-based entity incurs these costs associated with providing the telehealth service and should be reimbursed as if the services were provided in person.

Congress Should Allow Patients to Access Telehealth Services Delivered Across State Lines

As part of the COVID-19 response, Congress and CMS have allowed providers to be reimbursed by Medicare for telehealth services across state lines. This waiver creates an opportunity to improve patient access to services and to help improve continuity of care for patients who have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment under federal programs, states need to act to allow practice across state lines to occur.

The AAMC urges Congress to pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT Act, S. 168, H.R. 708). This bipartisan, bicameral legislation would expand care for patients by creating a temporary uniform licensing standard for all practitioners and professionals that hold a valid license in good standing in any state to be permitted to practice in every state – including in-person and telehealth visits – during the COVID-19 public health emergency.

The TREAT Act provides important flexibility during an emergency to ensure that patients receive the care they need. This would have many important benefits for patients, including providing access and continuity of care for mental health treatment, oncology patients, and others with serious or life-threatening conditions. It would also allow health systems to draw on available licensed clinicians to meet the demands of a surge as outbreaks continue to arise.

Congress Should Allow Payment for Audio-Only Services

In the March 31 COVID-19 Interim Final Rule with Comment Period, CMS established separate payment for audio-only (i.e. telephone services) for specific services (telephone evaluation and management, behavioral health counseling, or educational services). The audio-only services are reimbursed at the same rates as in-person services. CMS stated in its final 2021 physician fee schedule rule that when the PHE ends, there will be no separate Medicare payment for telephone-only visits. CMS explains that once it no longer can exercise the waivers that are allowed under the PHE, it does not have the statutory authority to allow coverage and payment for the telephone evaluation and management services under the telehealth benefit because section 1834(m) of the Social Security Act requires Medicare telehealth services to use video technology.

Audio-only calls improve access to virtual care for patients who do not have access to the devices or broadband for audiovisual calls, are not comfortable with digital technology, or do not have someone available to assist them. During the PHE, coverage and payment for audio-only calls has been critical to ensure access to care for some patients. Physicians have been able to provide a wide array of services efficiently, effectively, and safely to patients using the telephone.

Data from the CPSC shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient, with 17% of visits delivered via audio-only interaction for patients 41-60 years of age, 30% for patients 61-80 years of age, and 47% of visits for patients over 81. CMS data show that nearly one-third of Medicare beneficiaries received telehealth by audio-only telephone technology from March through June 2020,[4] which is consistent with CPSC data.

Many factors contribute to the high use of audio-only services. Patients in rural areas or those with lower socioeconomic status are more likely to have limited broadband access and may not have access to the technology needed for two-way audio-visual communication. The Pew Research Center found that about a third of adults with household incomes below $30,000 per year do not own a smartphone and about 44% do not have home broadband services.[5]

Some providers report that even when their patients have access to technology that would allow for audio-visual communication, they may be unable to use the technology without assistance, thus limiting them to telephone use. For these patients, their only option to receive services remotely is through a phone. Without coverage and payment for these audio-only services, there will be inequities in access to services for these specific populations. Therefore, we urge Congress to make changes to allow coverage and payment for audio-only services.

---

[4] ASPE Issue brief: Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic (7/18/2020); Health Affairs Blog; Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19. July 15, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/abs

[5] Pew Research Center, Digital divide persists even as lower-income Americans makes gains in tech adoption. May 7, 2019. https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

Congress Should Takes Steps to Improve Access to Broadband Technology

In some parts of the country, providers and their patients have limited access to broadband connectivity, which has been a major barrier to use of telehealth. This is particularly true for rural areas and underserved communities. The Federal Communications Commission has reported that 30% of rural residents lack broadband services.[6] Also, racial and ethnic minorities, older adults, and those with lower levels of socioeconomic status are less likely to have broadband access. We recommend that Congress take steps to increase funding for broadband access and infrastructure development to enable expansion of telehealth services to these populations.

Conclusion

The use of telehealth services has expanded access to care for patients throughout the public health emergency. We appreciate the significant actions that Congress and CMS have taken to support patients, hospitals, and physicians by providing important relief through waivers and other regulatory changes that have promoted the widespread use of telehealth and other communication-based technologies. Thank you again for examining these important issues during today's Subcommittee hearing. Please feel free to contact AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org) or AAMC Senior Director of Government Relations Leonard Marquez (lmarquez@aamc.org) with any questions or if we can provide more information. We look forward to continuing to work with you on this important issue.

[6] Federal Communications Commission, 2018 Broadband Deployment Report, February 2, 2018. https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report

March 2, 2021

The Honorable Anna Eshoo
Chairwoman, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Brett Guthrie
Ranking Member, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie,

The Alliance of Community Health Plans (ACHP) thanks the Energy & Commerce Subcommittee on Health for holding this important hearing on "The Future of Telehealth: How COVID 19 is Changing the Delivery of Virtual Care" and is pleased to submit this statement for the record. ACHP represents the nation's top-performing non-profit health plans improving affordability and outcomes in the health care system. ACHP member companies are provider-aligned health organizations that provide high-quality coverage and care to 24 million Americans across 36 states and D.C. They are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data-driven systems improvement.

Recent polling and research confirms the widely-held view that patients have embraced virtual care and want it to stay. However, if Congress fails to act this year patients will suffer from a lack of access and available providers once the public health emergency (PHE) ends. The patients most affected by this will be those without access to smartphones or video-capable technology and patients in rural and underserved areas. Fifteen percent of the American population owns a cell phone that is not a smartphone, and that number jumps to 24 percent in rural areas according to Pew. One hundred and twenty-two million Americans live in areas with mental health provider shortages and 83 million in areas with primary care provider shortages.

It is imperative that Congress ensures the continued access to telehealth that Americans need. Even with a temporary safeguard of the extended PHE, our member organizations continue to urge Congress to act now and make virtual care permanent. ACHP requests two important policy changes:

- **Expand telehealth clinician eligibility.** Congress should expand the types of clinicians eligible to deliver telehealth, such as Licensed Professional Counselors for mental and behavioral health services, adding much-needed resources to care delivery, especially in rural and underserved areas. This will improve patients' ability to receive equitable and robust virtual care by expanding patient choice and access to clinical experts. Making this change well in advance of the PHE's inevitable conclusion will offer clinicians much-needed certainty and stability.

- **Expand telehealth encounter data availability for Medicare Advantage risk adjustment.** Health plans need to be able to use encounter data from all telehealth visits, including audio-only. This will improve the ability for clinicians to manage chronic conditions for those relying on audio-only care. The ability to use claims data to better understand and predict an individual's risk is essential under normal circumstances, but even more so given the uncertain long-term implications of the COVID-19 pandemic. A recent study from Avalere estimates that the lack of sufficient data due to COVID-19 could lead to a 3%–7% reduction in 2021 risk scores and lower plan payments in 2021. Senate bill S. 150, Ensuring Parity in MA for Audio-Only Telehealth Act and its pending House companion would accomplish this necessary change.

ACHP Member Telehealth Experience During COVID-19
ACHP member companies addressed our current crisis by deploying creative solutions to protect the health and safety of the communities they serve. The following examples illuminate ways that ACHP member companies have operationalized a variety of impressive telehealth solutions. ACHP urges Congress to take action to support this progress, continuing to improve consumer health through virtual care and ensuring that the gains in telehealth are not lost. Our member organizations, championing capitated payments and value-based payment, will continue to lead the way for providing efficient, affordable and coordinated care using telehealth.

Priority Health (Grand Rapids, MI) and Harvard Pilgrim Health Care (Wellesley, MA)
Regional insurers bet big on virtual-first plans by Nona Tepper. Modern Healthcare. January 22, 2021.
Priority Health and Harvard Pilgrim Health Care launched virtual first products at the end of 2020. These products offer not only convenience, but significant savings: premiums averaging 8-10% less than similar plan products. This movement to virtual first plans showcases the effective role of a virtual front door for consumers, aiming to help consumers navigate the health care system in a cost-effective way. Because regional insurers such as Priority Health and Harvard Pilgrim have a dedicated provider network they can tap the offering is relatively easy for these payers to deploy.

Kaiser Permanente (Oakland, CA)
In the last two months, Kaiser Permanente published or contributed to two significant research articles quantifying the value of telehealth in various settings. The first, published in the Journal of Telemedicine and Telecare, found that telehealth encounters were successful in resolving urgent and non-emergent needs in 84.0–86.7% of cases. When visits required follow-up, over 95% were resolved in less than three visits for both telehealth and in-person cohorts. This study also determined successful telehealth visit outcomes related to specific conditions and can be a lower cost alternative that does not compromise quality.

The second, published in NEJM Catalyst, found that patients are more likely to engage in digital approaches to mental health. Early data suggest that patients using digital apps and tools experience symptom relief. Kaiser Permanente's updated mental health ecosystem helped meet the increased demand for mental health and wellness resources amplified by the pandemic.

Baylor Scott & White (Temple, TX)

In COVID-19's wake, hospitals look to hybrid model with in-person, virtual care on equal footing by Shannon Muchmore. HealthcareDive. September 17, 2020.
Baylor Scott & White made consumer education an early focus in the pandemic using simple and effective marketing strategies to make sure consumers were aware of the expanded telehealth benefits and options. This included email and social media platforms, such as Facebook and YouTube, to share consumer education on how to use the various virtual care options.

Geisinger Health Plan (Danville, PA)
Geisinger receives $979,000 to bolster telemedicine services. Geisinger News Releases. July 7, 2020.
Geisinger has been awarded $978,935 from the Federal Communications Commission to provide telehealth services during the COVID-19 pandemic. Geisinger will use the award to purchase telemedicine carts, tablet computers and telemedicine peripherals such as hand-held cameras and stethoscopes.

SelectHealth (Salt Lake City, UT)
Benefiting Permanently from Telehealth's Transformation by COVID-19 by Marc Harrison, MD. InsideSources. Feb 7, 2021.
Intermountain Healthcare president and CEO, Marc Harrison, MD, outlines his vision for seizing the telehealth momentum and three necessary steps for XXXXXXXXX. Intermountain, SelectHealth's provider system, has been able to assess the potential for bone marrow transplants by telehealth, eliminating the need for a potential donor to travel until the match has been confirmed.

Security Health Plan (Marshfield, WI)
Good for mental health: Telehealth therapy appointments. Security Health Plan Press Releases. June 16, 2020.
Security Health Plan expanded coverage of telehealth for all lines of business and found it is particularly beneficial for behavioral health care. Many patients are benefiting from virtual therapy visits right now because of the COVID-19 crisis, and it will remain a valid option for many even after social distancing requirements have been relaxed. "Patients are already untreated or undertreated for their behavioral health problems; nationally, only 35% of patients with serious behavioral health issues get the care they need," said Michael Schulein, Ph.D., a clinical psychologist at Marshfield Clinic Health System. "Telehealth removes barriers for those who are undertreated or not treated at all."

UPMC (Pittsburgh, PA)
New App Helps Patients Capture Telehealth Visits. UPMC Press Releases. May 20, 2020.
Quickly responding to the COVID-19 pandemic, UPMC shifted much of its care delivery from in-person to virtual, ensuring the safety of both patients and clinicians. With care rapidly moving to smartphones, tablets and telephones, patients face new challenges in recalling doctors' orders — particularly if they are distracted by the technology or activities in their homes. UPMC's partnership with Abridge addresses this potential communication gap. Abridge's technology records each doctor's visit and uses groundbreaking clinical natural-language processing to highlight key medical terms and next steps, enabling patients and clinicians to review important details.

PacificSource (Springfield, OR)
In early 2020, PacificSource greatly expanded telehealth benefits to recognize the importance of telehealth in improving access for members. In addition, it expanded the universe of telehealth eligible clinicians and the technology communication options, relaxed certain requirements and communicated that reimbursed telehealth visits continue to be covered at the same level as in-person office visits. PacificSource paid telehealth visits at parity with face-to-face services even before COVID-19. In addition, it is actively working with stakeholders in all footprint states to shape proposed telehealth legislation to keep the focus on appropriate evidence-based telehealth interventions and "visits" that add value through improved quality and outcomes, and don't impair the move to value-based provider reimbursement.

Addressing Concerns to Telehealth Expansion
ACHP recognizes that expanding telehealth may give rise to concerns about fraud and abuse, privacy and reimbursement. While some of these challenges may be addressed by Congress, ACHP maintains that there are existing business best practices to address many of these concerns. For example, our non-profit health insurer members have robust internal audit mechanisms to evaluate potential for fraud or abuse. Early in the pandemic, health plans actively monitored for potential errors in telehealth coding, and on rare occasions, conducted outreach and billing support to specific physician groups when issues arose. Anecdotally, conversations with our ACHP health plan medical directors indicate a growing trust in telehealth billing and services rendered by their provider networks, based on the data gathered over the past year. These systems and mechanisms will quickly evolve to accommodate more widespread use of telehealth.

ACHP is continuing to support the movement from volume to value and published a white paper on potential pathways to creating value-based payment for telehealth in fee-for-service Medicare. In addition, ACHP member plans are already offering expanded telehealth benefits through MA plan products and early research suggests that virtual care increases care coordination and lowers costs for patients, highlighting the value of the MA capitated payment model.

Health care privacy and security is not limited to current telehealth expansion. The health care industry is long overdue for the modernization of health data privacy and security. That was true before the pandemic and the resulting dramatic need for telehealth technology. ACHP is contributing to more robust oversight of current health data privacy and security beyond telehealth services.

In closing, we appreciate the Subcommittees interest in this important issue of making sure telehealth remains an option for patients after the PHE has ended. We look forward to continuing to work with the Subcommittee on improving and expanding access to virtual care.

Sincerely,

Ceci Connolly, President & CEO

AdvocateAuroraHealth

March 1, 2021

Chairwoman Anna Eshoo
House Energy & Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Brett Guthrie
House Energy & Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Re: Written Testimony Submitted to the House Energy & Commerce Health Subcommittee for the March 2, 2021 Hearing Record, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of Advocate Aurora Health (Advocate Aurora), we thank you for holding a hearing on March 2, 2021 titled, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." We very much appreciate your leadership on this important topic and thank you for the opportunity to submit this statement for the hearing record. We thank you in advance for your consideration of our recommendations for how to fully harness the potential telehealth holds for overcoming some of the most challenging health care issues facing our nation, including increasing access to quality care, lowering costs, and eliminating health care disparities by addressing the socioeconomic determinants of health (SDOH).

Overview of Advocate Aurora

Advocate Aurora is a leading employer in the Midwest with more than 75,000 team members, including more than 22,000 nurses and the region's largest employed medical staff and home health organization. The system serves nearly 3 million patients annually; across both Illinois and Wisconsin, in particular, we serve an estimated 695,000 Medicare beneficiaries and more than 485,000 individuals with Medicaid coverage.

With more than 500 sites of care, Advocate Aurora is engaged in hundreds of clinical trials and research studies, and is nationally recognized for its expertise in cardiology, neurosciences, oncology, and pediatrics. The organization contributed $2.2 billion in charitable care and services to its communities in 2019. Advocate Aurora brings its strengths, assets, and commitment to delivering value and outcomes to individuals, families, and communities throughout Illinois and Wisconsin.

Advocate Aurora & Telehealth

Advocate Aurora has long been engaged in the provision of care through telehealth, as it is an important tool in reaching rural and underserved communities, including individuals with special needs, such as people who are deaf and hard-of-hearing. For example, we are proud that more than 15 years ago we were the only Chicago area provider to offer tele-psychiatry visits using videoconferencing and providers who speak American Sign Language (ASL) to deaf and hard-of-hearing patients who were living in southern Illinois. These patients had unmet mental health needs but there were no providers in the community who spoke ASL and an audio-only visit is ineffective and inappropriate. By offering video-

tele-psychiatry with ASL speakers, patients could access the specialty care they needed without the burden of having to travel. Since that time, we have significantly expanded our telehealth and digital medicine offerings in Illinois and Wisconsin.

We connect to our patients through videoconferencing, remote monitoring, electronic consults, and wireless communications and we deploy these technologies to provide primary, urgent care, and specialty services. The strategic utilization of telehealth – both prior to and during the public health emergency (PHE) – allows us to offer patients an important, safe, and convenient care option.

Advocate Aurora Telemedicine ED Triage

For example, prior to the PHE, we successfully implemented remote video monitoring technology to help reduce overcrowding at Aurora Sinai Medical Center's Emergency Department (ED) in Milwaukee, Wisconsin, one of our busiest EDs. This telemedicine program allows patients to be seen initially by an Advocate Aurora provider via video when they arrive, with a nurse at the patient's side. By having additional providers available via telemedicine – with triage assistance and on-site provider support – patients are seen by a clinician faster and, in turn, they experience a reduced time to diagnoses and quicker initiation of treatment.

- The program has helped to reduce door-to-provider times from 60 minutes to about 10 minutes, on average.
- The average length of stay has declined by 40 minutes.
- The leave-without-being-seen rate has plummeted from 8% to 2%.
- Overcrowding in the ED has decreased significantly.

Advocate Aurora and Telehealth During the PHE

We are eager to sustain the recent advances made in the utilization and adoption of telehealth; while the advantages and power of telehealth have been known for decades, the importance of virtual care has become profoundly clear in the past year during the PHE. Starting in March 2020, providers and patients alike sought ways to interact that reduced their risk of exposure to COVID-19. Many providers could not be in the office or at the hospital due to COVID-19 restrictions but could still see patients through virtual care. Telehealth helped reduce unnecessary patient and provider exposure to COVID-19 and allowed us to preserve scarce PPE during shortages.

Many patients, including home care patients, were fearful of seeing providers in person but were eager to engage in a visit through audio or video means. Further, many patients have mobility issues, disabilities, or transportation challenges that make traveling to an office, clinic, or hospital campus extremely burdensome even in non-pandemic times. With vast disruption of public transportation systems and patients experiencing greater stress overall, telehealth allowed us to provide convenient, continuity of care for our patients across the care spectrum – primary, specialty, post-acute, chronic disease management, etc.

Before the pandemic in January 2020, about 300 Advocate Aurora providers were performing virtual

health visits and at the end of the year, 4,663 providers were conducting appointments via telehealth. During this time, we provided a total of 876,000 virtual visits, up significantly since before the pandemic. Our Family Practice providers accounted for 27% of these visits while our Internal Medicine providers accounted for 18% followed by Behavioral Health 14% and Cardiology 6% while other specialties accounted for the other telehealth visits.

Advocate Aurora Supports Making Permanent the PHE-Related Telehealth Policy Changes

Advocate Aurora very much appreciates the changes that both the Centers for Medicare and Medicaid Services (CMS) and Congress have made since the start of the PHE to ensure that patients can receive care via telehealth, should they so choose. Appended to this testimony please find comments that Advocate Aurora's Health at Home submitted in December 2020 to CMS in response to the agency's Request for Information on Regulatory Relief to Support Economic Recovery. Specifically, the comments submitted detail which regulatory changes have been beneficial to the provision of care and which changes should be extended or made permanent. We thank you for your attention to that correspondence from our colleagues and enumerate below a number of the flexibilities and waivers currently available that we respectfully request be made permanent. We understand that some of the waivers and flexibilities can be made permanent under existing CMS authority, while others require Congressional action. We urge you and your colleagues to work with CMS to ensure all of these policies are made permanent so patients can continue to benefit from that telehealth delivered care offers them. Specifically, we ask that you continue to allow:

- All patients, irrespective of their geography (e.g., rural) and physical location (e.g., home), to receive telehealth services in the location of their choosing.
- Medicare to pay for telehealth services at the same rate as in-office visits for all diagnoses.
- Practitioners to provide telehealth services to both new and established Medicare patients.
- Practitioners to provide audio-only telephone evaluation and management visits for new and established patients; this is especially important for patients who may not have internet access or a smart phone.
- Practitioners licensed in one state to be reimbursed for services provided to Medicare beneficiaries in another state and reduction of burdens preventing reciprocity in state licensures.
- Practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists to provide – and be reimbursed for – telehealth, virtual check-ins, e-visits, and telephone calls to patients.
- Practitioners to provide a greater range of services to beneficiaries via telehealth, including ED visits.
- Medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), to be performed via telehealth.

Further, we very much appreciate that CMS and the Office of Inspector General at the Department of Health and Human Services (HHS) have offered relief from enforcement of Stark Self-Referral and Anti-Kickback laws during the PHE. As you know, while well intended when they were designed, the nature of health care delivery has changed significantly in the decades since these laws were passed and their implementing regulations promulgated. We urge that many of these flexibilities be made permanent so

that patients can have access to the technologies they need to benefit from advances in virtual care. We are concerned that underserved and vulnerable patient populations may not have access to the needed technologies primarily used for telemedicine, including broadband internet access and smartphones, yet providers cannot provide financial help so patients can secure these needed tools.

Without a permanent change, hospitals face significant legal risk if they want to provide a subsidy to their physicians to purchase telehealth technologies, like specialized tablets to perform remote patient monitoring, or if they want to give patients, free of cost or at reduced prices, devices such as wearable "stethoscopes", blue-tooth enabled-digital blood pressure cuffs, or a virtual care kit for a home examination. Patients who cannot afford the out-of-pocket costs for these devices, apps, etc. will be unable to benefit from innovative, patient-centered virtual care. This further exacerbates inequities and health disparities and prevents providers from being able to address many SDOH.

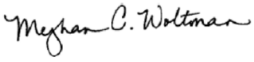
We appreciate the recent changes CMS and HHS have made to the Stark and Anti-Kickback regulations but we urge federal policymakers to further modernize these outdated laws and regulations so that underserved and vulnerable patients can have access to the care and tools they need and deserve.

Summary

Again, we thank you for the opportunity to submit this statement for the hearing record and we stand ready to work with you to ensure that the advances made in leveraging telehealth innovations are sustained so we can continue to improve and transform health care in America, particularly for our most vulnerable patient populations. We urge you and your colleagues to make permanent the PHE-related telehealth waivers and flexibilities.

On behalf of Advocate Aurora's physicians, nurses, other health professionals and associates, and the patients and families we serve, we thank you for your leadership and commitment to ensuring that we as a nation sustain the gains made in expanding access to care via telehealth and digital medicine offerings. Should you or your staff have any questions or if we can be of any assistance on this or other matters, please do not hesitate to contact me (meghan.woltman@advocatehealth.com or 312-933-0455) or Tony Curry (703-786-2571, anthony.curry@aah.org). We look forward to working with you throughout the 117th Congress to improve the health and well-being of the communities we serve.

Sincerely,



Meghan Woltman
Interim Chief Government Affairs Officer
Advocate Aurora Health

December 28, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S. W.
Washington, DC 20201

RE: Regulatory Relief to Support Economic Recovery: Request for Information

Submitted electronically via www.regulations.gov

Dear Administrator Verma:

On behalf of Advocate Aurora Health (Advocate Aurora), the 10th-largest not-for-profit integrated health care system in the country, and Advocate Aurora Health at Home, I am writing to express our appreciation for the opportunity to respond to your request for information (RFI) on regulatory relief to support economic recovery. We are grateful that Executive Order 13924 directed federal agencies to address the "economic emergency created by the COVID-19 pandemic by rescinding, modifying, waiving, or providing exemptions from regulations and other requirements that may inhibit economic recovering, consistent with application law and with protection of the public health and safety" and that you and the Centers for Medicare & Medicaid Services (CMS) for providing numerous flexibilities and waivers throughout this year to facilitate access to care and reduce burdens on patients and providers.

We thank you in advance for your attention to our feedback regarding which regulatory changes have been beneficial to the provision of health care, patients, and providers and which changes should be extended or made permanent. Further, for your reference below, we have included several additional changes that we urge CMS make to remove regulatory barriers that impede efficiency and innovation in the provision of home health care to Medicare beneficiaries. Extending or making permanent a number of changes combined with promulgating additional modifications would allow our home health and hospice providers deliver improved and more cost-effective care to the patients we are so privileged to serve.

Experience with COVID-19

Since the declaration of the National Emergency by President Trump and the Public Health Emergency (PHE) declared by U.S. Department of Health and Human Services (HHS) Secretary Alex Azar earlier this year, your office responded quickly with immediate action to issue waivers and flexibilities to assist both providers and frontline health care workers to expeditiously care for patients while adapting to the ever-changing COVID-19 care environment.

As a post-acute provider in a large health system, we worked with our system hospitals and community based skilled nursing facilities to ensure access for patients infected with COVID-19, offering home hospital programs and expanding capacity for virtual health. As we continue to navigate providing care

in a pandemic, we have found that some of the new flexibilities and innovations provided a better patient experience with the same high-quality outcomes, and that these efficiencies and changes would be beneficial for patients, regardless of whether we were providing care during a PHE. To that end, we ask that you consider making permanent the following waivers and regulatory flexibilities so these changes can benefit patients and providers beyond expiration of the PHE.

Communication Technology-Based Services (CTBS). [Page 75732]

Advocate Aurora has had a robust virtual health program for several years providing tiers of patient support using biometric monitoring, video visits, and telephonic support. As such, we very much appreciate that CMS provided flexibility regarding services provided via telecommunications technology that are not considered Medicare telehealth services. Specifically, we thank CMS for recognizing that these services could reduce or eliminate the need for a patient to have an in-person and that these services not be limited to "established patients." Further, we appreciate that the agency recognized that physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) "might also utilize virtual check-ins and remote evaluations" and provided designated HCPCS codes for billing of these important services. The provision of these services advances patient-centered care and helps reduce patient burden with respect to traveling to see a provider in-person, which for elderly, ill, and/or disabled patients can be particularly challenging. As such, we strongly urge CMS to consider making these changes permanent.

Telephone Evaluation and Management (E/M) Services Codes. [Page 75733]

We thank the agency for also providing – during the PHE – payment for certain CPT codes (98966-98968, 99441-99443) and that these services are extended to both established and new patients. Further, we appreciate that during the PHE, practitioners who cannot separately bill for E/M codes, such as PTs, OTs, and SLPs, are permitted to bill CPT codes 98966-98968. We strongly urge the agency to maintain this flexibility for at least six months following the end of the PHE to allow for patients and providers to transition back to the manner in which telephone E/M services are normally permitted and provided.

Clarification of Homebound Status under the Medicare Home Health Benefit. [Page 75733]

Given the significant threat that COVID-19 poses to individuals, families, and communities and the elevated risk faced by older individuals and individuals with chronic, serious, life-threatening, and/or disabling conditions, it was essential that the agency broaden the definition of homebound to "include beneficiaries whose physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if a patient has a condition that makes them more susceptible to contract COVID-19." We very much appreciate this important recognition to consider this broader group of individuals as eligible for home care and urge the agency to maintain this definition for six months following the end of the PHE because many of these individuals likely will face additional challenges in accessing the health care system and having care provided to them at home, should they choose and their provider deem appropriate, should be available to them.

Use of Telecommunications Technology Under the Medicare Home Care Benefit, [Page 75733] and Use of Telecommunications Technology Under the Medicare Hospice Benefit, [Page 75734]

When home care patients also are receiving hospice, it is essential that care and services are coordinated and continuity of care maintained. We appreciate that during the PHE, CMS has amended regulations on an interim basis "to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' [sic] terminal illness and related conditions without jeopardizing the patients' [sic] health or the health of those who are providing such services during the PHE." This flexibility has played an integral role in ensuring that Medicare home care patients who need hospice care continue to receive both types of services and it has been useful for reporting and cost capture purposes that costs associated with the use of telecommunications technology can be included under "other patient care services" on Worksheet A. We thank the agency for this flexibility and urge the agency to allow this change to be made permanent as it allows for greater flexibility in hospice staffing and facilitates the timely provision of hospice care to patients in need.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act. [Page 75736] and Eligibility for Telehealth. [Page 75749]

We commend CMS for significantly expanding the list of codes for which reimbursement is available for Medicare telehealth services during the PHE. The addition of these services has facilitated the use of telecommunications technology as a safe substitute for in-person services. Further, the elimination of the frequency limitations and other requirements associated with services furnished via telehealth has had a significant, positive impact on our ability to provide and maintain care, while keeping patients and health professionals safe. Moreover, we very much appreciate that CMS has waived the requirements that that specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. These changes have helped ensure that we can reduce COVID-19 exposure for patients and our health professionals, which in turn, has assisted in reducing COVID-19 transmissions and sustained availability of care. In particular, we have appreciated that a number of the additional services/codes pertain to outpatient physical therapy and that health care professionals, including PTs, OTs, SLPs, and others to receive payment for Medicare telehealth services. We realize that many of these changes require Congress to change underlying Medicare statute; however, we also know that some modifications can be undertaken by CMS and that the agency can extend these waivers beyond the PHE. As such, we strongly urge the agency to extend these waivers and flexibilities for another 18 months past the year in which the PHE ends to allow patients to continue to benefit from this expansion of services and for the agency to collect and analyze data to assess the impact of these changes on patients, providers, and the government, as a payor.

Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement. [Page 75736]

The use of telecommunications technology by the hospice physician or nurse practitioner (NP) for the face-to-face visit when a visit is for recertification has increased efficiency for providers and improved access to care for patients. Providers, patients, and family members all have embraced this efficient and patient-centered approach as this allows for prompt recertification, maintaining continuity of care and eliminating barriers. We urge that you make this change permanent, so it is available as an option for patients and providers, even after the PHE ends.

Home Health Orders from APPs. [Page 75736] and Care Planning for Medicare Home Health Services. [75737]

We appreciate that CMS has recognized the important role that NPs, clinical nurse specialists (CNSs), and PAs play in the provision of care to Medicare beneficiaries in home health. Specifically, we thank the agency for making changes to allow advanced practice providers (APPs) to order home health services, establish and periodically review a plan of care, certify and recertify the plan of care for home health patients. NPs, CNSs, and PAs have firsthand knowledge of the patient's current course of care before transitioning them to the home health setting; as such, allowing these professionals to order home health facilitates improved care coordination among providers and reduces delays and barriers to access to care. We thank CMS for amending regulations to define NPs, CNSs, and PAs as allowed practitioners for certifying, establishing, and periodically reviewing the plan of care, as well as supervising the provision of home health items and services. Further, we note that the regulations have been changed also to allow these practitioners to conduct the face-to-face encounter for certifying eligibility but acknowledge that the certifying practitioner may be different from the provider performing the face-to-face encounter. As noted in the RFI, these regulation changes are permanent and are not time limited to the PHE and as such, we believe they will have a profound and lasting positive impact on increasing access to home health, as many beneficiaries are medically managed by advanced practice nurses (APNs) and PAs in many other areas of the health care continuum, such as skilled nursing facilities and office-based settings.

Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients. [Page 75747]

This blanket modification importantly allows any rehabilitation professional, acting within their state scope of practice law, to perform the initial and comprehensive assessment. Home health professionals work as a team to provide a comprehensive care plan to patients and allowing any discipline to conduct the initial home visit and comprehensive assessment supports this team-based approach. We have had success, for example in cross-training OTs to conduct the OASIS assessments. We found that this improves access to care for patients, as well in situations where staffing is affected offers patients timely access to an initial assessment, decreasing wait times for the initiation of home health services. Having this flexibility is critical and making this waiver permanent would be incredibly helpful to maintain this improved efficiency in the initiation of home care for Medicare beneficiaries.

Waive Onsite Visits for Home Health and Hospice Aide Supervision. [Page 75744]

We recognize the importance of assuring personal care is provided safely and effectively – and consistent with the care plan – to vulnerable patients. However, we believe this does not always need to be done onsite. We have found supervision can be done in an effective and efficient manner by talking via phone to the patient and nursing aide. These team members also participate in team conferences, which allow for the adequate exchange of information to assure the care plan is reviewed and revised as necessary. We ask that for the future, CMS provide agencies the flexibility of performing onsite or virtual supervisory visits for patients every 14 days.

Clinical Records for Home Health Agencies [Page 75758]
We thank CMS for extending the deadline for completion of the requirement that HHAs need to meet to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). Specifically, we appreciate that CMS will allow HHAs ten business days to provide a patient's clinical record, instead of four. We respectfully request that CMS extend this waiver for six months following the end of the PHE; additional time will allow HHAs to adjust to the provision of care and services following the PHE and otherwise support compliance with this requirement.

Review Choice Demonstration for Home Health Services Claims Processing Requirements [Page 75760]

We very much appreciate that effective March 29, 2020, CMS paused the claims processing for the Review Choice Demonstration (RCD) until the PHE has ended. We understand that as of now, "following the end of the PHE for the COVID-19 pandemic, the MAC [Medicare Administrative Contractor] will conduct post payment review on claims subject to the demonstration that were submitted and paid during the pause.

Additional Recommended Changes

Over the April through June 2020 period – at the height of the PHE – our home health team made more than 51,000 telephonic and 300 video visits to patients in order to sustain continuity of care and reduce concerns of possible COVID-19 transmission. These calls were instrumental in keeping patients safe in their home while executing a home care plan necessary to avoid preventable emergency room visits or hospital admissions. In fact, our team created a Home Hospital program, which allowed patients with COVID-19 who would have been admitted to the hospital to return home from the emergency room and receive provider visits, biometric monitoring, oxygen, and nursing support. This program was successful in creating our "hospital without walls" approach and expanding capacity in our brick and mortar institutions. This patient-centered approach helped ensure that there were inpatient beds available to those patients who needed them while patients who did need a higher level of care, but not at the hospital, were able to receive care and services in the safety and comfort of their own homes.

Advocate Aurora participates in three Accountable Care Organizations in two states and manages more than 322,000 covered lives in the MSSP where risk is shared and managed. Our goal is to have every patient at the right level of care utilizing services that are appropriate to meet their health care needs at any given time. Virtual health is cost effective and should be used with every level of provider to assure continuity of care and patient access, and to avoid the seeking of higher levels of care when they are unnecessary. Therefore, we are disappointed that CMS does not recognize virtual home health visits as bona fide encounters. Leaders in the home health industry are interested in partnering with CMS to develop a reimbursement methodology that supports the delivery of telehealth to home health patients by home health agencies.

We recognize that current statute prohibits "payment for services furnished via telecommunications systems if such services substitute for in-person home health services ordered as part of a plan of care." However, we believe it is time for CMS to work with home health providers to explore innovative ways

to design and implement a reimbursement structure for virtual encounters in the home health setting that supports the deployment of technology to the benefit of Medicare beneficiaries, the Medicare Trust Fund, and providers.

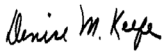
For example, *using its existing waiver authority*, CMS could allow participants in the MSSP to provide telehealth and other virtual visits in lieu of in-person visits and have such visits substitute for in-person home health. MSSP participants have built-in incentives to provide patient-centered care that keeps Medicare beneficiaries healthy and out of the hospital, because they are held accountable for both costs and outcomes. There is no incentive for MSSP participants to "skimp" or provide virtual care that should be provided in-person. Working together, we could enumerate an agreed upon list of the types of care, services, and encounters that all parties agree could safely and effectively be provided virtually and have those be on the "approved" list for permitted to be substituted for in-person visits. Further, we could identify the types of patients and circumstances under which virtual care can be provided in lieu of face-to-face. We welcome the opportunity to discuss this idea and explore others with you and your staff.

While it does not go as far we would like, we wish to thank the agency for making permanent under the 2021 Home Health final rule the change to "allow the use of telecommunications technology included as part of the home health plan of care as long as the use of such technology does not substitute for ordered in-person visits." In addition, we appreciate that the agency will soon allow "HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost report." Furthermore, we recommend that for purposes of data collection, virtual encounters be listed on future home health claims to better understand how these tools are used to benefit patients.

Conclusion

On behalf of the tens of thousands of individuals and families we serve across communities throughout Illinois and Wisconsin, we thank you for soliciting feedback from the public regarding which regulatory changes that have been made in response to the COVID-19 PHE have been beneficial, which should be maintained either through longer extension or permanence. As always, we stand ready to be a resource to the agency on these and other issues regarding the provision of quality care to Medicare beneficiaries who are homebound and/or in need of hospice care. Please do not hesitate to contact me, or Tony Curry, Advocate Aurora Director, Federal Government Affairs (Anthony.Curry@aah.org, 703/786-2571).

Sincerely,



Denise Keefe
President
Post-Acute Division
Advocate Aurora Health

March 2, 2021

MEMORANDUM

From: Charlie Katebi, Health Policy Analyst, Americans for Prosperity

For: Interested Parties

Subject: Making Federal Telehealth Expansions Permanent

Telehealth Expands Access to Life-Saving Care

Since the start of the COVID-19 pandemic, the Centers For Medicare and Medicaid Services (CMS) removed a series of harmful barriers on telehealth in order to expand health access and slow the spread of the virus. Prior to our public health emergency, only 13,000 Medicare enrollees on average received virtual care every week. After these reforms took effect, the number of enrollees receiving telehealth increased to 1.7 million every week.[i] By April, healthcare workers delivered nearly half of all primary care to seniors through telehealth.[ii]

Telehealth Lowers Health Care Costs

Expanding access to telehealth also lowers health care spending by providing patients a low-cost alternative to expensive in-person care. Primary care practitioners routinely use telehealth consultations to refer patients to urgent care clinics instead of making costly emergency department visits. Virtual care also allows providers to remotely monitor and treat patients at home instead of inside a hospital.

For example, the Veterans Health Administration has utilized telehealth to reduce hospitalizations by up to 40 percent by remotely monitoring chronically-ill patients and provide timely interventions.[iii] These innovations saved nearly $6,500 for every individual within the program. An analysis by Robert Litan from the Brookings Institute found that expanding remote patient monitoring could save nearly $200 billion nationwide.[iv]

Telehealth Recommendations For Congress

Unfortunately, most of CMS' emergency telehealth reforms are temporary. Without additional

actions from lawmakers, patients will lose access to life-saving virtual care when the emergency declaration ends. Policymakers should make these reforms permanent to strengthen America's capacity to combat COVID-19 and other long-term health care challenges.

Removes barriers on patient locations: Under changes implemented by the CARES Act, CMS authorized health care providers to deliver care to patients located in any zip code and setting, including their home.[v] Prior to this reform, patients could only receive telehealth services from select health care facilities in rural areas.

Removes barriers on provider locations: Under the CARES Act, CMS announced that health care practitioners can deliver telehealth from an expanded array of facilities, including Federally Qualified Health Centers, Rural Health Centers, and their own homes.[vi]

Expands list of telehealth services: Starting March 1, 2020, CMS announced that health professionals can deliver approximately 240 additional telehealth services to Medicare recipients, including mental health consultations, home health visits and emergency care.[vii]

Expands list of telehealth providers: Prior to COVID-19, federal law authorized only nine types of health care providers to deliver telehealth services.[viii] Fortunately, the agency expanded the list of telehealth provider-types to include all practitioners who are currently authorized to deliver in-person care to Medicare recipients, including physical therapists, occupational therapists, and speech language pathologists.[ix]

End technology restrictions on telehealth: The Office for Civil Rights (OCR) issued guidance allowing health care providers to deliver telehealth through any non-public facing telecommunication platform, including Zoom, Apple FaceTime, and Skype.[x]

Allow telehealth across state lines: Prior to COVID-19, federal law prohibited health care practitioners from delivering telehealth to patients across state lines.[xi] Fortunately, CMS issued a waiver allowing health care providers to deliver telehealth in states that explicitly authorize out-of-state providers to provide virtual care without an additional license.[xii]

---

[i] https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/
[ii] https://aspe.hhs.gov/system/files/pdf/263866/hp-issue-brief-medicare-telehealth.pdf
[iii] https://www.aha.org/system/files/content/16/16telehealthissuebrief.pdf
[iv]https://www.ambiohealth.com/uploads/Vital%20Signs%20Via%20Broadband%20Remote%20Health%20Monitoring%20Transmits%20Savings%20Enhances%20Lives.pdf
[v] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
[vi] https://www.cms.gov/files/document/covid-rural-health-clinics.pdf
[vii] https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes
[viii] https://www.law.cornell.edu/cfr/text/42/410.78
[ix] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf
[x] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

[xi] https://www.law.cornell.edu/cfr/text/42/410.78
[xii] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

AHRQ portfolio on chronic pain and/or telehealth 2021

Project type	Topic	Chronic Pain	Telehealth	Institution	Funding	Notes
Implementation	Management of Opioids in Older Adults	Y	Y	UChicago, UMichigan, UOklahoma	Total: $2.25 million over 3 years (FY2020-2022)	3 grants using telehealth and other approaches to improve opioid management in older adults
Implementation	Management of Opioid Use and Misuse in Older Adults in Primary Care Practices	Y	Possibly	Abt Associates	$3.3 million (FY2019-2022)	Contract to test tools and strategies which are likely to include telehealth
Intervention	CDS for chronic pain management	Y	Y	1) RTI 2) Medstar	1) $3.6 million 2) $3.7 million	2 contracts to develop patient and provider facing digital health applications for managing chronic pain
Intervention	Interoperable electronic (eCare) plan	Y	Y	RTI	$1.9 million; may add $1.4 million to expand to cover COVID care planning	Includes chronic pain and opioid use as one of the target conditions; not specifically telehealth but would make care planning possible through telehealth.
Intervention	Registry-Assisted Dissemination of Mobile Pain Management for Youth with Arthritis	Y	Y	Children's Mercy Hospital	$285,000	Investigator initiated grant using mHealth for JIA.
Interventions	Optimizing Acute Post-Operative Dental Pain Management Using New Health Information Technology	N	Y	UCSF	$1.2 million	Investigator initiated grant using mobile phone technology

Review	Telehealth for Acute and Chronic Care Consultations	N	Y	Pacific Northwest EPC	$500,000	Assessed the effectiveness of telehealth consultations and explored supplemental decision analysis
Review	Integrated Pain Management programs	Y	Y	OHSU	$370,000 (2021)	No trials of telehealth interventions identified
Review	Noninvasive Nonpharmacological Treatment for Chronic Pain	Y	Y	OHSU	$350,000 (2020)	No trials of telehealth interventions identified
Review (Brief)	Care Coordination and Care Plans for Transitions Across Care Settings	Y	Y	OHSU	$27,000 (2021)	No randomized trials specifically in patients with pain identified
Review (Brief)	Treatments and Technologies Supporting Appropriate Opioid Tapers	Y	Y	OHSU	$27,000 (2021)	No studies of technological interventions identified
Review (Brief)	Treatments, Technologies, and Models for Management of Acute and Chronic Pain in Persons With a History of Substance Use Disorder	Y	Y	OHSU	$27,000 (2021)	No studies of technological interventions identified
Review (Brief)	The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic	N	Y	OHSU	$5,000 (2020)	Summary of pre-COVID studies of telehealth applied to issues around providing care during COVID
Review (Brief)	Improving Rural Health Through Telehealth-Guided Provider-to-Provider Communication	N	Y	OHSU	$125,000 (2021)	In process

ALLIANCE FOR CONNECTED CARE STATEMENT FOR THE RECORD

"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

U.S. House Committee on Energy and Commerce Subcommittee on Health

March 3, 2020

Dear Chair Eshoo, Ranking Member Guthrie, and Members of the Subcommittee on Health:

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide input to the Committee on "*The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care.*" We applaud your continued leadership and critical role in ensuring Medicare beneficiaries were able to access virtual care during the COVID-19 Public Health Emergency (PHE).

The Alliance is dedicated to improving access to care through the reduction of policy, legal and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of more than 30 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

The Alliance will provide 1) overarching comments about telehealth research and evidence, 2) recommendations for telehealth expansions that Congress should consider and 3) recommendations for telehealth "guardrail" provisions that Congress could consider, if you feel they are necessary.

Telehealth Research and Evidence

We have a unique opportunity afforded by the PHE to understand the effects of telehealth on clinical practice – and to make direct apples-to-apples comparisons across service modality. The sudden shift to virtual services generated fee-for-service (FFS) data and empirical provider and patient experience that didn't exist prior to the pandemic. This data is just now being understood, and peer-reviewed studies and reports are forthcoming. We believe it is essential to take this new evidence into account when writing permanent laws especially given that pre-pandemic telehealth studies were either narrowly-focused or relied on inferences on the impact of Medicare using commercial or Veterans Affairs data.

The COVID-19 pandemic has resulted in drastic increases in telemedicine utilization, introducing millions of Americans to a new way to access health care. Data from the Centers for Disease Control and Prevention (CDC) finds that during the period of June 26 – November 6, 2020, 30.2 percent of weekly health center visits occurred via telehealth. In addition, preliminary data from the Centers for Medicare & Medicaid Services (CMS) show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE. Finally, an HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicare fee-for-service (FFS) telehealth report found that from mid-March through early July more than 10.1 million traditional Medicare beneficiaries used telehealth, including nearly 50 percent of primary care visits conducted via telehealth in April vs. less than 1 percent before the COVID-19 pandemic. In addition to

providing a lifeline to continuity of care, it is important to note that the net number of Medicare FFS primary care in-person and telehealth visits combined remained below pre-pandemic levels. As in-person care began to resume in May, telehealth visits dropped to 30 percent but there was still no net visit increase. We infer this and other data showing that as in-person visits increased, telehealth visits decreased, that there was a substitution effect. A claims-based analysis suggests that approximately $250 billion in health care spend could be shifted to virtual care in the long term – roughly 20 percent of all Medicare, Medicaid and commercial outpatient, office and home health spend. The effects of the COVID-19 pandemic on patients seeking or avoiding care still need further analysis, but these data suggest that telehealth substituted for in-person care without increasing utilization.

In addition to telehealth largely substituting for in-person care, policymakers should consider telehealth's ability to increase efficiencies and improve access where barriers to care exist. COVID-19 has dramatically heightened awareness of existing health disparities and made the call to address these longstanding issues more urgent. Transportation is just one example of a barrier to care that telehealth can alleviate. Transportation barriers are regularly cited as barriers to access, particularly for low-incomes or under/uninsured populations – leading to missed appointments, delayed care, and poor health outcomes. In a 2018 proposed rule, CMS estimated that telemedicine is saving Medicare patients $60 million in travel time, with a projected estimate of $100 million by 2024 and $170 million by 2029. CMS also noted that these estimates tend to underestimate the impacts of telemedicine. Higher projections estimate $540 million in savings by 2029.

The experience during COVID-19 has pushed forward a revolution in consumer attitudes toward virtual care. Polling data from the University of Michigan showed that one in four older adults had used telemedicine during the first three months of the pandemic, compared to just 4% in 2019. The same poll showed that 64% of those surveyed in June 2020 were comfortable with using videoconferencing technology for any purpose, up from 53% in May 2019.

Top Telehealth Priorities

These priorities were also outlined in the July 2020 group letter to Congress with 340 endorsing organizations. The following four items should be the core of any serious telehealth expansion.

- Removal all geographic and originating site restrictions on telehealth in Medicare. The COVID-19 pandemic has clearly demonstrated the need for telehealth in rural areas, in urban areas, at work, at school, at home and many other locations. These provisions are obsolete and outdated and should be removed from statute entirely. The location of the patient should not matter for telehealth.

- Remove distant site provider list restrictions to allow all Medicare providers who deliver telehealth-appropriate services to provide those services to beneficiaries through telehealth when clinically appropriate and covered by Medicare – including physical therapists, occupational therapists, speech-language pathologists, social workers, and others.

- Ensure Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics can furnish telehealth in Medicare and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each. Please note that critical access hospitals are sometimes omitted from this list, but are a crucial component of a healthcare system able to reach all Medicare beneficiaries and must be able to directly bill for telehealth services.

- Make permanent the Health and Human Services (HHS) emergency waiver authority for virtual care so that it can be quickly leveraged during future emergencies. Telehealth has maintained critical connections between patients and healthcare practitioners during the pandemic, and should be enabled for a future wildfire, flood, hurricane, or other emergency.

Additional Recommendations for Inclusion

- Enable the Centers for Medicare and Medicaid Services (CMS) to retain "Hospital Without Walls" authorities after the end of the public health emergency and encourage that these authorities be used to maintain site of care flexibility whenever the services provided are clinically appropriate for virtual delivery. We believe that expanded capability for hospitals to monitor and care for patients could lead to shorter or avoided hospital stays – a potential benefit for both seniors and the Medicare program.

- Fund a comprehensive study of telehealth during the COVID-19 pandemic using claims data and qualitative interviews with providers and patients who used telehealth during the pandemic. The study should to answer specific questions critical to future telehealth decision-making by Congress and regulators at CMS. Suggested priorities include:
    1. Is telehealth being adequately leveraged to address health disparities, and what policies could Congress or HHS enact to ensure telehealth is a tool to increase access to those most in need of healthcare?
    2. To what extent are Medicare telehealth services during the PHE replacing in-person care?
        - How often to telehealth services require a follow-up in person visit and how often are they fulfilling patient needs?
        - Is the availability of telehealth increasing utilization, and if so, are they primary care or preventative services with the potential to prevent a more costly encounter downstream?
    3. Are there specific, high-cost areas of the Medicare program that might lower long-term costs through telehealth utilization?
        - Are care coordination codes that have been shown to improve care such as 99495 and 99496 being used more frequently during virtual care?
        - Has the shift to using telehealth to manage lower acuity conditions in skilled nursing facilities prevented unnecessary transfers to hospitals?
    4. To what extent have CMS permissions for virtual/remote supervision of healthcare professionals been utilized during the COVID-19 pandemic? Have these permissions resulted in patient harm? How have healthcare providers expanded their capability and capacity using this tool during the PHE.
    5. In addition to HHS investigations of fraud and abuse, what has been the healthcare provider, patient, and health plan experience with fraud perpetrated through virtual tools during the PHE?

- Facilitate the removal of remaining telehealth restrictions on alternative payment models
    - Accountable Care Organization's (ACO) telehealth flexibility is limited a narrow set of ACOs with downside risk and prospective assignment – even though other tools apply to all ACOs. Since all participants in the Medicare Shared Savings Program are being held accountable for quality, cost, and patient experience, all of them should have flexibility to use telehealth tools to deliver care. We recommend eliminating Sec. 1899. [42 U.S.C. 1395jjj] (l)(2) requirements limiting participation to a select set of ACOs. *(We believe CMS may already have the statutory authority to make these changes under 42 U.S.C. 1315a(d)(1) and 42 U.S.C. 1395jjj(f) if directing the use of authority instead would keep the score down)*

- Allow the Centers for Medicare and Medicaid Services to cover audio-only telehealth services where necessary to bridge gaps in access to care. This would include, at a minimum, flexibility for areas with limited broadband service, for populations without telehealth-capable devices, or in necessary situations such as a future public health emergency. We anticipate that CMS would also maintain a list of services that were appropriate for this emergency audio-only care, as it has done during the PHE, and that the clinician would document the reason.

- Expand virtual chronic disease interventions with the potential to prevent downstream costs to the Medicare program. The most obvious example are virtual diabetes prevention programs (DPP), which can produce transformative weight loss reducing the prevalence of obesity and comorbidities including prediabetes and type 2 diabetes. These programs can produce better outcomes for patients and would likely reduce downstream costs to the Medicare program, not only by expanding access to a broader set of beneficiaries but by keeping patients engaged and creating more sustainable lifestyle changes. During the COVID-19 PHE, CMS has allowed DPP providers to practice virtually, but it has not created a long-term pathway for virtual DPP programs. As much of the commercial market has already moved to virtual care and app-driven interventions, the DPP program must be able to adapt to meet patients where they are and expand access to services for individuals not near a physical DPP provider.

- Expand the mandate of the Office for the Advancement of Telehealth at HRSA and require it to develop tools and resources on telehealth services that can be distributed to small healthcare practices, patients, and consumer organizations. Additionally, explore partnerships with leading consumer and patient organizations to educate seniors about telehealth services, including the use of technology and how to verify the identity of a healthcare provider.

- Encourage CMS to continue facilitating greater use of remote patient monitoring (RPM) technology through policy, including ongoing flexibility for allowing acceptance of patient-reported data for scales up to meet connected device requirements.

Recommendations for Fraud, Waste, and Abuse

The Alliance understands that with change sometimes comes risk, and that Congress holds ultimate authority for protecting the Medicare program. We understand and respect this responsibility. We also believe that, using the data we are collecting about the provision of telehealth services during the PHE, the Medicare program and the Office of the Inspector General at HHS will be able to target and differentiate nearly all fraudulent behavior. Congress must trust this capability and authority, rather than creating barriers to access between Medicare beneficiaries and critical health services.

The Alliance and its members strongly believe that an in-person requirement, as Congress created in the Consolidated Appropriations Act, 2021 (P.L. 116-260) is never the right guardrail for a telehealth service. Requiring an in-person visit constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. It does not constrain those using telehealth for convenience. This creates a perversion of the Medicare payment system by reducing access for those who need it most, while allowing access for others. We cannot create a guardrail that is an access barrier between patients and their clinicians – it will lead to harm the most vulnerable and access-constrained Medicare beneficiaries.

We also believe it is important to note that nearly all of the fraud Congress may seek to prevent is fraud that mirrors activities currently occurring during in-person care. These concerns include fraudulent Medicare enrollment, false claims, fake patients, and durable medical equipment (DME) prescribing. All of these issues are problems for the Medicare program – and should be addressed as Medicare fraud problems. They are not new problems for telehealth services. Therefore, an in-person requirement would hinder legitimate telehealth providers while doing very little to stop fraudulent actors. Instead of creating barriers to services for Medicare beneficiaries, Congress must empower CMS to address fraudulent actors.

We are pleased to note that on February 26, 2021, OIG Principal Deputy Inspector General Grimm issued a statement to this effect – differentiating between fraud perpetrated through virtual tools and telehealth fraud.

> *"We are aware of concerns raised regarding enforcement actions related to "telefraud" schemes, and it is important to distinguish those schemes from telehealth fraud. In the last few years, OIG has conducted several large investigations of fraud schemes that inappropriately leveraged the reach of telemarketing schemes in combination with unscrupulous doctors conducting sham remote visits to increase the size and scale of the perpetrator's criminal operations. In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. We will continue to vigilantly pursue these "telefraud" schemes and monitor the evolution of scams that may relate to telehealth."*

Recommendations

With the understanding the Congress may still want to pursue additional guardrails against fraud, waste, and abuse as part of telehealth legislation, we offer the following alternatives. Please note that many of these are simple regulatory changes, and could be issued as recommendations to CMS.

- Enhance the ability of HHS to fight fraud in Medicare through new resources and capacity
  - Provide additional funding for OIG to strengthen existing fraud, waste, and abuse mechanisms that have already been proven successful in fighting fraud perpetrated through virtual tools. The House Ways and Means minority staff has proposed workable text to this effect that we support.
  - We also support the development of OIG telehealth compliance guidance to healthcare organizations to help prevent and mitigate unintentional mistakes related to Medicare telehealth billing.
  - Strengthen the *Public-Private Partnership for Health Care Waste, Fraud and Abuse Detection* created by the Consolidated Appropriations Act of 2021 (Section 1128C(a) of the Social Security Act (42 U.S.C. 1320a-7c(a)). This public-private partnership must be empowered with experts with experience in virtual care delivery and payment.
    - After – (6)(E)(i)(II) add *"(III) The executive board shall include no less than 3 individuals with significant expertise delivering and managing the delivery of virtual care, including practitioners, medical directors and individuals with oversight of telehealth programs, and virtual care experts with experience in corporate fraud prevention.*

- Work with CMS to develop restrictions on the solicitation of Medicare Fee-For-Service telehealth services**.** It is our understanding that one of the primary ways in which fraudulent actors exploit virtual services is by calling Medicare beneficiaries to solicit their interested in high-value DME products. We believe a restriction on marketing, as currently exists for DME, would significantly hinder situations in which DME fraud actors exploit telehealth services to drive DME sales. As long as there was a significant allowance for legitimate marketing practices, we do not believe this restriction would hinder legitimate telehealth providers.

- Work with CMS to strengthen the Medicare provider enrollment process. The provider enrollment process is the best tool to prevent fraudulent actors from billing the Medicare program. Rather than placing barriers between patients and telehealth services, the enrollment process should be strengthened to identify and screen higher risk entrants.

- Encourage CMS to advantage of the enhanced data capabilities present in most telehealth platforms. Technology platforms that provide telehealth are often capable of automatically recording times, dates, patient information, prescribing, and other details which can be used to enhance compliance. These technologies should allow for the greater use of audits and other forms of retroactive monitoring approaches on providers. As long as data capture requirements are very clear, and that compliance with any requirements do not impose a significant regulatory burden they could be a compliance tool. (Please note that very small-providers should likely be exempted from these burdens.)

- Work with CMS to develop targeted restrictions on high-value, high-risk DME prescribing through a telehealth. While we continue to believe that there are some appropriate circumstances for this prescribing, a step like this could significantly lower risk to the Medicare program.

Thank you for your consideration of these recommendations. Some combination of these recommendations could protect the Medicare program while aligning with the recommendations of the Task Force on Telehealth Policy, which stated "*we should not hold telehealth to higher standards than other care sites, and we should trust clinicians providing telehealth services to triage patients needing a higher level or care or in-patient care, as we do in other care settings. As is done in other care settings, patients' preference for obtaining care in-person or via telehealth should be respected.*"

*****

The Alliance greatly appreciates the Energy and Commerce Committee's leadership in working to ensure that seniors are able to realize the benefits of telehealth and remote patient monitoring. We look forward to working with you to advance legislation supporting continued access to care for vulnerable seniors. If you have any questions or would like to hear from Alliance member experts on these topics, please do not hesitate to contact Chris Adamec at cadamec@connectwithcare.org.

Sincerely,

Krista Drobac

Krista Drobac
Executive Director

THE ALS ASSOCIATION
BOARD OF TRUSTEES

Officers

Chair
Sue Gorman

Chair-Elect
Scott Kauffman

Vice Chair
Fred DeGrandis

Treasurer
Connie Houston

Secretary
Keith A. Gary, Ph.D.

Lawrence R. Barnett
Founding Chairman
1913-2012

Trustees

Jinsy Andrews, M.D., MSc
Millie Arnold
Eugene Brandon, Ph.D.
Mark Calmes
Tom Carroll
Larry Falivena
Paul Ingholt, Esq.
Christi Kolarcik, Ph.D.
John P. Krave, Esq.
Tobin M. Kucharski
Nancy LeaMond
Lou Libby, M.D.
J. Thomas "Tommy" May
Kenneth Menkhaus, Ph.D.
Warren Nelson
Sandra Piersol
Judy Pratt, D.M.D.
Charles Robinson, D.Sc., P.E.
John A. Robinson, Ed.D.
Wendy Schriber, Esq.
Kevin Spinella, Esq.
Mark Stancil
David Van de Riet

President and CEO
Calaneet Balas

Statement for the Record

Neil Thakur, Ph.D., Chief Mission Officer, The ALS Association
for the
House Energy and Commerce Health Subcommittee Hearing
entitled
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

The ALS Association would like to thank Chairwoman Eshoo, Ranking Member Guthrie, and members of the Energy and Commerce Health Subcommittee for the opportunity to submit this statement for the record for the Subcommittee hearing entitled, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care."

The COVID-19 pandemic has been challenging for the more than 20,000 Americans with ALS we represent. People with ALS are at increased risk of death from COVID-19 and require routine monitoring and treatment from health care providers in order to maintain their health. We appreciate that in response to the public health emergency, federal and state agencies provided new, and in some cases time-limited, flexibilities for telehealth services to enable patients to see providers from the safety of their homes in order to reduce disruptions to care.

ALS is an always fatal neurodegenerative disease in which a person's brain loses connection with the muscles. People with ALS lose their ability to walk, talk, eat and eventually breathe. There is no cure, and the average life expectancy following diagnosis is less than 5 years.

Telehealth and Multidisciplinary Care

Multidisciplinary care is clinically proven to increase the quality of life[1] and survival[2] for people with ALS. Since 1998, The ALS Association's nationwide network of Certified Treatment Centers of Excellence has provided evidence-based, multidisciplinary ALS care and services in a supportive atmosphere with an emphasis on hope and quality of life.[3] The ALS Association's Certified Treatment Center of Excellence program provides a national standard of best-practice care in the management of ALS. Certifications are based on established

[1] Van den Berg L, Kalmihn S, Lindeman E, et al. Multidisciplinary ALS care improves quality of life in patient with ALS. Neurology. 2005; 65:1264-1267.
[2] Traynor BJ, Alexander M, Corr B, Frost E, Hardiman O. Effect of a multidisciplinary amyotrophic lateral sclerosis (ALS) clinic on ALS survival: a population based study, 1996-2000. J Neurol Neurosurg Psychiatry. 2003; 74:1258-1261.
[3] https://www.als.org/local-support/certified-centers-clinics/more-information-certified-centers-clinics

requirements of the program, professionals' skill sets, people living with ALS served, active involvement in ALS-related research, relationships with local chapters, and access to care.

As the disease progresses, people with ALS eventually become unable to leave their homes to attend a multidisciplinary clinic. Counterintuitively, the time-limited flexibilities for telehealth during the COVID-19 pandemic has provided people with ALS increased access to vital multidisciplinary medical care that was out of reach prior to the pandemic. Telehealth has proven an effective tool to allow clinicians more effective care for patients for whom travel to clinic is burdensome, fatiguing, or otherwise impractical.[4] Importantly, many states have suspended or relaxed interstate telehealth physician licensure requirements.[5] This has enabled telehealth infrastructure to improve and provided researchers with new opportunities to advance ALS science through remote clinical trials.

Remote Clinical Trials

The ALS Association's Certified Treatment Centers of Excellence also offer people with ALS the potential to participate in clinical trials and research. Recognizing the importance of remote trials, the Food and Drug Administration (FDA) published guidance in 2016 with recommendations on the use of electronic systems and processes for obtaining informed consent for both HHS-regulated human subject research and FDA-regulated clinical investigations of medical products, including human drug and biological products, medical devices, and combinations thereof.[6] Following the COVID-19 pandemic, the FDA published additional guidance on the conduct of clinical trials of medical products during the public health emergency.[7] While the challenges to research caused by COVID-19 are unprecedented, desperately needed research for ALS treatments can continue through remote televisits, home safety measures like sending a service to collect labs, medical surveys, and even wearable technologies.[8] Remote clinical trials are accelerating the science to find new treatments and cures

---

[4] Andrews JA, Berry JD, Baloh RH, et al. Amyotrophic lateral sclerosis care and research in the United States during the COVID-19 pandemic: Challenges and opportunities. Muscle & Nerve. 2020;62:182–186. https://doi.org/10.1002/mus.26989

[5] Federation of State Medical Boards. https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-fortelehealth-in-response-to-covid-19.pdf. Accessed February 24,2021.

[6] US Food and Drug Administration. *Use of electronic informed consent: questions and answers, guidance for institutional review boards, investigators and sponsors.* December 2016. https://www.fda.gov/media/116850/download. Accessed February 24, 2021.

[7] US Food and Drug Administration. (2020, February). *Conduct of Clinical Trials of Medical Products During the COVID-19 Public Health Emergency - Guidance for Industry, Investigators, and Institutional Review Boards*. https://www.fda.gov/media/136238/download

[8] Andrews JA, Berry JD, Baloh RH, et al. Amyotrophic lateral sclerosis care and research in the United States during the COVID-19 pandemic: Challenges and opportunities. Muscle & Nerve. 2020;62:182–186. https://doi.org/10.1002/mus.26989

through increased trial participation and availability that was previously restricted to patients living near a trial site.

Conclusion

The COVID-19 pandemic has catalyzed expansion of telehealth clinical care and research through remote clinical trials. The ALS Association believes that telehealth and remote clinical trials can and should be used to increase ALS patient access to care and clinical trials. We stand ready to work with Congress, the Administration, and state governments to ensure that all patients can continue to safely access appropriate telehealth services during and after the COVID-19 public health emergency. As policymakers begin to shape what telehealth looks like post-pandemic, it is important that the patient perspectives be considered to ensure that policymakers fully account for the needs of all Americans, including patients with rare, orphan diseases like ALS.

Again, thank you for the opportunity to submit this statement for the record. With your support, we can change the course of ALS for thousands of Americans and bring an end to this terrible disease. Please contact Abram Bieliauskas (abieliauskas@alsa-national.org / 202-464-8634) with any questions the Subcommittee may have.

Sincerely,

Neil Thakur, Ph.D.
Chief Mission Officer
The ALS Association
als.org

Attached: Andrews JA, Berry JD, Baloh RH, et al. Amyotrophic lateral sclerosis care and research in the United States during the COVID-19 pandemic: Challenges and opportunities. Muscle & Nerve. 2020;62:182–186. https://doi.org/10.1002/mus.26989

Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

United States House Committee on Energy and Commerce, Health Subcommittee Hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

March 2, 2021

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the House Committee on Energy and Commerce, Health Subcommittee hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." The Association and AIM thank the Subcommittee for its continued leadership on issues important to the millions of people living with Alzheimer's and other dementia and their caregivers. This statement provides an overview of telehealth policies that continue to help people living with Alzheimer's and other dementia during the COVID-19 pandemic and beyond, including efforts to expand capacity for health outcomes through Project ECHO, and the permanent expansion of Medicare and Medicaid coverage of certain telehealth services.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy arm, working in strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and development of approaches to reduce the risk of developing dementia.

Expanding Capacity for Health Outcomes (Project ECHO)

The Alzheimer's Association and AIM thank the Subcommittee and other members of Congress for including language in the Consolidated Appropriations Act, 2021 (P.L. 116-260) to expand the use of technology-enabled collaborative learning and capacity-building models. These innovative education models, often referred to as Project ECHO, help build workforce capacity and improve access to care. These models use a hub-and-spoke approach by linking expert specialist teams at a 'hub' with the 'spokes' of health providers in local communities to increase on-the-ground expertise. Using case-based learning, Project ECHO models can improve the capacity of providers, especially those in rural and underserved areas, on how to best meet the needs of people living with Alzheimer's and other dementia.

Project ECHO continues to play an important role in how health providers, public health officials, and scientists are sharing best practices and information for addressing the COVID-19 pandemic. Project ECHO dementia models are helping primary care physicians in real-time understand how to use validated assessment tools appropriate for virtual use to make early and accurate diagnoses, educate families about the diagnosis and home management strategies, and help

caregivers understand the behavioral changes associated with Alzheimer's, which can be heightened during social isolation. Project ECHO is also helping long-term care providers in real-time understand how to train temporary staff that may not be familiar with how to best care for people with Alzheimer's, implement important health strategies, such as hand-washing and social distancing for people with Alzheimer's, and effectively communicate with residents to help them understand the COVID-19 pandemic.

In fact, using funds from the Provider Relief Fund established by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), the Agency for Healthcare Research and Quality (AHRQ) established the AHRQ ECHO National Nursing Home COVID-19 Action Network of over 100 ECHO hubs to train nursing home staff on COVID testing, infection prevention, safety practices to protect residents and staff, quality improvement, and how to manage social isolation. The Alzheimer's Association is running several of these training centers, having launched 12 cohorts since November 2020 reaching 392 nursing homes across the country. These actions are especially important as at least 172,000 residents and employees of nursing homes and other long-term care settings have died from COVID-19, representing over 30 percent of the total death toll in the United States. These communities are on the frontlines of the COVID-19 crisis, where 48 percent of nursing home residents are living with dementia, and 42 percent of residents in residential care facilities have Alzheimer's or another dementia.

Beyond the COVID-19 pandemic, the Alzheimer's Association has conducted multiple Project ECHO programs in primary care and assisted living communities. These Project ECHO models focus on increasing access to dementia diagnoses and care through primary care providers and on increasing person-centered dementia care in assisted living communities. According to an evaluation of the Association's first two pilot programs by the Center for Evaluation and Applied Research at The New York Academy of Medicine, primary care participants reported the most significant knowledge gains in identifying and screening for dementia, medication management, and communication with patients and family members. The evaluation also showed that participants from assisted living communities said the increased knowledge led to a change in their practices and gave them a better understanding of person-centered care.

The Alzheimer's Association is also formalizing a global network of ECHO hubs to address Alzheimer's and other dementia, and will build momentum for additional ECHO hub creation by partnering with the research community, medical professionals, key stakeholders in the dementia care industry, and policy leaders and advocates. This consortium of thought leaders across the spectrum will increase evidence around the use of ECHO in promoting best practice dementia care, accelerate the uptake of evidence into practice, and help policy makers understand and support Project ECHO dementia models.

Expansion of Telehealth Services

The Alzheimer's Association and AIM also support the expansion of Medicare and Medicaid coverage for certain telehealth services in response to the COVID-19 pandemic. The Centers for Medicare & Medicaid Services (CMS) has permanently expanded coverage for numerous codes

that are beneficial to people living with Alzheimer's and other dementia. This population is particularly vulnerable to the effects of COVID-19 due to their typical age and their co-occurring chronic conditions, so we appreciate the flexibilities CMS has implemented to reduce the risk of their exposure to the virus and ensure regular access to quality care.

The Alzheimer's Association and AIM particularly support CMS's decision to allow for telehealth coverage of care planning CPT® code 99483. Care planning is critical for people with cognitive impairment under normal circumstances to help them manage comorbid conditions and make decisions about long-term care and support services, among others. Ensuring that a plan is established, documented, and updated is now more important than ever. Making this service available via telehealth will improve access to care planning for this vulnerable population. To that end, we also thank Congress for passing the bipartisan *Improving HOPE for Alzheimer's Act* (S. 880/H.R. 1873), which will educate clinicians on the importance and availability of this crucial Medicare care planning service.

Finally, we appreciate CMS's flexibility in allowing telehealth technology to be used in home health delivery. Thirty-two percent of individuals using home health services have Alzheimer's or other dementia. The ability to receive care in the home decreases visits to unfamiliar places that may cause agitation in people with dementia and can ease some burden on caregivers. This increased flexibility can reduce interruptions in access to this kind of quality care. We also support CMS's expansion of the licensed practitioners, such as nurse practitioners and physician assistants, who can order Medicaid home health services. Twenty-seven percent of older individuals with Alzheimer's or other dementia who have Medicare also have Medicaid coverage, compared with 11 percent of individuals without dementia.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Subcommittee and its continued commitment to advancing legislation important to the millions of families affected by Alzheimer's and other dementia. We look forward to working with the Subcommittee and other members of Congress in a bipartisan way to advance policies that would help this vulnerable population during the COVID-19 pandemic and beyond, through the continued expansion of Project ECHO models and through Medicare and Medicaid coverage of certain telehealth services.

Statement for the Record
American Nurses Association
The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care
House Energy and Commerce Health Subcommittee
March 2, 2021

The American Nurses Association (ANA), representing the interests of the nation's 4.2 million registered nurses, commends the House Energy and Commerce Health Subcommittee for convening this hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care," and appreciates the opportunity to submit this statement for the record.

ANA is committed to advancing the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving quality of health care for all.

Registered nurses work in a variety of health care settings, including in rural, urban, and underserved areas. They also work in a variety of specialties, and, for many, they are the sole and trusted provider in a community. Nurses are highly trained and well educated to effectively use telehealth technologies, supervise remote patient monitoring activities, and provide quality care using tools that promote access to timely care without the burdens often existing in remote geographic locations or appointment shortage areas.

The opportunities that telehealth technologies can provide are limitless and witnessing the potential for expanding access to care has been inspiring during the pandemic. The diversity of geographic regions, social determinants of health, and challenges to accessing quality care can create barriers to individual and population health; however, technology can bridge the gap between these divides. The urban and rural divide is just one area that we can close using telehealth through access to diverse providers across the country that meet the needs of patients and their families. This allows for the realignment of resources across the country in order to reduce barriers to quality care in every community.

As an organization, ANA has been a leader in telehealth policy since first developing principles on the subject in 1998[1]. There is robust evidence demonstrating that telehealth technologies make health care more effective and efficient by electronically connecting clinicians to clinicians, patients to clinicians, and patients and care givers to other resources. This approach facilitates remote diagnosis and treatment, continuous monitoring and adjustment of therapies, support for patient self-care, and the leveraging of providers across large populations of patients.

ANA continues to call on Congress to remove the Medicare originating site and rural area restrictions. Increased utilization of telehealth during the pandemic confirms that is not just rural and designated originating sites that benefit from using telehealth. There are appointment shortages, transportation challenges for populations, and patients with chronic conditions in urban areas that would benefit from telehealth beyond the current pandemic. Additionally, more research on health outcomes in order to prevent emergency room visits is needed to address the extra burden on the healthcare system that is already overwhelmed with COVID-19 response and lasting impacts.

[1] https://www.nursingworld.org/~4a9307/globalassets/docs/ana/practice/ana-core-principles-on-connected-health.pdf

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

Thank you for giving nurses the opportunity to provide input on the importance of telehealth now and in the future. ANA stands ready to work with the Subcommittee to find and implement sustainable solutions regarding this important issue. If you have any questions, please contact Ingrida Lusis, Vice President of Policy and Government Affairs, at (301) 628-5081 or Ingrid.Lusis@ana.org.

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

Feb. 26, 2021

The Honorable Anna Eshoo
Chair
Subcommittee on Health
House Energy and Commerce Committee

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
House Energy and Commerce Committee

Dear Chairman Eshoo and Ranking Member Guthrie,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to provide a statement for the record on the subcommittee's hearing "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span — helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

Value of Physical Therapy Through Telehealth

The ongoing coronavirus pandemic has highlighted the need for patients, health systems, payers, and providers to rapidly adopt or expand models and modes of care delivery that minimize disruptions in care and the risks associated with those disruptions. The expansion of telehealth payment and practice policies under the section 1135 waivers during this Public Health Emergency, including permitting physical therapy services to be furnished via telehealth by physical therapists and physical therapy assistants across settings has demonstrated that many needs can be safely and effectively met via the use of technology and that patients can have improved access to skilled care by leveraging these resources.

Physical therapy is well-suited for telehealth — primarily as an enhancement of in-person services, although a telehealth visit also may replace an in-person visit when needed or indicated. Physical therapists and physical therapist assistants can use telehealth as a supplement to in-person services to evaluate and treat a variety of conditions prevalent in the Medicare population, including but not limited to Alzheimer's disease, arthritis, cognitive/neurological/vestibular disorders, multiple sclerosis, musculoskeletal conditions, Parkinson disease, pelvic floor dysfunction, frailty, and sarcopenia.

Physical therapists make determinations, in consultation with patients and caregivers, regarding the appropriate mix of in-person and telehealth services to meet the goals in the plan of care. The evaluation and treatment of a patient via the use of telehealth allows the physical therapist to interact with the patient within the real-life context of their home environment, which is not easily replicable in the clinic. Patient and caregiver self-efficacy are inherent goals of care, and telehealth not only allows a physical therapist to maintain the continuity of care anticipated in the plan of care but also allows for immediate and effective engagement when a specific challenge arises. A patient's and/or caregiver's ability to interact in their own environment with a physical therapist when they are facing a challenge, rather than waiting for the next appointment, can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, and promote engagement.

Skilled physical therapy interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Further, physical therapists already are experienced in modifying exercises for the patient to perform them safely at home, as a home exercise program is a common element of a treatment plan for patients who are treated in person. Education and home exercise programs — including those focused on falls prevention — function particularly well with telehealth because the physical therapist can evaluate and treat the patient within the real-life context of their home environment. This is not easily replicated in the office setting.

Physical therapy progresses patients toward total independence of their program in their own homes. Telehealth facilitates this objective, as the physical therapist can progress the patient in their native environment rather than in a "simulated" one in the clinic. Moreover, a patient's and/or caregiver's ability to interact in their own environment with a physical therapist can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, and promote engagement. Telehealth expands the clinical impact of physical therapy by providing patients on-demand access to their physical therapist to promote increased adherence, access to booster sessions to ensure sustainability of therapeutic gains and functional performance, and access to supplemental care in-between in-person visits to reduce the length of the episode of care and to lower costs.

Moreover, physical therapy is not synonymous with exercise. Although much of skilled physical therapy is high-touch, a significant component is transition of skills — promoting self-efficacy, environmental assessment and modification, training and education, and, most important, ongoing assessment, analysis, and clinical decision-making. A critical component of physical therapy is the prescription of carryover techniques, tasks, and activities — not just exercise — by a patient in their own environment. Physical therapy services performed via telehealth enhance this component of care.

Examples of physical therapy providers using telecommunications technology to provide real-time, interactive audio and video care include the following:

- Physical therapy practitioners use telehealth technologies to conduct evaluations or reevaluations or provide quicker screening, assessment, and referrals that improve care coordination.
- Physical therapy practitioners provide interventions use telehealth by interacting with the patient in real time to provide instruction in exercise and activity performance, observing return demonstration and instruction in modifications or progressions of a program, providing caregiver support, and promoting self-efficacy.
- Physical therapy practitioners provide verbal and visual instructions and cues to modify how patients perform various activities. They also may suggest that the patient or caregiver modify the environment for safety reasons, or to potentially produce even more optimal outcomes.
- Physical therapy practitioners use telehealth technologies to provide prehabilitation and conduct home safety evaluations.
- Physical therapy practitioners use telehealth technologies to observe how patients interact with their environment and/or other caregivers, and to provide caregiver education.
- Physical therapy practitioners can assess the carryover of the activity modification strategies and activities to determine effectiveness immediately rather than waiting for the next in-person visit.
- Physical therapists use telehealth to reduce the number of "in-clinic" visits and still maintain important follow-up care. This might reduce travel time and/or burden for a patient — which, for some conditions, might result in faster healing. This also prevents any delays in modifying a program when it needs to be upgraded or downgraded.
- Physical therapists can use technology to satisfy supervision requirements.
- A physical therapist can co-treat with another clinician who is treating via real-time audio

and visual technology.
- A treating physical therapist can consult directly with another physical therapist or physical therapist assistant for collaboration and/or to obtain specialty recommendations to incorporate into an existing plan of care.
- Physical therapists use telehealth for quick check-ins with established patients.

Telehealth services furnished by physical therapists and physical therapist assistants offer cost savings, allow for coordination of care, and may improve adherence and patient satisfaction. Many studies have illustrated the clinical benefit of telerehabilitation for a variety of conditions, including pelvic floor dysfunction and multiple sclerosis.

A 2019 study examined the efficacy of home-based telerehabilitation versus in-clinic therapy for adults after stroke, finding that poststroke activity-based training resulted in substantial gains in patients' arm motor function whether provided via telerehabilitation or in person. Other studies show that home-based telerehabilitation significantly improved veterans' functional independence, cognition, and patient satisfaction. See Appendix A for additional studies. Physical therapists also have been collecting a variety of data related to health outcomes and ease of use of technology. To promote data collection, APTA developed a patient satisfaction survey for providers to share with their patients, which is available in both English and Spanish.

When considering the value of telehealth furnished by physical therapists and physical therapist assistants, Congress should consider the effects of telehealth on downstream spending. Hospital admissions and readmissions, emergency department visits, and urgent care visits, among other expenses, potentially will decrease if patients have access to both in-person and telehealth services.

Patient Access

Telehealth helps to overcome access barriers caused by distance, lack of availability of specialists and/or subspecialists, impaired mobility, and the burden associated with commuting/arranging transportation to a physical therapy appointment. Using virtual engagement tools can prevent unnecessary exposure during a pandemic, epidemic, or even the annual flu season — a feature especially important for frail and immunocompromised persons. Furthermore, access to telehealth services is critical for beneficiaries who live in areas with inclement weather, which is a deterrent to traveling outside of the home.

For patients who have difficulty leaving their homes without assistance, lack transportation, or need to travel long distances, the ability to supplement or replace in-person sessions with those furnished via telehealth greatly increases access to care and ensures uninterrupted courses of therapy. Telehealth is a tool to overcome access barriers caused by distance, unavailability of specialists and/or subspecialists, inclement weather, and impaired mobility. For example, a Colorado physical therapist practice that offers treatments for neurological conditions provides a significant portion of the care via telehealth, for several reasons: 1) the area's sometimes severe inclement weather; 2) the patient's vestibular condition that renders them unable to drive, forcing them to rely on friends or family to drive them; and 3) a lack of physical therapy providers within a reasonable driving distance — particularly providers that address dizziness and balance issues.

Access to health care services is critical to good health and functional performance, yet Medicare beneficiaries, particularly those who reside in rural areas, face a variety of access barriers. Individuals across the lifespan want the ability to appropriately access telehealth, and telehealth is key to helping individuals age in place. If we as a nation truly wish to help individuals age in their homes, telehealth is a key to making this a reality. As demand for care to help individuals with chronic conditions continues to grow, Congress should recommend telehealth payment and coverage policies that will improve

beneficiary access and increase collaboration and efficiency of care across the care continuum.

Further, access to physical therapy in rural, medically underserved, and health professional shortage areas often depends on the availability of physical therapist assistants to provide care under the supervision of physical therapists. Unfortunately, the 15% Medicare Physician Fee Schedule payment reduction for services furnished in whole or in part by physical therapist assistants beginning in 2022 will have a detrimental impact on the ability of physical therapy providers, particularly in rural areas, to continue to deliver care. The payment reduction will unfairly penalize providers in rural, medically underserved, and health professional shortage areas. Access to medical care already is dwindling in rural localities. Physical therapists and physical therapist assistants play a crucial role in bridging these gaps in access to care.

Quality

APTA developed a patient satisfaction survey about the use of telehealth for providers to share with their patients in English and Spanish based on AHRQ's guidance. Copied below are the results from a physical therapist vestibular practice in Colorado that asked some of the questions from this survey:

- The experience was an effective way to get my physical therapy: 70% of respondents strongly agreed; 30% agreed.
- Feelings of comfortability being evaluated and treated via telehealth: 67% of respondents strongly agreed; 20% agreed; 10% were neutral.
- Feelings of physical safety receiving physical therapy treatment via telehealth: 83% of respondents strongly agreed; 17% of respondents agreed.
- Overall satisfied with the experience: 93% strongly agreed; 7% agreed.
- In response to the question: If a telehealth visit was not available to you from this PT clinic, how would you plan to receive PT in future? 10% of respondents said they would seek telehealth from another clinic, 10% said they would not seek care, 60% said they would seek in-person care with the clinic, and 17% provided other answers, including:
    - "I don't know what I would do."
    - "I might not seek care. This is the safest way for me to receive care."

In addition, the following are stories shared by Medicare beneficiaries during the COVID-19 pandemic:

Medicare Beneficiary #1:

- The beneficiary was experiencing severe back pain, had significant physical limitations, and used pain medications daily. She was "high risk" for COVID-19, so she engaged in physical therapy via telehealth. After an initial evaluation in the clinic and several telehealth sessions at her home, she is now walking pain-free, can engage in more physical activity, and has reduced her pain medications. These telehealth visits have allowed her to care for her husband, who is in hospice.

Medicare Beneficiary #2:

- I am writing to express my gratitude for the telehealth services that were provided during the COVID-19 pandemic. I was happy to start in the clinic and then transition to a home-based program so that I could carry the work into my daily routine, while staying safe at home. After every meeting, I felt better and felt that I had gotten a good workout. I would recommend telehealth services to a friend or family member. Even out of quarantine, I feel as though the telehealth services may be beneficial to those who cannot go to an appointment in person. I advocate that Medicare continues to allow telehealth services to be furnished by physical therapists in the future.

Medicare Beneficiary #3:

- I was being treated for thoracic outlet syndrome and referred to physical therapy. I found my experience most successful. Due to COVID-19, I was able to do telehealth therapy from home.

Once the clinic was able to reopen, I was able to resume office visits and have continued to make good progress. I have had a very positive experience.

Medicare Beneficiary #4:

- I am writing to express my appreciation for the telehealth services that were provided during this COVID-19 pandemic. About 7 or 8 weeks ago I had to have physical therapy for a pinched nerve. I contacted you since my husband was already participating in your telehealth program. I have been working with the DPT and have had wonderful results. I have used my 1- and 2-pound weights as well as my wall to do push-ups. I also use my banister to do rowing exercises. I would recommend telehealth services to a friend or family member or anyone who should ask and I'm hoping that these telehealth services continue in the future. This is a great way to remain safe at home, which is critical during this pandemic

Recommendations

Current statutes limit Medicare beneficiaries from receiving telehealth services, including a geography limitation, site limitation, and provider limitation. Congress must pass legislation that permanently affords providers and patients the ability to furnish and receive telehealth, just as they have done during the COVID-19 PHE. This includes waiving the restriction on geography and location, allowing the patient to receive telehealth in their home, whether in a rural or urban location, and expanding the ability of physical therapists, physical therapist assistants, and facility-based therapy providers to provide telehealth under Medicare. Physical therapists are often part of interprofessional teams and work with patients on care management; to say that certain team members can management patients via technology and other team members cannot is contrary to interprofessional, integrated care management.

Congress should:

1) Enact changes to Section 1834(m)(4)(E) of the Social Security Act to include outpatient therapy services furnished "by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient" and physical therapy, occupational therapy, speech-language pathology, and audiology services "furnished an individual by a … therapist (in his office or in such individual's home)." (As defined in Sections 1861(p), 1861(g), and 1861(ll) of the Social Security Act.) Such a comprehensive definition of an outpatient therapy provider for the purposes of furnishing Medicare telehealth services would be consistent with existing sub-regulatory policy defining a "Qualified Professional" permitted to furnish Medicare outpatient therapy services in Chapter 15, Section 220 of the Medicare Benefit Policy Manual.
2) Enact changes to Section 1834(m)(4)(C)(i) of the Social Security Act so that telehealth services, including therapy services, will no longer be restricted by geographic location of the beneficiary or the originating site. All Medicare beneficiaries should be eligible to receive telehealth services from their home, whether that home is in the community or part of an institutional setting.

Federal policies also should advance a definition of parity that includes equal coverage, reimbursement, and cost-sharing (copayments, coinsurance, and deductibles) for audio-only telehealth, audio and visual telehealth, and in-person visits, particularly given the fact that telehealth is merely a modality to enable physical therapists and physical therapist assistants, for example, to provide care within their scope of practice. In addition, such policies should promote outreach to patients with limited technology and connectivity and offer flexibility in platforms that can be used for audio and visual (live video) interactions, audio-only options, online patient portals, etc.

Conclusion

We appreciate the opportunity to provide the subcommittee with our perspective on the role of telehealth

in physical therapy and the need to continue to provide Medicare beneficiaries this option beyond the PHE. Should you have any questions, please do not hesitate to contact David Scala, APTA congressional affairs senior specialist, at davidscala@apta.org. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

www.americantelemed.org

February 4, 2021

The Honorable Chuck Schumer
Majority Leader
United State Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, D.C. 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

RE: ATA Letter to Congress on Ensuring Access to Quality Health Care in COVID Relief Legislation

Dear Congressional Leaders,

On behalf of the American Telemedicine Association (ATA), thank you for your commitment to thoughtfully considering commonsense telehealth policy and for acting quickly at the beginning of the COVID-19 Public Health Emergency (PHE) to ensure access to telehealth services. We write today to urge Congress to include permanent telehealth reforms in any subsequent COVID-19 relief legislation. We further recommend a number of targeted provisions that should be passed into law now to ensure Americans do not lose access to care.

As the only organization exclusively devoted to expanding access to care through telehealth, the ATA appreciates the opportunity to share with Congress our federal policy priorities for 2021. During the COVID-19 PHE, telehealth has finally become a reality for millions of Americans out of necessity. This has been possible because of swift, decisive actions by Congress and the Department of Health and Human Services (HHS). However, unless Congress acts again before the end of the PHE, telehealth access will vanish for millions of Medicare beneficiaries overnight. As you consider how to address this looming telehealth cliff, we request that you review ATA's Permanent Policy Recommendations as well as ATA's Federal Legislative Priorities.

During the PHE, America's health care system has heavily depended on telehealth technology, and ATA members have been proud to help ensure the continuity of care for American patients. The ATA urges Congress to remove existing statutory barriers that limit access to care. For far too long, 1834(m) of the Social Security Act has categorically excluded too many patients from even having the option to access care via telehealth because of the law's antiquated and arbitrary barriers whose only purpose is to limit access. The 1834(m) restrictions are nearing 20 years old, and by allowing them to persist, Congress will only punish Medicare beneficiaries by banning their access to the technology on which they have relied during the PHE. Further, the ATA urges Congress to take great care in considering the consequences of having restrictions specifically codified in statute as opposed to allowing these issues to be decided at the regulatory level. By explicitly and arbitrarily limiting care in statute through so-called "guardrails," legislators will unnecessarily stifle innovation and tie the hands of regulators, providers, and patients.

While the ATA appreciates Congress's recent actions to expand access to care, specific restrictions on patients, providers, services, or the modality of care in statute only adds to complexities in the health care system. In summary, the ATA has prioritized the following policies for the 117th Congress which should be included in any moving COVID-19 relief legislation:

- Permanently remove the geographic and originating site barriers in statute.
- The originating site should be wherever the patient is located, including but not limited to, a patient's home.
- Enhance HHS authority to determine appropriate telehealth services and providers.
- Ensure Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can furnish telehealth and receive equitable reimbursement.
- Make permanent HHS's temporary waiver authority for future emergencies.

The ATA further recommends that the following targeted provisions be considered for inclusion in a moving COVID-19 proposal to ensure millions of American do not have access to care curtailed in the immediate future:

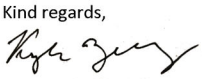
- Ensure regulatory flexibilities that have increased telehealth availability to Medicare recipients during the PHE remain in place until the end of the calendar year *after* the year in which the PHE ends.
- Remove the recently passed provision requiring a prior in-person relationship between practitioner and patient before a Medicare patient can access telehealth services for mental health care. While we appreciate Congress's interest in expanding access to this essential service post-pandemic, this unprecedented requirement will ultimately limit patients' access to care. Congress should instead continue to allow state licensing boards and practitioners to determine the appropriate standards of care for patients. As you know, a similar in-person requirement was included in the Coronavirus Preparedness and Response Supplemental Appropriations Act, which passed in March of 2020, and was then subsequently rescinded in the CARES Act following concerns that this type of requirement unnecessarily restricts care.
- Expand the FCC COVID-19 Telehealth Program, one of the most successful and widely supported federal funding mechanisms that enables providers across the country to scale virtual care programs in response to COVID-19. Even with the additional $249 million provided under the Coronavirus Response and Relief Supplemental Appropriations Act of 2021, there are still tremendous unmet needs to facilitate provider adoption, especially in rural and underserved communities. An additional $200 million should be allocated to the FCC COVID-19 Telehealth Program to equip providers across the nation to offer telehealth services.
- Extend the Telehealth Safe Harbor for HSA's and HDHP's. Section 3701 of the CARES Act created a temporary safe harbor that allows high-deductible health plans (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching their deductible. This safe harbor allows HDHPs to offer cost-free telehealth services to plan members before the annual deductible is met, ensuring that plans can better support patients that are leveraging virtual care to access a range of critical health care services during the pandemic. Currently the safe harbor expires December 31, 2021 and applies to plan years beginning before January 1, 2022. Efforts to fight the pandemic will extend into 2022 and the safe harbor similarly should be extended through the end of 2022 and apply to plan years beginning before Jan 1, 2023 which will provide Americans with HDHPs enhanced access to high quality virtual care.
- Congress should ensure OIG is staffed and resourced appropriately to enforce the current laws that are intended to prevent fraud, waste, and abuse, including through

existing mechanisms like the Health Care Fraud and Abuse Control Program. Congress should urge OIG to develop fraud detection models, systems, and audit mechanisms to catch illegal prescribing and billing.

The ATA urges Congress to include these policy priorities in COVID-19 legislation and to actively engage with telehealth stakeholders, including telehealth providers, health systems, and patient advocacy organizations as you consider any potential legislative vehicle related to the delivery of health care services in the 117th Congress.

Should you have any additional questions, please know the ATA is honored to continue to be a resource for you and your staff. We are always happy, too, to connect you directly with ATA members and experts to answer specific questions related to how telehealth is working for Medicare beneficiaries. If you have any questions or would like to further discuss the telehealth industry's perspective, please contact kzebley@americantelemed.org.

Kind regards,



Kyle Zebley
Public Policy Director
American Telemedicine Association

March 2, 2021

The Honorable Catherine Cortez Masto
516 Hart Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Teri Sewell
2201 Rayburn House Office Building
Washington, DC 20515

The Honorable Gus Bilirakis
2354 Rayburn House Office Building
Washington, DC 20515

Dear Senators Cortez Masto and Scott and Representatives Sewell and Bilirakis:

We write to express our strong support of the *Ensuring Parity in MA for Audio Only-Telehealth Act*. This important legislation will help ensure seniors continue to have access to the high value care and critical supplemental benefits provided by Medicare Advantage (MA) as well as reduce health disparities due to unequal access to health technology and video telehealth platforms. The legislation will also ensure audio-only telehealth continues to be an effective source of health care for seniors and support the millions of high-quality providers caring for them throughout the course of the COVID-19 Public Health Emergency.

Every American deserves access to the care they need. Since the COVID-19 pandemic began, patients have increasingly relied on telehealth to safely provide this care. Access to telehealth services is essential for older Americans and those with chronic conditions who face a higher risk of complications if they contract COVID-19. Utilizing telehealth services helps reduce the risk of exposure to and mitigates the spread of COVID-19 and other illnesses for both patients and providers.

To help facilitate the use of telehealth among MA patients the Centers for Medicare & Medicaid Services loosened many previous restrictions regarding telehealth, including allowing diagnoses from telehealth encounters to be used in the MA risk adjustment program. However, this guidance requires that the encounters include a video component, which is not an option for many patients. Seniors in rural and urban communities, in particular, may lack access to broadband internet services. In addition to the lack of access to broadband, 40% of MA enrollees earn less than $25,000 a year and may not be able to afford the technologies and infrastructure needed for video telehealth services. At the same time, older seniors or those with certain physical limitations and disabilities often struggle to access video platforms. For these patients, an audio-only telehealth visit may be the only option other than foregoing needed care.

Allowing diagnoses from audio-only telehealth services to count for MA risk adjustment helps to ensure that health costs are adequately covered while also providing coordinated care teams with the information necessary to assess and develop plans, deploy necessary resources, and inform approaches to manage patient care. Without the accurate documentation of diagnoses, MA will see cuts during the middle of a global pandemic, leaving plans and providers with fewer resources necessary to care for patients. This could ultimately lead to unequal access, fewer choices, higher premiums, or reduced benefits especially for the plans whose enrollees have the least access to video telehealth – exacerbating the already large disparities in our health system.

The *Ensuring Parity in MA for Audio-Only Telehealth Act* creates commonsense guardrails that will prevent the potential for fraud and abuse in the Medicare program by ensuring that only diagnoses that were previously documented via an in-person visit can be obtained via audio-only for risk adjustment. Patients would also have to have an established relationship with the provider or the practice for the audio-only diagnosis to be used.

Creating greater parity between video and audio-only telehealth platforms recognizes very real socioeconomic, age-related, and regional disparities in technology access that can have negative impacts on the health system. The *Ensuring Parity in MA for Audio-Only Telehealth Act* helps mitigate those negative impacts by preventing harmful cuts to the MA program and supports the providers who care for the more than 40% of eligible Medicare beneficiaries enrolled in the program.

Throughout the COVID-19 crisis, Americans have been relying on telehealth to continue receiving care and managing their chronic health conditions while reducing their risk of exposure to the deadly virus. We applaud your bipartisan efforts to support the MA program and ensure that patients continue to receive the care they need. We look forward to working with you to ensure this legislation is enacted this Congress.

Sincerely,

Alliance of Community Health Plans
America's Health Insurance Plans
America's Physician Groups
American Academy of Family Physicians
American Medical Group Association
Better Medicare Alliance
BlueCross BlueShield Association
Healthcare Leadership Council
National PACE Association
Premier Healthcare Alliance
SNP Alliance

Children's National Medical Center – Rare Disease Institute

Telehealth Stories from Providers

Dr. Marshall Summar, Division Chief, Genetics and Metabolism

Director, Rare Disease Institute

MSummar@childrensnational.org

Children's National Medical Center has been a leader in using telehealth to care for rare disease families across the country. Below are real stories from providers at Children's National about how telehealth has positively impacted the care and treatment of families living with rare disease.

1. I have had many patients who, despite the pandemic, live in rural areas over 2 hours away from any genetics specialist. With the aid of telemedicine, I was able to see these patients within 1 day of referral and talk parents through the rather scary process of having a child with an abnormal newborn screen. With telemedicine, I was able to see these families quickly and in the comfort of their own home. Many of these families have reverberated to me the ease that telemedicine had brought to them at such a difficult and scary time. Coming into a busy and bustling hospital far from home with your precious newborn child can be intimidating and scary even in normal times. I recently had a patient whose family did not have access to a car and urgently needed to be seen due to an abnormal newborn screen. Between figuring out childcare for their older children, arranging a ride to the clinic, and taking time off from work, it would have been days before this family could be seen in person. With the ease of telemedicine, I was able to see this family that very day with the help of a Spanish interpreter on zoom right there with us. This quick turnaround resulted in a quicker diagnosis. Equally as important, the use of telemedicine to ensure this family's care was prioritized in a timely fashion resulted in a trusting patient-provider relationship.

2. Our patient is a three-year old with Cardiofaciocutaneous syndrome, a rare genetic condition that causes learning problems, low muscle tone, heart defects, feeding issues, and other complications. His mother lives several hours from the hospital, and her husband was away in the military. She had an adult mother at home that needed help and other children to take care of on her own. During the pandemic, she worried about timely access to medical care and COVID, since her son had immune problems. Due to our ability to evaluate her child via telemedicine, we were able to treat an infection (asking our multidisciplinary team and dermatology for guidance), dehydration, help target services, and provide counseling. Her mother attributes our visits to help keep her child out of the hospital and her family safe.

https://wjla.com/news/coronavirus/mom-talks-challenges-of-caring-for-son-with-rare-disease-during-covid-19

3. Another patient is a 13 year old African-American patient who played football until he began to have episodes of undiagnosed rhabdomyolysis, muscle breakdown. He had a prolonged hospitalization prior to COVID. During the pandemic, he developed another episode. Our team had meanwhile developed and published a state of the art protocol for treating rhabdomyolysis. We were able to do several telemedicine visits, get genetic testing for him which showed a potential etiology, and when he had an acute crisis, do a same-day telemedicine visit and get immediate labs from a local laboratory near his house. Based on elevated CK (a measure of muscle breakdown), we advised him to start fluids, and dexamethasone, a drug that we had recently used with success. He was able to complete our regimen, go to a nearby lab to get follow-up testing, and stay out of the hospital all together by following our out-patient plan.

4. A family that lived several hours from the hospital had a mother with four children at home, all with diagnoses of autism or delay. She herself had severe anxiety. She had multiple transportation issues that kept her from accessing medical care. In one telemedicine visit, we were able to evaluate her and her four children. She had previously had a test for a condition called Fragile X, and her results showed she had the condition, but she had never been counseled. We confirmed the diagnosis in her and explained that her children likely had it as well. We were able to arrange testing close to home through her pediatrician, and get the testing she needed and confirm the diagnosis in her children who ranged in age from infants to teenagers. Due to the testing, she has been able to get proper supports in place and treatment for her own condition. In addition, she has a twin sister who also has the diagnosis, and we were able to recommend that her sister and family members get testing. For over 15 years, the diagnosis in this family was missed, and in one telemedicine visit, as she herself put it "One telemedicine visit changed our lives."

5. I have a sweet family affected by an ultra-rare leukodystrophy who lives on the southern edge of Va. Mom had a baby who was diagnosed with the disease prenatally. She was anxious to bring the baby for an extended clinic visit, as infections/inflammation causes disease progression. We were able to see her remotely, order confirmatory genetic testing sent to the home, and order the baby's feed-and-bundle MRI to be performed when convenient for the family. The family was exceedingly grateful to not have to leave their home with a newborn during COVID19 to drive hours to our institution for a visit that was completely able to be telemed.

6. Patient with POTS/dysautonomia, possible Mast cell activation, Migraine headaches, Hypermobile EDS, AMPS, IBS-mixed, Generalized anxiety with Panic and associated somatization, and Physical deconditioning. She has not walked since November, discontinued school secondary to pain and migraines. Unable to attend outpatient visits - sensitive to light and cannot ambulate. She has been seen inpatient by other services for evaluation. Telemed visit was mostly history provided by parents. Based on history and complexity WES was recommended with mt DNA. Mitochondria was denied so we started with WES only Consent via

telemed - she was unable to participate but called with her verbal consent. Testing kit was sent to the home

7. Couple of years ago had a case of a thirtysomething-year-old woman with very advanced colon cancer from rural southeast MS. Was getting intensive chemo and in last few months of life. She had 3 sons. Astute doc wanted her to see genetics but she couldn't travel so we saw her by TH in Hburg, tested her quickly and cascaded her sons (age 5-15), 2 of whom were positive for her APC mutation- got them in for surveillance and care before she passed. All done remotely and with TH visits. I think that made a huge difference for her- knowing that her sons were caught early.

Statement for the Record
Submitted by CommonSpirit Health

House Energy and Commerce Subcommittee on Health
The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care

March 2, 2021

On behalf of the patients and communities we serve, CommonSpirit Health is pleased to provide the following statement for the Record to the House Energy and Commerce Subcommittee on Health. As one of the largest nonprofit health systems in the United States, CommonSpirit serves individuals across 21 states in our 139 hospitals and myriad long-term care facilities, home health organizations, academic medical centers, nursing schools, medical clinics, and community service organizations. As a faith-based system, CommonSpirit seeks to create healthy communities with a special focus on those individuals who are medically, economically, or socially vulnerable. We appreciate the Committee's attention to the important and timely issues of telehealth policy post pandemic and their impact on the patients we serve.

Historically, Congress and CMS have taken a deliberate, incremental approach to expanding telehealth services to beneficiaries, despite consistent evidence of the value telehealth brings to both the patient experience and quality outcomes. In response to the COVID-19 public health emergency (PHE), CMS and Congress acknowledged the important role telehealth could play in ensuring patients have safe access to health care. The telehealth waivers allowed hospitals and health systems to greatly expand the use of telehealth and other communication technology-based services. Indeed, these legislative and regulatory flexibilities have been key to maintaining access to care for patients while preventing the spread of COVID-19.

CommonSpirit was able to quickly scale and expand patient care through telehealth services, from providing 500 virtual visits per week prior to the PHE to providing more than 5,000 per day almost immediately. Due to patient demand and the constraints of COVID, currently 17% of all ambulatory visits with CommonSpirit clinicians are via telehealth. The quick adoption and deployment of services is a clear indication that beneficiaries desired telehealth services and CommonSpirit was ready to respond to meet the need of our patients and our communities. As one of the nation's largest Medicaid providers, this has been an essential tool in meeting the needs of the vulnerable populations that we serve.

CommonSpirit greatly appreciates Congress taking swift action as part of the CARES Act to provide the necessary flexibilities that allow for virtual services to be provided during the PHE. During this time of flexibility, we agree it is important to collect data to evaluate and understand the value of telehealth as an important modality of care, and continue to build on the progress of integrating telehealth into our systems of care by not creating undue uncertainty for providers or patients regarding how care will be delivered in the future.

While telehealth expanded greatly as an infection control strategy during the pandemic, it has become an important tool to improve access to care and reduce barriers to entry for some of our most vulnerable populations. Moreover, CommonSpirit has taken a thoughtful, systematic, and team-based approach to deployment of virtual care strategies to ensure services are patient-centric, medically appropriate, technologically sound, and financially viable. Given the quick implementation of the PHE waivers, we appreciate that Congress now needs to look closely at how to ensure access to care while maintaining program integrity and fiscal solvency for the Medicare program post-COVID.

Telehealth has long been a central tool in expanding care access to rural, underserved communities. During the PHE, it has also become a critical modality of care for patients in urban and suburban areas. Telehealth services in these communities is particularly important for the most vulnerable patients, some of whom lack reliable access to transportation, or for whom a virtual visit is key to managing a chronic illness. As providers continue to gain experience providing virtual care, telehealth will continue to play an important role in addressing health equity by reaching vulnerable communities in innovative ways. Just imagine how millions of hourly workers who can't afford to take time off work to seek medical treatment can use a virtual visit on their work break and not be forced to decide between money to put food on the table and going to the doctor.

Telehealth behavioral health services, particularly in areas that experience provider shortages has been absolutely essential during this pandemic and will continue to be a need as we all continue to confront the lasting emotional and psychological effects of isolation and more than a year of largely sheltering in place. Finally, as technology has advanced, the population in general has become more accustomed to interacting virtually, patients – including Medicare beneficiaries – have become much more comfortable utilizing virtual care options from the comfort of their home.

Virtual care should not be viewed as a replacement for in-person care. Instead, it is a crucial element in the integrated care continuum, we can use to reach patients and provide them with the right care in the right setting for improved outcomes. The cost structure of providing telehealth services largely mirrors the costs associated with in-person care including staff support, EHR integration, clinicians, technology, etc. Regardless of the type of care (virtual or in-person), clinicians provide the same level of and quality service in both settings and are the majority of the expense. We have made significant investments in our technology infrastructure to support telehealth, in addition to maintaining our commitments to in-person care.

While telehealth can improve health equity, access to telehealth also needs a better technology infrastructure across the country, in rural areas and for vulnerable populations. Telehealth must be accessible, inclusive, culturally competent and available across all payers. Patient engagement and education will be critical factors in overall success

CommonSpirit looks forward to working with the Committee to bring forward additional data to help support policy discussions that will advance our common goals including expanding access to care for our patients with a particular focus on improving health care equity and reducing disparities. As the Committee proceeds in deliberating on these and other related topics this year, we stand ready to work with you in advancing policy proposals that improve the lives of the patients and communities we serve. Thank you for your continued attention to and deliberations on this important policy discussion.

##########################

About CommonSpirit Health
CommonSpirit Health is a nonprofit, Catholic health system dedicated to advancing health for all people. It was created in February 2019 by Catholic Health Initiatives and Dignity Health. With its national office in Chicago and a team of approximately 150,000 employees and 25,000 physicians and advanced practice clinicians, CommonSpirit operates 140 hospitals and more than 1,000 care sites across 21 states. In FY 2020, CommonSpirit had revenues of $29.6 billion and provided $4.6 billion in charity care, community benefit, and unreimbursed government programs. Learn more at www.commonspirit.org.

For more information, please contact Shelly Schlenker at shelly.schlenker@commonspirit.org or Alyssa Keefe at alyssa.keefe@commonspirit.org.

Statement for the Record
American College of Physicians
Hearing before the House Energy and Commerce Subcommittee on Health
"The Future of Telehealth: How Covid-19 is Changing the Delivery of Virtual Care"
March 2, 2021

The American College of Physicians (ACP) is pleased to submit this statement and appreciates that Chairwoman Eshoo and Ranking Member Guthrie are holding this hearing to examine the importance of telehealth and its role in health care delivery during the COVID-19 pandemic and beyond. We also hope that this important discussion will provide a platform to act on bipartisan solutions to improve the nation's capacity to confront the ongoing national public health emergency (PHE) caused by COVID-19 but also promote telehealth as an essential part of health care in the future. We are pleased to offer our perspective and suggestions, as detailed below, on specific aspects of telehealth as they relate to the delivery of primary care and the patient-physician relationship.

The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

TELEHEALTH DURING THE COVID-19 PANDEMIC

According to initial data from 2020, the role of telehealth as a method of health care delivery has taken on greater significance as a result of the COVID-19 pandemic where social distancing now permeates every aspect of our daily lives. Routine health care in urban and rural areas alike has moved into the virtual realm of telehealth, in varying degrees, largely out of necessity, as we desperately try to gain a foothold on containing this deadly virus. In an October 2020 report from the Centers for Disease Control and Prevention (CDC), during the first quarter of that year, the number of telehealth visits increased by 50 percent, compared with the same period in 2019, with a 154 percent increase in visits noted in surveillance week 13 in 2020, compared with the same period in 2019. Data for this analysis were provided to CDC from four large national telehealth providers as part of partner engagement to monitor and improve

25 Massachusetts Avenue, NW, Suite 700, Washington, DC 20001-7401 | 202-261-4500, 800-338-2746 | www.acponline.org
190 N Independence Mall West, Philadelphia, PA 19106-1572 | 215-351-2400, 800-523-1546 | www.acponline.org

outcomes during the COVID-19 pandemic.[1] A recent survey of 1,594 physicians and other qualified health care professionals from across the U.S. also revealed that only a small percentage reported not having used telehealth for patient care.[2]

In addition, a February 2021 study in *Health* Affairs examined data of 16.7 million commercially insured and Medicare Advantage enrollees from January to June 2020 and noted that telemedicine use was lower in communities with higher rates of poverty (31.9 percent versus 27.9 percent for the lowest and highest quartiles of poverty rate, respectively). Across specialties, the use of any telemedicine during the pandemic ranged from 68 percent (endocrinology), to 35 percent (primary care), to 9 percent (ophthalmology).[3]

As noted in another recent study, health equity in medicine is also a real issue and there are disparities in access to telehealth technology. For those in rural and underserved communities, the nearest clinic may be hours away. Unfortunately, rural communities also suffer from more limited access to broadband internet, which restricted the ability of many in rural communities to access telemedicine pre-pandemic. Additionally, research shows that Black and Hispanic Americans own laptops at lower rates than White Americans, further dividing pre-pandemic access to telemedicine.[4] Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. Congress should provide support for further broadband deployment to reduce geographic and sociodemographic disparities and access to care.[5]

TELEHEALTH AND PRIMARY CARE

ACP supports the expanded role of telehealth as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. Telehealth can be most efficient and beneficial between a patient and physician with an established, ongoing relationship and can serve as a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area. Primary care physicians have had to convert in-person visits to virtual ones in response to the COVID-19 PHE, and practices are experiencing huge reductions in revenue while still having to pay rent, meet payroll, and meet other expenses without patients coming into their practices.

During this pandemic, internal medicine specialists continue to deliver care to their patients with the expanded utilization of telehealth made possible by new policies enacted by Congress,

---

[1] Centers for Disease Control and Prevention, Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020 (cdc.gov), October 30, 2020
[2] COVID-19 Healthcare Coalition, Telehealth Impact - Physician Survey Analysis (c19hcc.org), November 16, 2020
[3] Health Affairs, Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States | Health Affairs, February 1, 2021
[4] 2020-state-telemedicine-report.pdf (doxcdn.com), September 2020, p. 12
[5] American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, Joint Letter to Congress on Telehealth Principles - July 1, 2020 (aafp.org)

and implemented by the U.S. Department of Health and Human Services (HHS), as well as private payers. However, many of the telehealth flexibilities and policy changes made by Congress and HHS are due to expire at the conclusion of the PHE, wherein patients and physician practices would be expected to revert to primarily face-to-face services without any type of risk-based assessment for gradually reopening medical practices and health systems to care for non-COVID and non-acute patients.[6] This quick reversal in policy does not take into account patients' comfort level in returning to physician offices to seek necessary care, as well as changes in office workflow and scheduling practices to mitigate spread of the virus within practices resulting in substantially lower volume of in-person visits for as long as the pandemic is with us. Therefore, the quick reversal in policy is not an effective way to recover from the PHE, nor prepare for possible future outbreaks.

The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. In order to address the many barriers to patient access and physician adoption and use of telehealth prior to the COVID-19 pandemic, and properly assess how to foster and strengthen longitudinal, patient-centered care delivery, ACP believes that the following existing PHE flexibilities and waivers should be continued—and not allowed to expire—to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded:

- Pay Parity for Audio-Only and Telehealth Services
- Geographical Site Restriction Waivers
- Telehealth Cost-Sharing Waivers
- Flexibilities in Direct Supervision by Physicians at Teaching Hospitals
- Revised Policies for Remote Patient Monitoring Services
- Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports many actions taken by the Centers for Medicare and Medicaid Services' (CMS) to provide additional flexibilities for patients and their doctors by providing payment for telephone services. During the PHE, Medicare has covered some audio-only services and will reimburse for both telehealth services and audio-only services as if they were provided in person. These changes in payment policy address some of the biggest issues facing physicians as they struggle to make up for lost revenue and provide appropriate care to patients.

[6] Doherty R., Erickson S., Smith C., Qaseem A. "Partial Resumption of Economic, Health Care and Other Activities While Mitigating COVID-19 Risk and Expanding System Capacity." American College of Physicians, May 6, 2020: https://www.acponline.org/acp_policy/policies/acp_guidance_on_resuming_economic_and_social_activities_2020.pdf

Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue and while still providing appropriate care to patients. ACP is discouraged to learn that CMS will not continue coverage of telephone evaluation and management (E/M) services beyond the PHE, despite mounting evidence about the effectiveness of expanding coverage for these services. While ACP has supported the Agency's actions to provide coverage and payment parity for such telephone services, the College is very concerned about the impact of reversing these changes at the conclusion of the PHE.

Evidence shows that patient visits to ambulatory practices have declined significantly and despite a rebound, visits remain 30 percent lower than they were pre-pandemic[7], with utilization for practice areas such as adult primary care declining by well over 60 percent.[8] As the need to contain the virus and maintain appropriate social distancing protocols continues throughout the year, and likely beyond, it is unlikely that in-person visits to practices will return to pre-pandemic levels as patients remain uncomfortable with making these in-person visits and physicians schedule fewer patients to be seen in the office. **ACP believes that existing PHE flexibilities and waivers should be continued, and not be allowed to expire—including pay parity for audio-only phone calls—to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded. We also urge removal of the requirement for the use of two-way, audio/video telecommunications technology so that telephone E/M services can continue to be provided to Medicare beneficiaries.**

Additionally, the HHS Office of Civil Rights (OCR) announcement regarding enforcement discretion around non-HIPAA-compliant technologies during the PHE has shown to be useful in allowing physicians to quickly shift their predominately in-person practices to more virtual care, as well as allowing increased access by patients to more widely available technologies. **Due to the long-lasting effects of the pandemic, and the need for physician practices to maintain the ability to provide care virtually, ACP recommends Congress urge OCR to maintain this enforcement discretion after the PHE is lifted.**

As part of the 2021 Physician Fee Schedule Final rule, CMS instituted a new permanent code describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit which can be conducted via audio-only technology similar to a virtual check-in. ACP does not

---

[7] Mehrotra, A., Chernew, M., Linetsky, D., Hatch, H., & Cutler, D. (2020, May 19). What Impact Has COVID-19 Had on Outpatient Visits? Retrieved June 03, 2020, from https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits

[8] FAIR Health. Healthcare Professionals and the Impact of COVID-19, A Comparative Study of Revenue and Utilization. June 10, 2020. https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/Healthcare%20Professionals%20and%20the%20Impact%20of%20COVID-19%20-%20A%20Comparative%20Study%20of%20Revenue%20and%20Utilization%20-%20A%20FAIR%20Health%20Brief.pdf

agree that the establishment of G2252 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion) on an interim basis is the solution to providing an alternative to telephone E/M visits. ACP strongly disagrees with CMS' conflation of virtual check-ins, of any duration, with audio-only (telephone) E/M services, which are completely different. As the College has noted, telephone E/M services are not just a longer virtual check-in service, it *is* an E/M service. A more detailed explanation as to why ACP does not support use of G2252 as a replacement for telephone E/M visits can be found in its February 2021 comment letter to the Agency.[9]

Geographical Site Restriction Waivers

ACP strongly supported CMS' policy changes to pay for services furnished to Medicare beneficiaries in any health care facility and in their home — allowing services to be provided in patients' homes and outside rural areas. ACP has long-standing policy in support of lifting these geographic site restrictions that limit reimbursement of telehealth services by CMS to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas.[10] While limited access to care is prevalent in rural communities, it is not an issue specific to rural communities alone. Underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social determinants of health such as lack of transportation or paid sick leave, or sufficient work schedule flexibility to seek in-person care during the day, among many others. The experience with COVID-19 suggests many patients are at higher overall risk of mortality and morbidity due to these types of social determinants and racial and ethnic characteristics, particularly for African-Americans.[11] Such patients are more likely to reside in these underserved communities that fall within the metropolitan statistical areas that are normally not included in Medicare telehealth reimbursement outside of the waivers offered through the PHE.[12] Research has shown the extensive role that social drivers play in health and health equity,[13] and the pandemic has highlighted how providing expanded access to telehealth services within underserved communities, rural and urban, is an important aspect for infection control as well as addressing social determinants that exist outside of the pandemic. Moreover,

---

[9] American College of Physicians, ACP Comments on 2021 Final Physician Fee Schedule and Quality Payment Program Rule (acponline.org), February 1, 2021, p. 14

[10] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

[11] Webb Hooper M, Nápoles AM, Pérez-Stable EJ. "COVID-19 and Racial/Ethnic Disparities." JAMA. Published online May 11, 2020. doi:10.1001/jama.2020.8598

[12] Robert Wood Johnson Foundation. "Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America." Princeton: Robert Wood Johnson Foundation; February 2008. Accessed on 11 May 2017at: www.rwjf.org/content/dam/farm/reports/reports/2008/rwjf22441

[13] Daniel H, Bornstein S, Kane G. "Addressing Social Determinants to Improve Patient Care and Promote Health Equity." American College of Physicians, April 17, 2018: https://www.acpjournals.org/doi/10.7326/M17-2441

the funding provided through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to the Federal Communications Commission (FCC), and other efforts through the FCC to expand access to telehealth services, offer the opportunity to provide the technologies and broadband needed for these underserved patient populations to utilize these services. **Accordingly, it is essential to maintain expanded access to and use of telehealth services for these communities, as well as rural communities, and ACP recommends that Congress permanently extend the policy to waive geographical and originating-site restrictions after the conclusion of the PHE.**

Telehealth Cost-Sharing Waivers

ACP appreciated the flexibility provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. At the same time, we call on CMS or preferably Congress to ensure that they make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding these physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining treatment. This critical action has led to increased uptake of telehealth visits by patients. **At the conclusion of the COVID-19 PHE, ACP recommends that Congress or CMS continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service. This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they are. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded.**

Flexibilities in Direct Supervision by Physicians at Teaching Hospitals

CMS has noted that in instances where direct supervision is required by physicians and at teaching hospitals, the agency will allow supervision to be provided using real-time interactive audio and video technology through the calendar year 2021. The College welcomes this decision by the agency to allow attending physicians and residents/fellows the ability to communicate over interactive systems asynchronously by waiving the in-person supervision requirement. This important step promotes efficient patient care and allows physicians and supervisees to work together unencumbered by social distancing restrictions. **We encourage Congress or CMS to maintain these modifications, and not allow them to expire.**

Revised Policies for Remote Patient Monitoring (RPM) Services

CMS finalized policy stating that following expiration of the COVID-19 PHE, there must be an established patient-physician relationship for RPM services to be furnished – ending its interim policy permitting RPM services to be furnished to new patients. The Agency also finalized

policies allowing consent to receive RPM services to be obtained at the time RPM services are furnished and noted that practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions.

RPM services have been a critical component of care, especially during the COVID-19 pandemic. ACP is pleased to see the Agency finalized a number of policies that will be beneficial to both patients and their care teams. These changes expand access to services at an important time, as patients and their care teams need additional resources to meet current challenges. These changes will help relieve physician burden and allow physicians more time to treat complex patient issues that require more than remote monitoring. **We continue to believe that Congress or CMS should extend the interim policy to allow RPM services to be furnished to patients without an established relationship. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded. The College continues to request the same for CMS' interim policy allowing RPM services to be reported for periods of less than 16 days, but not less than two days, so long as the other requirements for billing the code are met. While CMS did not take any action on these recommendations, we look forward to working with CMS to understand the need for additional policy changes in this regard.**

Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action

ACP supports a streamlined approach to obtaining several medical licenses that would facilitate telehealth services across state lines while allowing states to retain individual licensing and regulatory authority.[14] **We appreciated CMS' temporary waiver allowing physicians to provide telehealth services across state lines, as long as physicians meet specific licensure requirements and conditions. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded.** These waivers offer an opportunity to assess the benefits and risks to patient care in addressing the pandemic as well as the ability to maintain longitudinal care for patients who move across state lines. While these waivers do not supersede any state or local licensure requirements, they provide the opportunity to promote state-level action that may further promote more streamlined licensure requirements across the country. ACP also supports the Temporary Reciprocity to Ensure Access to Treatment Act or the "TREAT Act" (S. 168/H.R. 708), which would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

[14] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

In conclusion, we appreciate this opportunity to offer our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies to continue telehealth expansion beyond the PHE. Thank you for considering our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Should you have any additional questions, please contact Jonni McCrann at jmccrann@acponline.org.

Written Testimony
of the
American Psychological Association

Submitted to the
Subcommittee on Health of the
House Committee on Energy & Commerce

HEARING: THE FUTURE OF TELEHEALTH:
HOW COVID-19 IS CHANGING THE DELIVERY OF VIRTUAL CARE
Tuesday, March 2, 2021 - 10:30 am

The American Psychological Association (APA) is the leading scientific and professional organization representing psychology in the United States, with over 122,000 researchers, educators, clinicians, consultants, and students. APA's mission is to make a positive impact on critical societal issues through the application of psychological science and practice. APA applauds the Committee for examining the ways in which the COVID-19 pandemic affected patient access to an array of health care services furnished remotely via telehealth. Our testimony will highlight how this transformation in virtual service delivery prompted a broad expansion of access to mental and behavioral health services, and how this expansion benefited patients in a time when prompt access to these services was particularly needed.

APA urges Congress to advance tele-behavioral health policies that provide equitable access for all individuals in need of treatment. Such policies should:

- Permanently allow Medicare to continue reimbursement for routine mental and behavioral health treatment, including psychotherapy and Health Behavior Assessment and Intervention (HBAI) services, neurobehavioral status exams, and psychological and neuropsychological testing evaluation feedback sessions furnished through audio-only telephone after the COVID-19 public health emergency ends.
- Require all payers, including ERISA self-insured plans, to cover and reimburse for tele-behavioral health services, at parity with services furnished via face-to-face visits, and through multiple access modalities to ensure equitable access to essential care.
- Avoid imposing in-person service requirements that inequitably limit access to care.

The need for mental and behavioral health services continues to surge because of the COVID-19 pandemic. The pandemic continues to exacerbate existing behavioral health needs, as the public health and economic impact of the pandemic causes greater levels of stress, anxiety, depression, and trauma, the impacts from which our country will face long after the pandemic's end. According to APA's latest *Stress in America Survey*, 84% of U.S. adults reported feeling at least one emotion—such as anxiety, sadness, and anger—associated with prolonged stress within the previous two weeks, with the COVID-19 pandemic among the top sources of this stress.[i] Even in the early months of the pandemic, over 40% of Americans reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder, depressive disorder, stressor-related disorder, or substance use disorder, with significantly higher rates amongst Black and Latino communities.[ii] Today, most of our member-clinicians

continue to see an increase in patient demand for treatment of anxiety (74%) and depressive disorders (60%) than before COVID-19.[iii]

Telehealth access, including access to services furnished via audio-only transmissions, remains a critical tool to meet the increased need for mental and behavioral health services. APA views access to behavioral health care through a four-level model of health care delivery: (1) in-person services; (2) traditional telehealth services provided at an originating site such as a clinic or health care facility; (3) telehealth service without originating site restrictions to allow for certain services to be delivered directly into a patient's home; and (4) audio-only telehealth for a subset of services and/or particular populations. Audio-only telehealth is an option that clinicians should be able to recommend and patients should be able to choose based on their individual needs and preferences.

The evidence is clear that psychotherapy delivered by telehealth is at least as effective as in-person care.[iv] There is also clear evidence that the provision of mental health services over the telephone is equally as effective as face-to-face visits for patients with depression and anxiety. A review of 13 studies found reduced symptoms of anxiety and depression when therapy was conducted via telephone.[v] There is additional evidence that telephone therapy particularly benefits patients who have certain comorbid medical and psychological conditions, such as depression, HIV, and epilepsy.[vi]

Given the reported increases in adjustments related to the pandemic as well as a general increase in mental and behavioral health concerns, access to evidence-based services should be top priority. Audio-only therapy provides an efficient way to manage behavioral health concerns when symptoms are identified. When mental and behavioral health treatment is available early in the course of identified stressors, it can significantly improve quality of life and reduce further symptom severity, and ultimately reduce further behavioral health care costs.

The experiences of patients and clinicians alike illustrate the positive impact of access to audio-only telehealth. One patient, who lacks access to reliable Internet services and needed to stay home to care for a husband in recovery from recent surgeries, reports that "[Teletherapy] saved my life and saved my marriage. If I hadn't had this opportunity to do the audio I don't know where I'd be right now or if I'd even be here." A rural mental health specialist who primarily provides services to farmers, their families, and agricultural industry personnel reports that many of her clients prefer phone conversations for their appointments due to the "flexibility and accessibility that they afford." Another mental health clinician reported to us that audio-only telehealth "expanded the ability of many of the potential consumers of psychological services to access the help that they need," as many of his patients "either don't have the access to the technology that allows both audio and video connection…or they are not technologically sophisticated enough to really make that an easy or readily available means of accessing that service."

Despite recent advancements in coverage, many practical challenges remain for accessible audio-video telehealth services. According to a September 2020 survey of APA's membership, problems with "Internet access or connectivity" (69%) and "general technological difficulties with computer, webcam, etc." (66%) were identified as the leading barriers or challenges experienced by patients.[vii] Access to audio-only telehealth is an especially critical tool to remedy long-standing disparities in access to mental and

behavioral health services. Audio-only services remain a lifeline to mental and behavioral health services for many individuals, especially older adults, individuals with disabilities, people in rural and frontier areas, lower-income families, racial and ethnic minority communities, and other underserved populations who often lack sufficient broadband, do not have access to computers or smartphones, or are unable to utilize audio and video enabled communication devices due to disability or difficulties with digital literacy. Nearly 22 million older adults in the U.S. do not have broadband access in their homes, and those making less than $25,000 in yearly income are 10 times less likely to have reliable internet access. Additionally, older black and Latino groups are between 2.6 and 3.4 times less likely to have reliable Internet access than their white counterparts. [viii]

APA thanks the Subcommittee for taking these recommendations into consideration. For more information, please contact Laurel Stine, J.D., M.A., Senior Director of Congressional & Federal Affairs and Partnerships (lstine@apa.org) or Stephen R. Gillaspy, Ph.D., Senior Director, Health & Health Care Financing (sgillaspy@apa.org).

---

[i] American Psychological Association (2021). Stress in America: January 2021 Stress Snapshot. https://www.apa.org/news/press/releases/stress/2021/stress-snapshot-january.pdf.

[ii] Czeisler, M.É., Lane R,I., Petrosky, E., et al. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report*. *69,*1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

[iii] American Psychological Association (2020, November). Patients with depression and anxiety surge as psychologists respond to the Coronavirus pandemic. https://www.apa.org/news/press/releases/2020/11/telehealth-survey-summary.pdf.

[iv] See, e.g., Varker, T., Brand, R. M., Ward, J., Terhaag, S., & Phelps, A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: A rapid evidence assessment. *Psychological Services, 16*(4), 621-635. https://doi.org/10.1037/ser0000239

[v] Coughtrey, A. E., & Pistrang, N. (2018). The effectiveness of telephone-delivered psychological therapies for depression and anxiety: A systematic review. *Journal of Telemedicine and Telecare, 24*(2), 65–74. https://doi.org/10.1177/1357633X16686547

[vi] Heckman, T. G., Heckman, B. D., Anderson, T., Lovejoy, T. I., Markowitz, J. C., Shen, Y., & Sutton, M. (2017). Tele-interpersonal psychotherapy acutely reduces depressive symptoms in depressed HIV-infected rural persons: A randomized clinical trial. *Behavioral Medicine, 43*(4), 285-295. https://doi.org/10.1080/08964289.2016.1160025; Heckman, T. G., Markowitz, J. C., Heckman, B. D., Woldu, H., Anderson, T., Lovejoy, T. I., Shen, Y., Sutton, M., & Yarber, W. (2018). A randomized clinical trial showing persisting reductions in depressive symptoms in HIV-infected rural adults following brief telephone-administered interpersonal psychotherapy. *Annals of Behavioral Medicine, 52*(4), 299-308. https://doi.org/10.1093/abm/kax015; Thompson, N. J., Patel, A. H., Selwa, L. M., Stoll, S. C., Begley, C. E., Johnson, E. K., & Fraser, R. T. (2015). Expanding the efficacy of Project UPLIFT: Distance delivery of mindfulness-based depression prevention to people with epilepsy. *Journal of Consulting and Clinical Psychology, 83*(2), 304–313. https://doi.org/10.1037/a0038404.

[vii] American Psychological Association (2020, December). Internet access, technical difficulties, and lack of privacy are top barriers to telehealth. https://www.apa.org/workforce/publications/telehealth-barriers-coronavirus.pdf.

[viii] Older Adults Technology Services (2020). Aging connected: Exposing the hidden connectivity crisis for older adults. https://agingconnected.org/wp-content/uploads/2021/02/Aging-Connected_Exposing-the-Hidden-Connectivity-Crisis-for-Older-Adults.pdf.

This website uses a variety of cookies, which you consent to if you continue to use this site. You can read our **privacy policy (http://www.xtelligentmedia.com/privacy-policy)** for details about how these cookies are used, and to grant or withdraw your consent for certain types of cookies. Consent and dismiss this banner by clicking agree. **Agree**

EHR INTELLIGENCE
xtelligent HEALTHCARE MEDIA
(https://ehrintelligence.com/)

Topic

USE & OPTIMIZATION NEWS

Health Experts Misjudged EHR Clinician Burnout at HITECH Act Passage

Clinicians and healthcare experts did not fully grasp the high potential of EHR clinician burnout at the time of the HITECH Act passing in 2009.

Source: Getty Images

alth-experts-misjudged-ehr-clinician-burnout-at-hitech-act-H%20Act%20Passage) (https://twitter.com/intent/tweet?=https%3A%2F%2Fehrintelligence.com%2Fnews%2Fhealth-ch-act-passage) (https://www.linkedin.com/shareArticle?alth-experts-misjudged-ehr-clinician-burnout-at-hitech-act-linician%20Burnout%20at%20HITECH%20Act%20Passage)

By Christopher Jason (mailto:cjason@xtelligentmedia.com)

February 17, 2021 - Following the passage of the HITECH Act in 2009 and the subsequent increase in EHR adoption, clinicians and healthcare experts significantly underestimated the degree of clinician burnout and its contributing factors, according to a study **published (https://academic.oup.com/jamia/advance-article/doi/10.1093/jamia/ocaa320/6135062?searchresult=1)** in the *Journal of the American Medical Informatics Association (JAMIA)*.

On the contrary, healthcare professionals overestimated the concern over patient privacy and fraud.

After the **HITECH Act (https://ehrintelligence.com/news/hitech-directly-responsible-for-hospital-ehr-adoption-spike)** passed, clinician burnout has run rampant across the country amidst poor EHR usability, unintuitive EHR design, and high clinician workload.

> **Dig Deeper**
>
> • **New Data Shows Heavy EHR Adoption Investment Prior to HITECH Act (https://ehrintelligence.com/news/new-data-shows-heavy-ehr-adoption-investment-prior-to-hitech-act)**
>
> • **Meaningful Use, HITECH Sparked Spike in EHR Venture Capitalism (https://ehrintelligence.com/news/meaningful-use-hitech-sparked-spike-in-ehr-venture-capitalism)**
>
> • **Improving Provider Satisfaction in the Post-HITECH Era (https://ehrintelligence.com/news/improving-provider-satisfaction-in-the-post-hitech-era)**

Healthcare professionals, including individuals from the American College of Medical Informatics (ACMI), met at the 2009 AMIA Policy Meeting to dissect the potential unintended consequences associated with the EHR adoption increase following the HITECH Act. Participants established 17 possible consequences and 15 recommendations to address the consequences.

Twelve years later, 40 ACMI fellows attended a symposium to discuss the EHR impact of **clinician burnout (https://ehrintelligence.com/news/increased-ehr-workload-has-a-major-impact-on-clinician-burnout)** and dissect the 2009 AMIA Policy Meeting predictions and recommendations.

The individuals found none of the 2009 predictions directly addressed clinician burnout. However, several predictions addressed burnout components, such as increased documentation, increased cognitive load, data overload, and clinicians retiring early.

The study authors said the most underestimated EHR impact was, "behaviors like cut/paste will result in decreased data quality." On the other hand, the most overrated effect was, "false positives from abuse and fraud detection algorithms will harm clinicians and/or patients."

"The collective opinion of the ACMI fellows participating in this session was that, while many consequences of the HITECH act were foreseen in 2009, the magnitude of the current burnout crisis largely was not," wrote researchers. "On a brighter note, the problems of rampant identity theft or 'false positives from abuse and fraud detection algorithms' have not been as severe as was feared, perhaps owing to advancements in EHR security and regulations."

The study group credited the 2009 healthcare experts because of their initial concerns about EHR documentation burden and the potential harm of EHR system interfaces. Furthermore, informatics researchers at the time also attempted to enhance EHR efficiency to prevent clinician burnout from becoming as widespread as it is now.

But research and workshops are not enough to address current clinician burnout issues, the study authors said. For example, individuals at the 2009 AMIA Policy Meeting recommended further research and regulatory tools to mitigate EHR-related problems. However, legislation, such as gag clauses and other patient data-sharing practices, stymied those efforts.

"Another observation is that, even though scores of informatics research projects have developed potential approaches to mitigate these problems, too few of those have been translated into real-world solutions," wrote the study authors. "In hindsight, we suggest that implementing more of the 2009 recommendations, such as research on the cognitive burden of commercial EHRs and incentives to share best practices, may have been able to mitigate some of the clinician burnout currently being experienced."

Researchers did note study participants strictly identified specific EHR-related causes of clinician burnout. For example, the group did not differentiate intrinsic EHR software impact or the different optimizations or functions that contribute to burnout.

"While informatics experts did accurately predict a number of the issues that now contribute to clinician burnout, we did not accurately foresee the magnitude of the current crisis," concluded the study authors. "Perhaps equally important, the Policy Meeting included a number of recommendations that may have reduced the severity of HIT-related unintended consequences, including physician burnout. Unfortunately, few of these recommendations were enacted."

Heart Failure Society of America

Testimony for the Record
House Committee on Energy and Commerce Subcommittee on Health

"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

March 2, 2021

Chairwoman Eshoo, Ranking Member Guthrie, and members of the Subcommittee, thank you for the opportunity to submit testimony related to the future of telehealth and how the COVID-19 pandemic is changing the delivery of virtual care.

The Heart Failure Society of America (HFSA) represents more than 2,000 members of the multidisciplinary heart failure team, including physicians, nurses, pharmacists, physician assistants, researchers, and patients, dedicated to significantly reducing the burden of heart failure and improving and expanding heart failure care through collaboration, education, innovation, research, and advocacy. HFSA appreciates the U.S. House Energy and Commerce Committee's consideration of the evolving role of telehealth in our nation's health care system, which has been exacerbated by the COVID-19 pandemic, and we would like to share our experience with telemedicine during this public health emergency.

The COVID-19 pandemic has presented an unprecedented crisis for patients, clinicians, and health care systems. Most U.S. health care systems have reduced ambulatory outpatient clinics – pillars of the longitudinal care of patients with chronic illnesses, such as heart failure. In this context, synchronous audio/video interactions, also known as virtual visits, have emerged as innovative and necessary alternatives to in-person care. Last April, HFSA members published a paper in the *Journal of Cardiac Failure* that delves into virtual visits and telehealth for the care of patients with heart failure in the COVID19 era[1]. In short, the paper reviews the platforms, reimbursement models, advantages and limitations of virtual visits.

Prior to the COVID-19 pandemic, there was little impetus for clinicians to learn or use virtual visits. In the current era, however, innovative approaches to performing physical exams and medication reconciliation emerged as a result of COVID-19, necessitating the transition to virtual visits. Virtual visits during the COVID-19

---

[1] Gorodeski et al. (2020, April 18). Virtual Visits for Care of Patients with Heart Failure in the Era of COVID-19: A Statement from the Heart Failure Society of America. *Journal of Cardiac Failure*. Retrived from https://www.onlinejcf.com/article/S1071-9164(20)30367-5/fulltext

pandemic have given health care providers the ability to continue to care for patients with chronic conditions, like heart failure, that need to be closely monitored, but who are unable, or reluctant, to travel to an office setting. Virtual visits have improved patient access to care, successfully prevented disruptions in treatment, increased connectivity, facilitated patients' caregiver involvement in care, and given older patients the opportunity to explore online alternatives to care. Many patients with heart failure, especially older adults with disabilities and those living in rural communities, often have difficulty attending in-person visits due to very poor exercise tolerance, inadequate transportation and difficulty in transporting oxgyen, among other barriers. For these patients, virtual visits are certainly more convenient; likewise for their caregivers, who sometimes have to take time off from work to take their family member to the appointment.

While significant benefits to administering care through virtual visits exist, challenges have presented themselves in selected circumstances. To conduct a virtual visit successfully, patients must be willing and able, and the technology must be available and effective. Some patients may be reluctant to participate in virtual visits because they feel uncomfortable with technology or feel self-conscious about interacting on video. Virtual visits also present a barrier to performing a full physical examination, though many components of a partial examination can be completed, and existing and emerging diagnostic technologies and wearables may fill in the gaps. Some patients may have limited access to the internet, and/or may not have a computer or smart device to engage in virtual visits, including low income and elderly in inner city and rural areas. Although there may be geographic and financial challenges to obtaining WiFi for some patients, we anticipate that future technology will provide hotspots via ubiquitous cellular networks, thus alleviating most barriers to internet access. Some health care systems are investing in these technologies and providing equipment and connectivity to ensure that telehealth does not widen health disparities. Further, older adults may be viewed as a subpopulation in which virtual visit challenges (especially in terms of using new technology) are common. This is important in the context of heart failure, in which approximately half of the patients living with heart failure are 70 years and older. Finally, patients and clinicians may occasionally encounter technical difficulties when conducting virtual visits. These may include an inability to initiate the virtual visit, connectivity issues and/or audio/video problems. Some of this may be a direct result of larger than anticipated volumes of users concurrently attempting to use a platform in the setting of the COVID-19 crisis. Over time, the hope is that software upgrades will address these issues and that platforms will be able to accommodate a greater number of users. Of note, if and when these technical issues arise, switching to a telephone visit is a reasonable solution.

Recent legislative and administrative policy changes related to licensing, privacy, location of patient, prior existing relationships between patients and clinicians, prescriptions, and reimbursements have been relaxed and/or updated to allow

telehealth to thrive in the era of the COVID-19 pandemic. Distant health technologies that align with virtual visits, including biosensing wearables and other diagnostic tools, may be increasingly adopted. Whether the use of virtual visits can improve adherence, decrease no-show rates, decrease office overhead, improve transitions of care from the inpatient to outpatient setting, or prevent emergency department visits and hospital admissions and readmissions for patients with heart failure is yet unknown. This underscores the need to collect outcomes data.

In summary, the COVID-19 pandemic has generated an important opportunity to learn about delivering heart failure care in a different way that should be fully embraced well beyond the current crisis. Even after this pandemic crisis recedes, patients may continue to have concerns about in-person office visits and travel, and may prefer to continue with a degree of physical distancing through virtual visits. There is great potential to increase visits and maintain close patient interactions virtually beyond the end of the current public health emergency. With these expectations in mind we believe that virtual visit models of care will become the norm in the U.S. health care system as we move forward, especially for patients with heart failure.

HFSA urges the committee to review it's full paper in *Journal of Cardiac Failure* and to take our society's experience into consideration when developing any legislation related to the future use and implementation of a robut telehealth system to benefit patients, caregivers, and the nation's overall healthcare system.

Telehealth: Potential Program Integrity Issues

OIG Technical Assistance as Requested
February 2021

Overview

This document provides technical assistance for policymakers considering program integrity as it relates to telehealth. It focuses on the Medicare program, but the principals articulated here may have broader application to other programs. This technical assistance focuses on three main areas:

- Quality of Care and Patient Safety
- Verification of Services and Patient Consent
- Infrastructure

For each area, OIG identifies potential risks and safeguards that should be considered by policymakers to protect patients and ensure that telehealth delivers on its promise to expand access to, and delivery of, quality health care.

Background

In response to the COVID-19 public health emergency, both Congress and the Department of Health and Human Services (HHS) acted to make telehealth more widely available. Based on those efforts and regulatory action taken by the Centers for Medicare & Medicaid Services (CMS), Medicare has seen significant, well-documented changes in telehealth utilization and service type.

The HHS Office of Inspector General (OIG) has conducted data analysis throughout the public health emergency on preliminary telehealth claims data in Medicare to monitor trends and aberrant patterns that may indicate potential program integrity concerns. These analyses have provided some early indications of vulnerabilities for fraud, waste, and abuse associated with expanded utilization of telehealth. OIG has a general understanding of many of these risks because they are common in a fee-for-service program (e.g., overutilization and upcoding). However, more work is needed to identify the magnitude of those risks and how differences in telehealth service delivery may lead to new program integrity concerns.

OIG's prior work recognizes telehealth can be used to improve access to care, increase patient convenience, and increase efficiency in the delivery of services.[1] While permanent changes and improvements are considered, program integrity vulnerabilities should be one factor among many others that are considered so that use of telehealth leads to more effective and efficient delivery of health care services. To better understand telehealth issues, OIG has ongoing work specifically assessing Medicare and Medicaid telehealth services during the public health emergency.[2] Once complete, OIG's reviews will provide in-depth, objective, and independent findings and recommendations that can further inform policymakers and other stakeholders.

Since the expansion of telehealth services due to the public health emergency, the **OIG Hotline** has reported an uptick in telehealth-related complaints. Examples of the types of complaints include:

- providers instructing staff to "cold call" Medicare beneficiaries via telephone and bill each for a telehealth visit;
- "upcoding" telehealth visits by billing for visits longer than they lasted;
- billing for services not rendered to the patient, or providing basic services and billing for more complex visits;
- billing for an impossible number of virtual visits in one day; and
- using overseas providers to provide telehealth services that do not appear to be licensed or credentialed in the United States

To date, OIG's data analysis on preliminary telehealth claims data in Medicare indicates some potential concerns related to fraud, waste, and abuse. For example, an analysis of claims from 3/1/2020 through 7/31/2020 shows that providers are billing telehealth office visits for new patients at a higher complexity level than those provided face to face. Twenty-two percent of telehealth visits for new patients were billed at the highest complexity level, versus 16 percent for non-telehealth visits. Additional analysis may explain the difference is appropriate, but this trend warrants further monitoring.

---

[1] *Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care*, OEI-02-17-00490, Sept. 2019.

[2] Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency; Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency; Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks; Use of Medicare Telehealth Services During the COVID-19 Pandemic; Medicaid—Telehealth Expansion During COVID-19 Emergency.

Telehealth: Potential Program Integrity Issues

OIG Technical Assistance as Requested
February 2021

The program integrity issues summarized below reflect both OIG Hotline complaint trends and OIG's data analyses.

Technical Assistance: Three Areas of Focus

OIG has identified the following potential program integrity risks and safeguards. The information provided in this section is based on OIG experience and work completed to date. This document is intended to provide preliminary context, and issues identified may not warrant specific action at this time. New issues may emerge or our understandings of existing issues may change as we continue our oversight work. The risks noted below derive from OIG work and are not exhaustive of all telehealth program integrity risks that may arise. OIG will share updated information as telehealth oversight and enforcement work provides additional insights on potential program integrity vulnerabilities.

Quality of Care and Patient Safety

OIG suggests considering the following risks and safeguards related to potential quality of care and safety concerns in connection with telehealth flexibilities. Telehealth waivers have expanded potential service areas for many providers. For example, OIG has identified more than 100 providers who served beneficiaries via telehealth in at least 10 States during the pandemic, whereas in prior years the same providers mostly treated beneficiaries in one or two states. While not directly indicative of fraud or abuse related to quality of care, it demonstrates that telehealth waivers may create challenges with existing safeguards such as requirements for provider enrollment and screening. Analyses also demonstrate that the types of providers engaging in services are changing. For example, office-based opioid treatment was much more likely to be provided by physician assistants and nurses when delivered via telehealth (37 percent of claims) than face to face (10 percent of claims). Again, this is not a direct indication of fraud or abuse but provides data that stakeholders should consider when assessing permanent changes to telehealth services.

Risks

- New service with limited accepted standards of care when provided via telehealth
- Expanded scope of services that may be more appropriate for in-person care or require in-depth assessment via physical exam
- Lack of infrastructure and/or programs for quality oversight
- Supervision via telehealth (e.g., the provider is not present and accountable for service if another professional provides the care)

Safeguards

- Incentivize quality by linking telehealth reimbursement with quality-of-care measurements
- Create a standard that requires CMS to consider clinical appropriateness as part of the process of approving new services for telehealth reimbursement
- Document consent to ensure patient understands services being provided and is capable of carrying out provider instructions at home
- Develop oversight mechanisms that help ensure telehealth delivery is safe and effective for patients
- Ensure telehealth services have standard-of-care and medical-necessity parity with in-person visits (e.g., in-person service quality requirements should apply to telehealth)

Telehealth: Potential Program Integrity Issues

OIG Technical Assistance as Requested
February 2021

Verification of Services and Patient Consent

OIG enforcement and oversight work indicates that bad actors and unscrupulous providers may take advantage of telehealth services to expand well-known fraud schemes. Recent fraud schemes used "telefraud" or telemarketing to reach beneficiaries at home and used that interaction to bill for medically unnecessary items and services, such as durable medical equipment (DME). These schemes have not regularly included billing for fraudulent telehealth services but have involved sham "telemedicine companies." With additional telehealth flexibilities, bad actors may double dip by billing for fraudulent telehealth services and order other unnecessary items or services.

To provide context, the following data is about audio-only telehealth. Since 3/1/2020, Medicare has paid more than $440 million for audio-only phone call codes involving more than 300,000 providers and 5.2 million beneficiaries. Most of these calls were between patients and providers with prior relationships, but approximately 5 percent were between providers and patients with no prior relationships. Collectively, approximately 90,000 beneficiaries received approximately $43 million worth of DME supplies ordered by providers with whom they had a phone call billed. These data are not indictive of any particular fraud and abuse trends. Instead, it may reflect other issues, such as lack of Medicare beneficiary access to video technology or broadband access.

Risks

- Gaps in requirements for validating that a given telehealth event took place and was appropriate for the patient
- Different modalities may present verification challenges (e.g., audio-only services are harder than video calls to verify from an oversight perspective)
- Patient verification of the provider can be harder than over telehealth, particularly for audio-only
- Current coding and modifiers are limited and do not provide granular data that enable specific analysis of telehealth services and modality
- Challenges with verifying that provider is appropriately licensed and credentialed in the United States
- Difficulties with consent verification that service was needed if patient receives unsolicited calls and does not need to leave the home, and special concern for vulnerable populations with cognitive issues that may have limited protections and/or understanding of consent

Safeguards

- Use technology to document service (e.g., screenshot of video)
- Condition payment on a patient attestation or consent to ensure patient agreed to service
- Limit reimbursement for audio-only to patient-initiated or scheduled services, or for patients with a documented lack of video technology access
- Improve CPT and modifiers to track modality of technology
- Capture additional data to support verification similar to mobile phone call metadata (e.g., call detail records).
- Verification that a doctor who signed up to provide services is the one providing services (could augment use of screenshots)
- Require or provide guidelines for vulnerable individuals with cognitive issues or impaired decision-making abilities to authorize another designated individual for dual consent of services on their behalf

Telehealth: Potential Program Integrity Issues

OIG Technical Assistance as Requested
February 2021

Infrastructure

The increased demand for services may lead to privacy and security concerns as providers and patients adopt new technology for telehealth and other virtual care. Expanded access to telehealth services should consider how best to ensure that the technology remains safe and secure for use and protects patient health information.

Risks

- Early concerns regarding cybersecurity that expanded technology for telehealth has the potential to expose patients' protected electronic health information or other personal information to data breaches and/or phishing attempts
- Evolving cybersecurity threats specifically configured to target telehealth IT infrastructure through malware toolkits and unique strains of ransomware
- More of the onus is put on patients to ensure cybersecurity (e.g., installing smartphone operating system updates)
- Different tiers of permitted technology or security requirements may pose risks (e.g., public-facing video technology is acceptable for some services, but not all)
- Security issue that the provider on the other end is the provider who is supposed to be seen (e.g., identify theft)
- Patients with limited access to reliable internet connections may not have the capabilities to regularly engage in telehealth or other virtual care, and may need to utilize secure communication methods to virtually interact with providers (e.g., text messages)

Safeguards

- Require expanded technology for telehealth should be to meet a consistent level of security expectation
- Ensure security requirements take into account the patient role and potential vulnerabilities
- Harmonize security requirements as much as possible across service types.
- Create a system between provider and patient to verify the provider (e.g., technology verification "handshake" or something similar to the electronic visit verification system for home health and personal care services)
- Continue addressing patient access to reliable internet connection to ensure patients can securely communicate with their providers
- Ensure training on telehealth-specific health care privacy and security training for providers and staff who provide telehealth services

For questions, please contact Britanny Vanderhoof in OIG's Office of Congressional Affairs at 202-893-4969 or by email at Britanny.Vanderhoof@oig.hhs.gov.

March 1, 2021

The Honorable Anna Eshoo
Chairwoman
Committee on Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
272 Cannon HOB
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member
Committee on Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
2434 Rayburn HOB
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies –advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

The COVID-19 health pandemic has highlighted several challenges to delivering care. State imposed stay-at-home orders limited access to care for vulnerable populations, however increased telehealth use alleviated many challenges. We greatly appreciate the flexibilities permitted by the Department of Health and Human Services (HHS) to expand access to telehealth services. These waivers, however, are only temporary and are set to expire at the end of the current public health emergency (PHE). In order to ensure that these gains in telehealth continue into the future, Congress must act to make permanent changes. One of the biggest limitations on widespread telehealth use is the existing prohibition under Section 1834(m) of the Social Security Act that prevents patients from receiving telehealth services in their homes. Limiting patients to receive telehealth services to originating sites reduces their ability to receive important care. Additionally, we support efforts to allow federally qualified health centers (FQHCs) and rural clinics to be able to permanently offer telehealth services. This will help close the gap of vulnerable patients who have been unable to receive necessary care.

The opportunities of improved telehealth have given patients access to a variety of virtual care options. We encourage Congress to recognize the benefits of additional methods of delivering care, such as audio-only telehealth and remote patient monitoring (RPM) services. Allowing providers to deliver a variety of virtual care options will better allow patients to receive important

treatment. These care options recognize the infrastructure challenges many rural communities have and ensure patients are not left behind in future care innovations.

One of the greatest opportunities of increased telehealth is that patients can now receive essential care from the safety of their homes. While this improves patients access to providers, existing state licensure requirements have prevented patients from being able to access a broad variety of providers. HLC supports provisions in the *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* that temporarily waive licensing requirements through the end of the COVID-19 health pandemic. Allowing providers to deliver care to patients outside of their states will alleviate staffing challenges so patients can continue to receive telehealth care. Additionally, the *TREAT Act* creates a single licensing standard that will reduce the regulatory challenges of providing telehealth services. During this unprecedented crisis and despite governors' best intentions, a state-by-state solution proved insufficient to appropriately address staffing needs in a timely manner.

HLC looks forward to working with you on steps to permanently allow improved telehealth services that deliver essential care to patients. Please contact Tina Grande at tgrande@hlc.org or 202-449-3433 with any questions.

Sincerely,

Mary R. Grealy
President

HealthEquity

15 W. Scenic Pointe Dr.
Draper, UT 84020

P: 855.437.4727
F: 801.727.1005

www.HealthEquity.com
info@healthequity.com

March 2, 2021

The Honorable Anna Eshoo
Chairwoman, Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member, Subcommittee on Health
House Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

We write to you today to thank you for holding a hearing entitled, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." Your attention to this critical issue is appreciated by HealthEquity and by the millions of Americans who utilize telehealth services.

HealthEquity administers health savings accounts ("HSAs") and other consumer-directed benefits for more than 12 million accounts on behalf of American workers. We partner with employers, benefits advisors, and health and retirement plan providers who share our mission to connect health and wealth and value our culture of remarkable "Purple" service.

In response to the COVID-19 pandemic, Congress included temporary provisions in the CARES Act (P.L. 116-136) permitting an HSA-eligible high deductible health plan to cover telehealth and other remote services without a deductible or before the deductible has been met. These temporary provisions providing access to vital care expire at the end of 2021.

While these provisions are temporary, the growth in telehealth is likely not. Surveys have shown explosive growth in telehealth since the pandemic began:

- A study in *Health Affairs* found that 30.1% of all healthcare visits – a 23-fold increase – were conducted via telemedicine between January and June 2020[1];
- A coalition of self-insured plan sponsors reported a 28-fold increase in telemedicine visits between January and May 2020[2]; and

[1] Population of 16.7 million participants with commercial insurance or a Medicare Advantage plan. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01786?journalCode=hlthaff

[2] https://www.prnewswire.com/news-releases/patient-officehospital-visits-down-telemedicine-visits-up-for-non-covid-19-health-issues-based-on-claims-analysis-by-health-transformation-alliance-301236052.html

HealthEquity®

- A major telemedicine company reported a 156% increase in appointments for 2020 compared to 2019[3].

These statistics show how critically important telemedicine has become. Few observers believe the practice of medicine will return to the way it was before COVID. As society and technology evolve, so should health and tax policy.

We respectfully request that you make the CARES Act telehealth provisions permanent and support the millions of Americans who have found telemedicine to be a safe and effective means of receiving medical care.

Thank you for your attention to this issue. We are happy to be of assistance in any way.

Sincerely,

Jody L. Dietel, ACFCI, CAS, HSA*e*
Senior Vice President, Advocacy and Government Affairs
HealthEquity, Inc.
jdietel@healthequity.com
650.577.6372

Cc: The Honorable Frank Pallone, Jr.
The Honorable Cathy McMorris Rodgers

[3] https://ir.teladochealth.com/news-and-events/investor-news/press-release-details/2021/Teladoc-Health-Reports-Fourth-Quarter-and-Full-Year-2020-Results/default.aspx

COVID-19 & Rural Health Equity in Northern New England

Summary of Findings on Telehealth

Elizabeth Carpenter-Song, PhD, Anne N. Sosin, MPH

Telehealth has emerged as a powerful tool for health equity

The other thing that I hope comes about, is that I hope that tele-health does not become a moment in time,
Healthcare Executive, North Country

Research Overview

In mid-March, researchers at Dartmouth's Center for Global Health Equity launched the first phase of a study on the COVID-19 pandemic and rural health equity in Northern New England. The first phase of the study sought to assess the immediate impacts of the COVID-19 pandemic on rural health equity in Northern New England, identify mid- to longer-range concerns and opportunities for rural health and health systems, and identify priorities for future research, action, and policy. The first phase of research consisted of 50 qualitative interviews conducted with key informants from health systems, social service organizations, public health entities, mutual aid groups, and town and city/governments from across Vermont and New Hampshire. The research focused on four geographic areas that included the Upper Valley, the Greater Sullivan/Windsor County area, the Northeast Kingdom (NEK) of Vermont, and the North Country of New Hampshire. Additional interviews were conducted with representatives of state and regional organizations as well as some organizations outside of these focus areas. The second phase of research examining the next period of pandemic response will begin in June 2020.

This brief summarizes the research findings on telehealth. A full report is available at: https://www.covid19healthequity.com/rural-health-equity.

Expansion of Telehealth

Prior to the pandemic, many rural hospitals in New Hampshire and Vermont benefited from growing telehealth collaborations with Dartmouth-Hitchcock's Connected Care program, the University of Vermont Medical Center, and other academic medical centers; however, telehealth was primarily limited to the provision of specialty care between academic medical centers and rural settings. Very few primary care and behavioral service providers had telehealth services in place at the start of the pandemic, and licensing requirements limited the utilization of telehealth across the NH/VT state border.

"I think if there's any good that's come out of all this, Telehealth, the genie is out of the bottle. And so, it will definitely be a part of the way care is delivered in the future. And, I think that's probably a good thing."
Health Care Leader, North Country

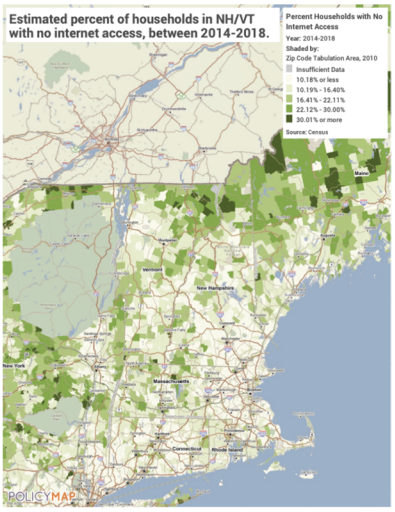
"...thinking about going forward, I think we're all kind of excited. I know my colleagues nationally, most of us share this sort of opening up of a future of medicine that allows us more flexibility in terms of meeting people's needs via teleconference or even telephone care and actually getting paid to do that. It would be nice. So we're hopeful that continues."
Primary Care Provider, Northeast Kingdom

"Many, many of us have the feeling that we're never going to provide care in exactly the same way again. That this has been something that has upended the paradigms of care so radically, so dramatically, and so quickly. And many of us in primary care, of course, have called for this kind of change long ago because we've been aware. And it's been the payment models, unfortunately that have predicated, you don't get paid unless you see people in person. So, as you probably know, everybody in the face of the pandemic emergency had to relax those rules. We're getting paid for those visits. It's pushed patients into recognizing, gee, there's a lot that can be done this way."
Primary Care Provider, Upper Valley

Relaxation of telehealth regulations, including the lifting of privacy restrictions and reimbursement for telehealth and telephone visits, enabled a vast expansion of telehealth across a broad spectrum of clinical and social services across the region. In the bi-state region, a temporary waiver on state licensing requirements also enabled the delivery of care by telehealth across the NH/VT border. Most healthcare organizations converted most of their in-person activities to telehealth within the span of a few days. Social service organizations also migrated large parts of their in-person operations to virtual platforms. Remote visits employed a range of technologies, from videoconferencing to telephone-based visits. One behavioral service center also reported using Facebook to deliver some of its services.

Opportunities and Limitations for Rural Health Equity

Health systems leaders and providers from New Hampshire and Vermont consistently described the expansion of telehealth within their systems as a promising tool for addressing long-standing rural health equity challenges. Many highlighted its effectiveness in increasing access for patients with transportation constraints, including elderly patients. Behavioral healthcare providers across the bi-state region consistently reported a precipitous drop in no-show rates. Telehealth may be a strategy to address the stigma of seeking care for mental health and substance use. Stigma is a significant barrier in rural areas as people worry about being seen at clinics in small towns in which "everyone knows everyone." Behavioral service providers further described it as an effective platform for delivering behavioral services for teens and adolescents. In addition, geriatric providers described it as an important tool in closing gaps in access to care at skilled nursing facilities that struggle to recruit providers.



Health systems leaders and providers also described areas of limitations and structural challenges related to telehealth. Participants found telehealth to be a less effective substitute for in-person care for some vulnerable populations, including persons in early stages of substance use recovery, patients with severe mental illness, patients requiring home health services, and socially vulnerable patients. Providers saw in-person visits as critical for establishing trusting relationships for patients in the early stages of recovery and noted that some telehealth platforms prompted paranoia in some patients with severe mental illness. Health centers also described challenges in converting wrap-around patient support/social work services for vulnerable populations to virtual platforms. Providers also encountered challenges related to privacy and confidential delivery of care remotely to patients in home environments with

> "Pretty universally though, the success of telehealth is rate limited by the patient or client's access to the infrastructure that allows them to engage in that mode. So, in pockets of Coös County, for example, where there is no broadband internet, that's a very real issue for patients."
> *Public health leader, North Country*

limited personal space. They believed that some patients were reluctant to have healthcare providers view their home and family environments. Others noted more limited success in utilizing telehealth in pediatric settings with young children.

One of the key barriers to the success of telehealth was limited access to digital infrastructure. Twenty-three percent of Vermonters lack access to broadband internet, and around half of addresses in the Northeast Kingdom do not have high-speed internet.[1] In some areas of the North Country of New Hampshire, close to twenty percent of the population lacks access to the internet (Figure 3[2]). Additionally, many rural households lack access to computers and digital technology. To address this, providers reported delivering some care using the telephone. Early in the pandemic, lower rates of reimbursement for telephone consultation represented a significant concern for providers in regions with low internet coverage. In addition, providers reported that older populations preferred telephone-based visits, particularly for behavioral health services.

Implications for Rural Healthcare Delivery

A key component of the successful migration to telehealth has been its integration into existing healthcare delivery systems. Primary care patients accessing telehealth were already medically homed and continuing care with a provider familiar with the clinical and social histories of patients and community resources. Few practices reported enrolling new patients via telehealth. Both providers and health systems leaders cautioned against viewing telehealth as a solution to the deficit in primary care providers. Many also reflected concern that an increase in standalone telehealth services delivered from outside the region might weaken the health system and compromise patient health.

Second, one of the central successes in the bi-state region, where many healthcare organizations serve patients from both states, was the ability to use telehealth across the NH/VT border enabled by the temporary waiver on licensing requirements. Ensuring continued ability to deliver telehealth across state lines to increase access to care represents a priority. In addition, access to telehealth may help to limit travel and contact with the health system for highly vulnerable patients reliant on distant academic medical centers as reopening occurs.

"I've had more than a few situations that I've heard about where people are getting better service because of tele-health. One gentleman ... car broke down, can't get anywhere. It's okay because he wants to be isolated with the COVID, anyway, right now. But I wouldn't have been able to meet with him. And other things, kids and childcare and money and gas money ... There are a lot of people who are able to participate more as a result of this."
Mental Health Leader, Upper Valley

"Interestingly, one of the clinics that we work with says that they've had a significantly reduced no show and cancellation rate in their primary care clinic and they think that it's because transportation is a non factor when you're conducting telehealth visits."
Public Health Leader, North Country

"Interestingly, one of the clinics that we work with says that they've had a significantly reduced no show and cancellation rate in their primary care clinic and they think that it's because transportation is a non-factor when you're conducting telehealth visits. So that's a piece of it. People who've been challenged by transportation are even more so now."
Social Service Leader, North Country

"The nursing homes for example, you can't get medical directors in rural nursing homes. You cannot get providers in rural nursing homes. But you know what, now that we can do this, or we can do the visits through telehealth and get reimbursed for them. So...the biggest barrier was that we could do these, but we couldn't get reimbursed. Now that you can make money doing this, we see there are some companies that literally have expanded overnight to be able to provide. Is this a great thing? All of a sudden now, rural nursing homes will actually get much better medical care than what they were getting."
Geriatric Leader, Upper Valley

[1] Sims, "Katherine Sims"; "Emergency Broadband Action Plan | Department of Public Service."
[2] PolicyMap, "Estimated Percent of Households with No Internet Access, between 2014-2018"; "U.S. Census Bureau QuickFacts: New Hampshire."

Key Policy Priorities for Telehealth

Achieving permanent reform to enable rural healthcare institutions to continue to use telehealth represents a key policy priority for the rural health system and community. Rural hospitals cited the following three key policy priorities for the bi-state region related to telehealth:

1. Parity in reimbursement for telehealth services
2. Inclusion of telephone-based services as a modality to ensure equity of access.
3. Ability to use telehealth across the Vermont-New Hampshire state line
4. Increasing access to broadband across both states

"For a couple of weeks, we were not getting paid for phone based care for Medicare which is a problem because here in Vermont and general rural America, we have a lot of old people and those are the people less likely to be comfortable using this format or others similar. So that was a real challenge."
Primary Care Provider, Northeast Kingdom

"[Telemedicine] is a huge bright spot. Yeah. I mean, even Medicare today I guess said that they would reimburse phone only, maybe starting in July with some special code that retroactive all the way to March 1st. ... That's huge because I mean, how many of our Medicare patients are comfortable using technology and getting a video connection. I mean, we're still doing those visits of course and we would have done them for free because, just yesterday I talked with a woman who's recently lost her husband, her daughter's on hospice. I mean, she's struggling and she needs to talk to her primary and she can't establish a visit over the video. She doesn't have that technology. She just has a phone. She doesn't want to come in. And I don't blame her. So, I needed to talk with her and any amount of time, whatever it took, but it would have been free versus being able to bill, whatever they'll let us bill for it."

Primary Care Provider, Northeast Kingdom

"I think that that's important that we continue to offer [phone]...We would still like to have that option because it's much more convenient for some people, especially if they have somebody sick in their home. And so, without this relaxation if we go back to the old way, that means if somebody's sick in the home they just don't get any services, and that's just not the way we want it to go."

Social Service Leader, Sullivan/Windsor Country

"One thing I wanted to add, too, about insurance coverage, I think we were talking about equity issues. And I think there are some class issues and equity issues that are involved here, which I'm sure you've already thought about. I was talking. [with a colleague] about how important I think it is to continue to have telephone services. And to not have telephone services is biased against who? It's biased against poor people who don't have equipment and don't have money to get equipment."

Mental Health Leader, Upper Valley

Tuesday, March 2, 2021

Representative Angie Craig
1523 Longworth House Office Building
Washington, D.C. 20515

Congresswoman Craig:

On behalf of the Medical Alley Association, we submit this statement for the record of the House of Representatives Committee on Energy and Commerce Subcommittee on Health hearing titled "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care."

As you know, this pandemic has profoundly changed many aspects of life for the foreseeable future, perhaps none more than the delivery of healthcare services. While telehealth has been touted as the future of healthcare for decades, the COVID-19 pandemic accelerated a telehealth revolution across our country in just a few months.[1] Before the pandemic, telehealth had high potential to transform care models, yet only 14% of Americans had participated in a telemedicine visit at least once.[2] But when the novel coronavirus came to the United States, federal policymakers eased regulations to encourage the use of telemedicine by patients in all locations, and the number of Americans who reported having participated in at least one telehealth visit increased by 57%.[2] By early April, just one month after the federal government and most states had declared a state of emergency, telemedicine accounted for 69% of health visits, and the home had become a hub of healthcare delivery.[3,4]

The swift transformation of healthcare through the expansion of telehealth and virtual care delivery enabled the critical continuity of care for patients across the country, and our members have played a critical role. With on-demand platforms and integrated solutions, they enabled an overburdened healthcare system to effectively respond to the extraordinary patient demand nationwide.

Telehealth played a critical role in the beginning of the response to the pandemic by helping reduce the spread of COVID-19 and lessen the strain on hospital systems by minimizing the surge of patient demand on facilities and equipment.[5] Nearly half of Americans have chronic conditions, and many needed non-virus-related care throughout the pandemic.[1] Telehealth helped patients with chronic illnesses or other non-virus-related problems to continue their care plans without increasing their risk of infection.[5]

Looking ahead, telehealth has the strong potential to provide value beyond the pandemic. In most cases, telehealth drives down the cost of care by decreasing hospital admissions, reducing opportunity

---

[1] Weeks Where Decades Happen: Telehealth 6 Months into COVID-19, https://www.healthcaredive.com/news/telehealth-6-months-coronavirus/581447/.
[2] 2020 State of Telemedicine Report, https://c8y.doxcdn.com/image/upload/v1599769894/Press%20Blog/Research%20Reports/2020-state-telemedicine-report.pdf.
[3] Telehealth Grew Wildly Popular Amid Covid-19. Now Visits are Plunging, Forcing Providers to Recalibrate, https://www.statnews.com/2020/09/01/telehealth-visits-decline-covid19-hospitals/.
[4] How the Pandemic is Accelerating the Hospital-at-Home Concept, https://liberatehealth.medecision.com/how-the-pandemic-is-accelerating-the-hospital-at-home-concept/.
[5] Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic, https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html.

costs, and improving management of chronic diseases.[6] Critically, telehealth also improves patient engagement and satisfaction, ultimately leading to better clinical outcomes, as telehealth is convenient and allows patients to receive care in the comfort of their own homes.[5,7,8,9] It offers a new means to locate health information, communicate with practitioners, and access follow-up care.[5]

Despite these positives, too many seniors, people of color, and low-income individuals have reduced access to the internet, less technological expertise, or face other language, cultural, or social barriers limiting their ability to access and use telehealth.[10] Health equity must be a focus of efforts to expand telehealth and a key consideration when performing outreach during and beyond the pandemic.[11]

Many federal telehealth policy changes are temporary, ending after relevant public health emergencies (PHEs) subside, prompting the question: What policy changes should be made permanent and what policy changes are still needed? Further, as a result of PHEs, the expanded use and awareness of how telehealth can be integrated into care delivery has provided an opportunity to update and modernize the law so it does not prevent patients from receiving care in the most efficient and effective manner possible.

Specifically, Medical Alley encourages Congress to consider the following policies:

1. Allow patients to access safe and effective care from the most convenient location for them that does not compromised the quality of care and ensures the safety of the patient.
2. Provide and protect the flexibility to use the most effective care delivery models available to manage and treat chronic or acute conditions to keep patients at home, resulting in lower costs through the avoidance of costly emergency room visits or hospital readmissions.
3. Prevent unnecessary utilization of telehealth in care delivery, while retaining flexibility for willing patients to conveniently, safely, and securely access care through all eligible synchronous and asynchronous telehealth modalities.
4. Ensure sustainable payment for delivery of telehealth services without restricting innovation in care delivery while accruing as many benefits as possible for the patient including lower costs, time saved, reduced work and transportation challenges, and improved outcomes.
5. Continue the increased adoption and use of telehealth to treat all conditions – when medically appropriate – safely and effectively by regularly evaluating and expanding provider types eligible to deliver care via synchronous and asynchronous telehealth modalities and enabling access to digital devices and technology, such as artificial intelligence (AI), virtual coaching, and other asynchronous telehealth delivery modalities.
6. Identify opportunities to use telehealth to better understand, track, and approach social detriments of health (SDOH) impacting patients and more effectively provide access to the care or other assistance necessary to help meet their needs.

---

[6] The Promise of Telehealth Beyond the Emergency, https://americansforprosperity.org/wp-content/uploads/2020/08/20_77978_Telehealth_v04.pdf.
[7] Substitutive Hospital at Home for Older Persons: Effects on Costs, https://medicallyhome.wpengine.com/wp-content/uploads/2018/12/Substitutive_Hospital_at_Home_for_Older_Persons-_Effects_on_Costs.pdf.
[8] Scalable Hospital at Home With Virtual Physician Visits: Pilot Study, https://medicallyhome.wpengine.com/wp-content/uploads/2018/12/Clinically_Home_Trial.pdf.
[9] Scalable Hospital at Home With Virtual Physician Visits: Pilot Study, https://medicallyhome.wpengine.com/wp-content/uploads/2018/12/Clinically_Home_Trial.pdf.
[10] The Digital Divide in Adoption and Use of Personal Health Record, Arch Intern Med. 2011; 171(6):568-574. doi:10.1001/archinternmed.2011.34
[11] How to Make Remote Monitoring Tech Part of Everyday Health Care, https://hbr.org/2020/07/how-to-make-remote-monitoring-tech-part-of-everyday-health-care.

As you and your colleagues consider the merits of permanent changes, the Medical Alley Association and our members are ready to provide insights, experiences and expertise to support advancing the transformational gains already made and continue to move telehealth and virtual care delivery forward to meet the needs and shifting expectations of patients.

Thank you for your consideration. If you have any questions, please contact me at bpatrick@medicalalley.org

Sincerely,

Bobby Patrick, VI
Vice President, Strategic Growth and Policy
The Medical Alley Association

200 First Street SW
Rochester, Minnesota 55905

March 2, 2021

The Honorable Anna Eshoo
Chairwoman
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515

Ranking Member Brett Guthrie
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of Mayo Clinic and the patients we serve, thank you for holding a hearing on March 11, 2021 on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care."

More than one million people from all 50 states and 135 countries come to Mayo Clinic to receive the highest quality care at sites in Minnesota, Arizona, Florida and Wisconsin. As part of the largest integrated, not-for-profit medical group practice in the world, Mayo Clinic is dedicated to finding answers for patients through medical care, research and education. With more than 70,000 employees, Mayo Clinic brings together teams of specialists with a persistent and unwavering commitment to excellence.

The COVID-19 pandemic has highlighted the importance of telehealth in delivering critical health care services to all populations, particularly to disadvantaged and vulnerable patients. In the face of state stay-at-home orders, telehealth has served to reduce health care disparities and to protect patients and doctors from spreading or contracting the disease. Mayo Clinic applauds the U.S. Department of Health and Human Services (HHS) and the United States Congress for acting quickly to provide greater flexibilities in the telehealth space, such as Health Insurance Portability and Accountability (HIPAA) and billing and reimbursements flexibilities, and Centers for Medicare and Medicaid Services (CMS) waivers. However, these flexibilities and waivers are temporary and will expire at the end of the COVD-19 public health emergency.

The emergence of COVID-19 accelerated the transformation of health care delivery across the Mayo Clinic enterprise in Minnesota, Florida, Arizona and Wisconsin. This dramatic transformation was the result of necessity as providers, at Mayo Clinic and beyond, raced to meet the immediate needs of the populations we serve – from the very rural to the most urban.

Efforts in the telehealth space have increased access to allow for care delivery in safe and local environments. Patients can conduct these visits from home without having to risk virus exposure by traveling. Recent data received from Mayo Clinic patient surveys also indicates that patients are equally satisfied with video visits as with in-person visits overall.

While many types of care are best provided in-person, Mayo Clinic has demonstrated the benefits of providing care virtually to some patients in appropriate situations over the past decade. Since the onset of the COVID-19 pandemic, Mayo Clinic has conducted more telehealth visits per day across all our sites than we completed in calendar year 2019. While the COVID-19 pandemic has presented many challenges, perhaps its greatest opportunity and legacy will be the transformation in the practice of health care delivery itself. Mayo Clinic Platform and the Center for Digital Health enabled the exponential growth of telemedicine and remote care, artificial intelligence and data analytics. Our teams provided essential remote care through 1.2 million telephone and video visits. We were able to monitor more than 9,200 COVID-19 patients through our remote monitoring complex care program, allowing patients with even moderate to severe symptoms to be cared for safely at home, while also increasing bandwidth in our hospitals for the sickest patients.

Patients receiving routine care have experienced real benefit from care appointments conducted virtually, including within their homes (or current location) and via telephone. For some patients with limited access to broadband or high-speed internet, audio-only appointment options still allow a patient to receive care without burden or increased risk of exposure by needing to travel. Of course, allowing patients to receive this care where they are has also been essential to minimizing exposure risk while still caring for patients and their ongoing health needs.

Even before the pandemic, Mayo Clinic's innovation allowed us to offer successful virtual care programs in fields where access issues impact outcomes, such as obstetrics and gynecology (OBGYN). In 2011, Mayo Clinic created "OB Nest," a new prenatal care program based on constant and direct support from a nursing team to meet the on-demand needs of expecting mothers through 24/7 support and at-home monitoring. The program was designed collaboratively with input from patients, OB/GYN staff (including midwives and physicians), and researchers.

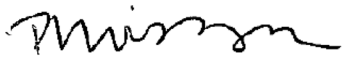
OB Nest focuses on the patient experience. It utilizes proactive patient check-ins and asynchronous connected care visits as well as secure online messaging. A randomized controlled trial regarding OB Nest in 2014-2015 shows that the program: significantly reduced prenatal care appointments, improved patient satisfaction with care, decreased pregnancy related stress and maintained the quality and safety of prenatal care. Given the program's success, Mayo Clinic has transitioned all low risk patients to the OB Nest model of care. The ability to use telehealth to provide care for expecting mothers is essential to improving access and equity. OB Nest also aims to de-medicalize the experience of pregnant women by providing a supporting and empowering experience that fits within a patient's daily life. Our patients are using self-monitoring tools via a text-based smartphone application to communicate with our care team and moderated online communities to connect with other pregnant women. For many women, this personal connection alleviates isolation, particularly in rural areas.

As you consider proposals to codify certain flexibilities and recognize care provided virtually as an appropriate delivery modality, please know that Mayo Clinic strongly believes that the leading care delivery models of the future will, as appropriate for the patient, incorporate virtual care as an essential component of achieving high-value care delivery with optimal outcomes. As such, the regulatory environment must also evolve to ensure that it supports innovative modes of care delivery that meet the patient in his or her home. This regulatory stability is necessary to support future delivery innovation as well, and Mayo Clinic continues to develop innovative models of care that build upon virtual care benefits. For example, last year Mayo Clinic launched its Advanced Care at Home model of care in June 2020 with pilot projects in the Jacksonville, Florida, and Eau Claire, Wisconsin, areas to offer acute care in a home environment, serving 226 patients who would otherwise have been hospitalized. Mayo Clinic is building upon that experience as an approved participant under the Acute Care at Home program announced by CMS in November.

In addition to the federal regulatory flexibilities granted by HHS, it is also critically important that the state regulatory environment address the evolving needs of the virtual care delivery to ensure that patients across the country can access specialized expertise from physicians at Mayo Clinic despite their location. Currently, one of the single most challenging barriers to offering Mayo Clinic's expertise to patients with serious and complex disease across the country is the lack of a coordinated licensure system for physicians who could treat patients in multiple states. As such, Mayo Clinic strongly supports provisions in the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act that temporarily waive licensing requirements through the end of the COVID-19 health pandemic.

Thank you again for holding this important hearing. Should you or your staff have any questions about Mayo Clinic's work in virtual care or would like more information, please contact Anne Rohall-Andrade, Director, Federal Policy and Engagement at Rohall-Andrade.Anne@mayo.edu.

Sincerely,



Piper Nieters Su, JD
Division Chair, External Relations
Mayo Clinic

Cc: Chairman Frank Pallone
Ranking Member McMorris Rodgers
The Honorable Angie Craig

March 1, 2021

The Honorable Anna Eshoo
Chairwoman
House Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
2322 Rayburn House Office Building
Washington, D.C. 20515

Re: MGMA Testimony – "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care" Hearing

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care" and we appreciate the opportunity to provide feedback on this topic. Throughout the COVID-19 pandemic, MGMA members have embraced the telehealth flexibilities to safely care for their patients. In late March 2020, 97% of MGMA members reported that their practices expanded telehealth access due to COVID-19.[1] MGMA supports congressional efforts to ensure that Medicare beneficiaries have greater access to telehealth services but would like any future legislation to take into account the importance of the patient-physician relationship.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations as the Subcommittee and lawmakers consider legislation to potentially extend telehealth flexibilities past the conclusion of the COVID-19 public health emergency (PHE).

Medicare telehealth policy recommendations for consideration:

I. Preserve the patient-physician relationship to promote high-quality care

MGMA supports the expansion of telehealth access, but believes it is critical to develop policies that would preserve and promote the patient-physician relationship. Policies should bolster care continuity within a medical practice setting and not encourage one-off fragmented care in the form of patients seeking services from outside vendors. Vulnerable Medicare patients must look to telehealth to support, not disrupt, the continuity of care they receive from their physicians.

[1] MGMA Stat, March 31, 2020

1717 Pennsylvania Ave. NW, #600 · Washington, DC 20006 · T 202.293.3450 · F 202.293.2787 · mgma.com

II. Remove geographic and originating site restrictions

To successfully expand telehealth services to Medicare beneficiaries, the geographic and originating site restrictions under current section 1834(m) should be permanently removed. Before the COVID-19 PHE, in 2016, only 0.25% of beneficiaries in fee-for-service Medicare utilized telehealth services.[2] After the telehealth waivers went into effect, from March 17, 2020 through June 13, 2020, over 9 million beneficiaries had received a telehealth service.[3] Without the removal of existing geographic and originating site restrictions, telehealth utilization will drop significantly to the detriment of millions of Medicare beneficiaries who would otherwise continue to benefit from the increased access to their physicians.

III. Allow permanent coverage of audio-only services

Audio-only visits can provide a lifeline to patients who are unable to attend visits in person or participate in telehealth visits due to lack of broadband access or necessary equipment to facilitate the live video component of the visits. Throughout the COVID-19 PHE, MGMA has received feedback from group practices on the incredible value of audio-only services. In an August 2020 poll conducted by MGMA, 82% of respondents reported that they have billed an audio-only service during the PHE.[4] MGMA members report that in some cases, these services are the only means of treating certain patients virtually. One MGMA member in Oregon reported that 80% of the practice's virtual visits were audio-only due to the majority of their population not having access to video capabilities. A 2019 Federal Communications Commission (FCC) report estimates that over 21 million individuals do not have access to broadband.[5] Further, researchers have estimated that 41% of Medicare patients lack access to a desktop or laptop computer with a high-speed internet connection at home.[6] The need for these services will not disappear upon the conclusion of the COVID-19 PHE, but the ability to deliver them to Medicare beneficiaries will without congressional action.

IV. Reimburse telehealth visits equally to in-person visits

Outside of the COVID-19 PHE, telehealth visits are reimbursed at the "facility rate" in Medicare, which represents a significant reduction in practice expense payments for overhead costs. However, MGMA has heard from member practices that the cost and administrative burden of providing care to patients is not significantly reduced when care is furnished via telehealth. Practices still must schedule visits, facilitate the visits, virtually check-in patients, document the visits, and schedule follow-up appointments. There is also the added expense of implementing a HIPAA-compliant IT infrastructure and troubleshooting technical issues. Practices have struggled to establish multiple workflows to accommodate both virtual and in-person visits. MGMA believes that for telehealth to be a viable option following the conclusion of the COVID-19 PHE, reimbursement should account for the many factors and costs that are involved in facilitating a telehealth visit.

Conclusion

We thank the Subcommittee for its leadership on this critical issue. We look forward to working with you and your congressional colleagues to craft sustainable telehealth policies that will allow medical group

[2] "Information on Medicare Telehealth," Centers for Medicare & Medicaid Services, Nov. 15, 2018
[3] "Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19," Seema Verma, Health Affairs, July 15, 2020
[4] MGMA poll, Physician Fee Schedule Q&A, Aug. 26, 2020
[5] FCC, "2019 Broadband Deployment Report," May 19, 2019.
[6] Eric T. Roberts, PhD1; Ateev Mehrotra, MD, MPH, "Access Among Medicare Beneficiaries and Implications for Telemedicine," JAMA Internal Medicine, Aug. 3, 2020.

practices to continue providing virtual care to vulnerable patient populations following the COVID-19 PHE. If you have any questions, please contact Claire Ernst at cernst@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs

MHLG | MENTAL HEALTH LIAISON GROUP
MENTAL HEALTH AND ADDICTION ADVOCATES ADVANCING POLICY, LEADING CHANGE

March 1, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2322 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Chairwoman
Committee on Energy and Commerce
Health Subcommittee
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Ranking Member
Committee on Energy and Commerce
Health Subcommittee
United States House of Representatives
2322 Rayburn House Office Building
Washington, DC 20515

RE: Comments for the Record - March 2nd, 2021 Hearing on The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care Recommendations for Tele-Behavioral Health Priorities

Dear Chairs Pallone and Eshoo and Ranking Members McMorris Rodgers and Guthrie;

On behalf of national organizations representing consumers, family members, mental health and addiction professionals, advocates, payers and other stakeholders, we thank you for your ongoing leadership to advance telehealth both during the COVID-19 Public Health Emergency (PHE) and beyond.

As you are well aware, the flexibilities granted by the §1135 emergency telehealth waivers have provided critical stability for healthcare professionals, patients and families across the nation during this challenging time. In particular, telehealth access for mental health and substance use disorder treatment services have served as a lifeline for many Americans struggling with isolation, grief, future uncertainty, and other new stressors this past year. On August 14, 2020, the Centers for Disease Control and Prevention (CDC) reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics.[1] Of grave concern, the report indicated that *over 1 in 4 young adults*

[1] https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932-H.pdf?deliveryName=USCDC_921-DM35222

had recently contemplated suicide. Additional research revealed that *over 40 states saw a rise in opioid-related overdose deaths* since the start of the pandemic.[2] Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020—signifying an almost 20% increase year over year, with no indication that this trend is reversing.

To that end, we applaud the Committee for holding this important hearing to shed light on the important role that telehealth has taken in the COVID-19 pandemic. With a surge in demand for behavioral health services that are only expected to increase, our nation needs to apply every tool at our disposal to ensure that Americans have access to the mental health and substance use services they need. As such, our respective organizations offer the following recommendations to the Energy & Commerce Committee and Health Subcommittee as members review next steps on telehealth.

I. Extend all telehealth flexibilities for mental health and substance use disorders at least one year beyond the end of the PHE to maintain access to care and better inform policymakers how to make permanent telehealth policies that increase equitable access to quality, evidence-based care

Telehealth helps to reduce the stigma around seeking mental health or substance use disorder treatment for those who want to seek care confidentially, and it makes access to services more available to those without childcare or transportation. Furthermore, audio-only telehealth, which has been a digital equalizer for those who lack access to broadband internet or video-enabled devices and for those who cannot utilize dual audio-video devices, is a critical flexibility. The ability to communicate between patients and behavioral health providers according to individuals' own needs is crucial to eliminating artificial barriers to care.

Extending these flexibilities for at least one year beyond the conclusion of the PHE will allow for additional time to evaluate questions associated with cost, utilization, efficacy, and compliance. This additional time could provide more baseline data to address concerns, such as those relative to Congressional Budget Office (CBO) scoring, by allowing real world data rather than non-dynamic projections to guide policy decision making. Historical advancements have been made in telehealth over the last year and consumer support for continuing these advancements remains strong, particularly for mental health and substance use disorder treatments. We therefore implore this Committee to take action – via seeking an extension of telehealth flexibilities at least one year beyond the PHE – to ensure that these immense gains in virtual care are not lost or discontinued abruptly.

[2] https://www.ama-assn.org/system/files/2020-11/issue-brief-increases-in-opioid-related-overdose.pdf

II. Allow telephonic (audio only) services for mental health and substance use disorder services after the PHE concludes.

In 2019, the Federal Communications Commission (FCC) reported that between 21.3 and 42 million Americans lacked access to broadband. Many older adults and people with disabilities lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have access to them. Likewise, many in racial/ethnic and low-income communities lack access to broadband or video-enabled devices.

Additionally, there is strong evidence to support the efficacy of telephonic behavioral health services. A review of 13 studies found reduced symptoms of anxiety and depression when therapy was conducted via telephone.[3] Patients have also benefited from receiving various interventions over the telephone, such as combined tele-pharmacotherapy and tele-cognitive-behavioral therapy (tele-CBT),[4] tele-CBT alone[5, 6, 7], receiving short-term tele-CBT in primary care settings,[8] and tele-bibliotherapy for older adults with anxiety.[9] Veterans with comorbid psychological distress and combat-related mild traumatic brain injury have also benefited significantly from receiving telephone-problem solving therapy (Tele-PST).[10] After receiving tele-PST, veterans reported improved quality of sleep and reduction of symptoms of depression and PTSD.

---

[3] Coughtrey, A. E., & Pistrang, N. (2018). The effectiveness of telephone-delivered psychological therapies for depression and anxiety: A systematic review. *Journal of Telemedicine and Telecare, 24*(2), 65–74. https://doi.org/10.1177/1357633X16686547

[4] Ludman, E. J., Simon, G. E., Tutty, S., & Von Korff, M. (2007). A randomized trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *Journal of Consulting and Clinical Psychology, 75*(2), 257-266. https://doi.org/10.1037/0022-006X.75.2.257

[5] Mohr, D. C., Hart, S. L., Julian, L., Catledge, C., Honos-Webb, L., Vella, L., Tasch, E. T. (2005). Telephone-administered psychotherapy for depression. *Archives of General Psychiatry, 62*, 1007-1014. https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1108409

[6] Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014). Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology, 82*(2), 349-354. https://psycnet.apa.org/fulltext/2014-02032-001.html

[7] Stiles-Shields, C., Corden, M. E., Kwasny, S., Schueller, M., & Mohr, D. C. (2015). Predictors of outcome for telephone and face-to-face administered cognitive behavioral therapy for depression. *Psychological Medicine, 45*(15), 3205-3215. https://doi.org/10.1017/S0033291715001208

[8] Watzke, B., Haller, E., Steinmann, M., Heddaeus, D., Härter, M., König, H.-H., Wegscheider, K., & Rosemann, T. (2017). Effectiveness and cost-effectiveness of telephone-based cognitive-behavioural therapy in primary care: study protocol of TIDe – telephone intervention for depression. *BMC Psychiatry, 17*(263). https://doi.org/10.1186/s12888-017-1429-5

[9] Brenes, G. A., McCall, W. V., Williamson, J. D., & Stanley, M. A. (2010). Feasibility and acceptability of bibliotherapy and telephone sessions for the treatment of late-life anxiety disorders. *Clinical Gerontologist, 33*(1), 62-68. https://doi.org/10.1080/07317110903344968

[10] Bell, K. R., Fann, J. R., Brockway, J. A., Cole, W. R., Bush, N. E., Dikmen, S., Hart, T., Lang, A. J., Grant, G., Gahm, G., Reger, M. A., De Lore, J. S., Machamer, J., Ernstrom, K., Raman, R., Jain, S., Stein, M. B., & Temkin, N. (2017). Telephone problem solving for service members with mild traumatic brain injury: a randomized, clinical trial. *Journal of Neurotrauma, 34*, 313-321. https://doi.org/10.1089/neu.2016.4444

Given the significant increase in demand for behavioral health services and the significant role of audio-only as a digital equalizer, we recommend continuing this flexibility for the provision of mental health and substance use disorder services for at least one year beyond the PHE. During this time, regulators may evaluate data to better understand which modalities may be considered for audio-only on a permanent basis.

III. Remove the in-person requirement for telemental health services

While we applaud inclusion of the telemental health services in the end-of-year COVID relief package, we urge this Committee to remove the in-person requirement it established. Imposing service restrictions on telehealth access through arbitrary in-person requirements undermines the flexibility and access afforded by telehealth and other virtual care modalities. Additionally, as many providers around the nation have created virtual front doors for their services, they have also started serving larger geographic areas. As such, this new requirement, which would go into place after the PHE concludes, would place an unnecessary burden on consumers and providers alike.

IV. Continue payment parity for telehealth services

As more providers transitioned to telehealth, payers are starting to evaluate cutting rates, often making the case that delivering care for telehealth is less expensive. This is simply not the case for behavioral health providers that provide both in-person and telehealth services. First, it assumes that behavioral health rates were already actuarially sound. However, because the Mental Health Parity & Addiction Equity Act has not been enforced since its inception over ten years ago, in many cases rates are already below the actuarial costs of delivering care and coverage of behavioral health services is limited.[11, 12] Second, proposing rate cuts for telehealth assumes that telehealth delivery for providers operating a hybrid (in-person and digital) service environment is less costly than the delivery of in-person care. However, this is also inaccurate as many providers continue to maintain much of their brick and mortar overhead while also seeking to invest in telehealth platforms, hire more tech support staff, and make overall and continuing IT investments. These additional costs do not have a reimbursement mechanism and overlay current operating costs. As such, we recommend that telehealth - for mental health and substance use disorder services - continue to be reimbursed on par with in-person services.

In conclusion, even with today's telehealth emergency waivers, providers around the nation are struggling to meet the growing need for services at a time when many payers

[11] https://www.naatp.org/sites/naatp.org/files/MillimanReport11-20-19.pdf
[12] https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/

are already beginning to decrease rates for telehealth encounters. These combined effects – limited workforce, rate cuts, and an already underfunded system coupled with predictions that demand for behavioral health services will only increase – signals the clear need for urgent and immediate action. Through passing legislation that extends the telebehavioral health flexibilities, including audio-only services, beyond the PHE, removes the in-person requirement for telemental health services, and secures telebehavioral health parity – we can provide additional tools to increase access, break down stigma, and advance health equity.

We thank the Committee for its ongoing attention to telehealth and the critical role that telehealth access can play for our nation both during and, importantly, beyond the PHE. Should you have any questions, or we can be of further assistance, please reach out to Laurel Stine (lstine@apa.org), Lauren Conaboy (Lauren.conaboy@centerstone.org), and Elizabeth Cullen (elizabeth.cullen@jewishfederations.org).

Sincerely;
American Art Therapy Association
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychoanalysis in Clinical Social Work
American Association of Child and Adolescent Psychiatry
American Association of Suicidology
American Association on Health and Disability
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Psychiatric Association
American Psychological Association
Anxiety and Depression Association of America
Association for Ambulatory Behavioral Healthcare
Centerstone
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
College of Psychiatric and Neurologic Pharmacists (CPNP)
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
Education Development Center
Global Alliance for Behavioral Health and Social Justice
The Jed Foundation
The Jewish Federations of North America

International OCD Foundation
International Society for Psychiatric-Mental Health Nurses
Mental Health America
NAADAC, The Association for Addiction Professionals
National Association of County Behavioral Health & Developmental Disability Directors
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Behavioral Health
National Federation of Families for Children's Mental Health
National Register of Health Service Psychologists
Postpartum Support International
Psychotherapy Action Network (PsiAN)
REDC Consortium
RI International, Inc.
Schizophrenia and Related Disorders Alliance of America
SMART Recovery
The American Counseling Association
The Kennedy Forum
The Michael J. Fox Foundation for Parkinson's Research
The National Alliance to Advance Adolescent Health
The Trevor Project
Well Being Trust

Check for updates

Received: 18 May 2020 | Accepted: 21 May 2020
DOI: 10.1002/mus.26989

ISSUES & OPINIONS

MUSCLE&NERVE WILEY

Amyotrophic lateral sclerosis care and research in the United States during the COVID-19 pandemic: Challenges and opportunities

Jinsy A. Andrews MD[1] | James D. Berry MD[2] | Robert H. Baloh MD, PhD[3] | Nathan Carberry MD[1] | Merit E. Cudkowicz MD[2] | Brixhilda Dedi MD[1] | Jonathan Glass MD[4] | Nicholas J. Maragakis MD[5] | Timothy M. Miller MD, PhD[6] | Sabrina Paganoni MD, PhD[2] | Jeffrey D. Rothstein MD, PhD[5] | Jeremy M. Shefner MD, PhD[7] | Zachary Simmons MD[8] | Michael D. Weiss MD[9] | Richard S. Bedlack MD, PhD[10]

[1]The Neurological Institute, Columbia University, New York, New York
[2]Healey Center for ALS, Department of Neurology, Massachusetts General Hospital, Boston, Massachusetts
[3]Department of Neurology, Cedars-Sinai Medical Center, Los Angeles, California
[4]Department of Neurology, Emory University School of Medicine, Atlanta, Georgia
[5]Department of Neurology, The Johns Hopkins University School of Medicine, Baltimore, Maryland
[6]Department of Neurology, Washington University School of Medicine, St Louis, Missouri
[7]Barrow Neurological Institute, Phoenix, Arizona
[8]Neurology, Penn State Health Milton S Hershey Medical Center, Hershey, Pennsylvania
[9]Department of Neurology, University of Washington, Seattle, Washington
[10]Department of Neurology, Duke University, Durham, North Carolina

Correspondence
Richard Bedlack XX, Duke ALS Clinic, 932 Morreene Road, Box 3333, Durham, NC 27705.
Email: richard.bedlack@duke.edu

Abstract

Coronavirus disease 2019 has created unprecedented challenges for amyotrophic lateral sclerosis (ALS) clinical care and research in the United States. Traditional evaluations for making an ALS diagnosis, measuring progression, and planning interventions rely on in-person visits that may now be unsafe or impossible. Evidence- and experience-based treatment options, such as multidisciplinary team care, feeding tubes, wheelchairs, home health, and hospice, have become more difficult to obtain and in some places are unavailable. In addition, the pandemic has impacted ALS clinical trials by impairing the ability to obtain measurements for trial eligibility, to monitor safety and efficacy outcomes, and to dispense study drug, as these also often rely on in-person visits. We review opportunities for overcoming some of these challenges through telemedicine and novel measurements. These can reoptimize ALS care and research in the current setting and during future events that may limit travel and face-to-face interactions.

KEYWORDS

amyotrophic lateral sclerosis, clinical care, clinical trials, COVID-19, pandemic

1 | INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic has created unprecedented challenges for neuromuscular clinicians and researchers working across several different diseases.[1–5] The specific

Abbreviations: ALS, amyotrophic lateral sclerosis; ALSFRS-R, Amyotrophic Lateral Sclerosis Functional Rating Scale—Revised; COVID-19, coronavirus disease 2019; FDA, US Food and Drug Administration; NEALS, Northeast Amyotrophic Lateral Sclerosis Consortium.

©2020 Wiley Periodicals, Inc.

impact on amyotrophic lateral sclerosis (ALS) care and research is illustrated in a recent survey of members of the Northeast ALS (NEALS) Consortium, a network of ALS clinical centers. Most of the 133 sites surveyed between April 21, 2020 and May 1, 2020 are affiliated with academic medical centers in the United States, have multidisciplinary care teams, see large numbers of patients, and participate in a variety of ALS research studies, including clinical trials.[6] The survey itself is included in Figure S1 (see Supplementary Material online). Results from the 61 sites that responded are shown in Tables 1, 2, and 3.

2 | IMPACT OF COVID-19 ON ALS CLINICAL CARE AND RESEARCH

The first two survey questions asked about available options for the clinical evaluation of new and return patients (Table 1). One third of responding centers were no longer able to see new patients in-person. More than half of the responders were able to see new patients from their same state by video visit. Smaller numbers were able to offer video visits outside their state. Only 3% of responders were unable to see any new patients. With regard to follow-up patients, again a large number of responders (47%) were unable to see these in-person. Most could offer video visits to return patients in their same state, with smaller numbers being able see patients from other states. All responders were able to see follow-up patients in some manner.

Question 3 asked about evidence- and experience-based ALS measurements and treatments that may be challenging to obtain during the pandemic (Table 2). Spirometry was unavailable at most sites. Many sites reported difficulty getting feeding tubes, multidisciplinary team care, wheelchairs, home health/hospice, lifts, or hospital beds. Only 16% of responders reported being able to get everything they could for their patients before the pandemic.

Question 4 asked about available options for research participants (Table 3). Very few responding centers were able to enroll new participants into studies, either in-person or by phone or video. Most were unable to see participants for return in-person visits. About half the responders were able to see return participants virtually, even those residing in states beyond where the clinic was located. Twenty percent of responders were unable to see any research participants by any means during the pandemic.

TABLE 1 Options for evaluation of new and return clinic patients at NEALS sites

	New patients: number offering (%)	Return patients: number offering (%)
In-person	41 (67%)	32 (53%)
Video (in any state)	18 (29%)	24 (56%)
Video (in some but not all states)	14 (23%)	19 (31%)
Video (in my state)	38 (62%)	42 (69%)
Phone	25 (41%)	52 (87%)
Not able to offer	2 (3%)	0 (0%)

Abbreviation: NEALS, Northeast Amyotrophic Lateral Sclerosis.

3 | CHALLENGES TO ALS CLINICAL CARE AND RESEARCH

Our survey results confirm that COVID-19 has created specific challenges to ALS care and research in the United States. The first of these is making/confirming new ALS diagnoses. It is not clear how this may occur at sites that are now unable to offer in-person visits. Current ALS diagnostic criteria require a physical examination showing widespread upper and lower motor neuron signs.[7,8] Although some aspects of a neurological examination can now be performed virtually, including measures of muscle bulk and power, assessment of muscle tone and tendon reflexes still cannot.[9] This is likely to aggravate the already significant problem of diagnostic delay in ALS.[10] Unfortunately, there may be no immediate way around it because previous work has shown that preliminary ALS diagnoses by nonexperts are inaccurate about 5% of the time.[11] Even if a clinician could be certain of the findings documented by another provider, he or she may not feel comfortable breaking the news of an ALS diagnosis virtually. This idea is supported by a survey of clinicians

TABLE 2 Limitations on evidence- and experience-based ALS care options at NEALS sites

Option	Sites reporting difficulty (%)
Spirometry	42 (69%)
Feeding tubes	21 (34%)
Multiciplinary team care	20 (33%)
Wheelchairs	14 (23%)
Home health/hospice	11 (18%)
Ventilators	6 (10%)
Lifts	6 (10%)
Hospital beds	1 (2%)
None (can get everything I need)	10 (16%)

Abbreviations: ALS, amyotrophic laterial sclerosis; NEALS, Northeast Amyotrophic Lateral Sclerosis.

TABLE 3 Options for research patients at NEALS sites

	Number offering (%)
New enrollments in person	12 (20%)
New enrollments by phone or video	15(25%)
Follow-ups in person	24 (39%)
Follow-ups by phone or video (in any state)	31 (51%)
Follow-ups by phone or video (in some but not all states)	11 (18%)
Follow-ups by phone or video (in my state)	28 (46%)
Unable to see any research patients	13 (21%)

Abbreviation: NEALS, Northeast Amyotrophic Lateral Sclerosis.

showing they felt that telemedicine visits lacked the emotional connection associated with in-person visits.[12]

The second challenge relates to monitoring disease progression for clinical care and in trials. The most commonly used measure of ALS progression in clinics and in trials, the Amyotrophic Lateral Sclerosis Functional Rating Scale—Revised (ALSFRS-R), can be obtained reliably and easily over the phone or by telemedicine.[13] Unfortunately, another important measure, spirometry, has recently been unavailable at almost 70% of NEALS sites. Even when patients can be seen in-person, use of spirometry has been cautioned by experts because it can stimulate a cough, which can aerosolize COVID-19 droplets and thus create an increased risk of spread.[14] Spirometry is one of the main ways ALS clinicians determine prognoses, and make decisions about when to offer various evidence-based ALS care options, including noninvasive ventilation, invasive ventilation, feeding tubes, and hospice.[15,16] It is also a key inclusion criterion for most ALS trials. With the restrictions placed on in-person visits at some sites, it is also not clear how key parts of safety monitoring in research participants such as blood draws and electrocardiograms can be performed.

A third challenge is the sudden unavailability of many key ALS treatment options. Multidisciplinary team care, which is associated with improved quality and length of life in people with ALS,[17] is currently unavailable at one third of NEALS sites. Placement of feeding tubes, which are important for maintaining weight and improving survival in ALS patients[18]; wheelchairs, which keep patients active and prevent falls; home health and hospice, which provide education as well as support and palliative care, are also all currently unavailable at some NEALS some sites. These restrictions can also affect research studies. It has largely been assumed that baseline ALS care being provided at different sites of a multicenter trial is similar; this assumption is currently incorrect.

TABLE 4 COVID-19 challenges and opportunities in ALS care and research

Challenges	Opportunities
Inability to offer face-to-face clinic and research visits	• Capitalize on the large growth in telemedicine availability, at least for follow-up clinic patients and research patients
Inability to perform spirometry, including vital capacity which is used as an inclusion criteria in trials, and to plan timing of several care options (eg, NIV initiation)	• Use home-based spirometry • Develop alternative measures that correlate well with spirometry but are simpler and carry no increases risk of infection (eg, counting out loud, vocalizing a sound)
Limited availability of several evidence- and experience-based ALS care options	• Capitalize on previous work showing that multidisciplinary ALS care is possible via telemedicine • Account for variability in care options across different trial sites

Abbreviations: ALS, amyotrophic laterial sclerosis; COVID-19, coronavirus 2019; NIV, noninvasive ventilation.

4 | OPPORTUNITIES FOR ALS CLINICAL CARE AND RESEARCH

The rapid expansion of telemedicine represents an exciting opportunity to improve clinical care and expand access to research opportunities for many patients (Table 4). At the beginning of 2020, a small but growing number of ALS centers were offering telemedicine visits to patients in their homes.[12,19–21] Because no billing codes existed for this, it was supported by philanthropy, ALS nonprofits, or local institutions. Many states had laws restricting telemedicine visits to clinicians licensed in that state.[22] The current pandemic has catalyzed the creation of new billing codes for telemedicine in the home,[23,24] and many states have recently suspended their telemedicine licensure requirements.[25] As evidenced by the NEALS survey, within a matter of weeks of the COVID-19 pandemic in the United States, more ALS centers were offering telemedicine for established patients than were offering traditional in-clinic visits. In medicine, where change is usually slow, the rapid acceptance and delivery of telemedicine is unprecedented. Although some patients still do not have internet access at home, that number is dwindling.[26] In addition, hospital systems have invested in telemedicine teams to handle the massive increase in internet traffic to and from their institutions. Even as the COVID-19 pandemic resolves, partnering with patient advocacy groups will help ensure that telemedicine remains an effective tool to allow clinicians more effective care for patients for whom travel to the clinic is burdensome, fatiguing, or otherwise impractical.

We should also expand upon this new telemedicine infrastructure. First, we should increase the number of sites that can use it to provide multidisciplinary team care. Such care is known to improve quality of life[27] and survival[28] for people with ALS. During an in-person visit, the multidisciplinary providers generally see patients in succession while the patient remains in a single room for a multi-hour visit. Although this approach is still tenable for some teams using telemedicine,[12] other approaches can also be successful. These can include hybrid models in which some clinicians see patients face-to-face and others see them virtually,[29] models where the physician visit is scheduled and follow-up visits with the multidisciplinary team occur ad hoc over time,[19] and asynchronous visits using recorded video for patients without access to internet.[17] In the Veterans Affairs hospital system, one analysis demonstrated that quality of ALS care was independent of its delivery by telemedicine or in clinic.[20]

Some measurements or evaluations will need to be altered to be administered via telemedicine. Although spirometry is generally considered a clinic-based assessment, it can also be done using a home spirometer and having a trained clinic staff monitor the patient as he/she performs the spirometry.[30] Some home spirometers are approved by the US Food and Drug Administration (FDA) and web-connected, transmitting data directly to a central database. Ultimately, these devices could transmit data directly into the electronic medical record. Preliminary studies in the national Answer ALS program suggest app-based vital capacity can be monitored (unpublished observations).

Surrogates for spirometry could also be explored for ALS patients. These may include single-breath counting or vocalizing a sound; these have proven to correlate with spirometry in other study populations.[31]

When it comes to using telemedicine for research, remote or virtual consent platforms already exist. In fact, the FDA published a final guidance in December 2016 for institutional review boards, investigators, and sponsors.[32] This can ease the hurdle of recruiting and enrolling people living with ALS into clinical trials. Another aspect of clinical trial design that can be improved is the frequency of in-person visits. It may be possible to conduct remote or virtual visits, conducting home safety measures by sending a service to the home to collect labs or electrocardiograms. Novel research outcomes are emerging that can be obtained virtually. Digital voice recordings and quantitative speech analysis can be evaluated through recordings from cellphone apps to monitor disease progression.[33] Medical surveys can be delivered to people with ALS, and quantitative data about movement can be collected. As algorithms for processing data mature, passive cell phone data could be used to inform providers about patient well-being.[34,35] Wearables may paint an even more detailed picture of patient function and behavior, although with the cost of requiring the patient to wear an additional device.[35]

5 | DISCUSSION

The COVID-19 pandemic has created an unprecedented challenges to ALS clinical care and research. The traditional face-to-face paradigm of medical decisionmaking and trial conduct have become difficult or impossible for many sites. An unexpected silver lining to these challenges is the development and maturation of a telemedicine infrastructure, providing clinicians and researchers with opportunities to fortify and even improve the way we approach ALS care and research. Our combined experiences of clinician-patient interactions during this pandemic will provide us with new paradigms that will likely improve the efficiency of clinical care and availability of research participation.

CONFLICT OF INTEREST

J.A. has consulted for Avexis, AL-S Pharma, Biogen, and Cytokinetics, and has received research grants from Neuraltus, Roche, Biogen, and Novartis. J.B. has consulted for Biogen, Clene Nanomedicine, and Alexion, and has received research support from Alexion, Biogen, MT Pharma of America, Amylyx Therapeutics, Anelixis Therapeutics, Brainstorm Cell Therapeutics, Genentech, nQ Medical, the National Instutes for Health/National Institute of Neurological Disorder and Stroke (NINDS/NIH), the Muscular Dystrophy Association (MDA), and ALS One. R.B. has consulted for Modulus Pharmaceuticals, Mitochondria in Motion, Acurastem, Sarepta, and Kite Pharma, and has received research grants from the NINDS/NIH, California Institute for Regenerative Medicine, Target ALS, Burroughs Wellcome Fund, the MDA, and the Charcot–Marie-Tooth Association. M.C. has consulted for Biogen, Cytokinetics, Sunovian, AL-S Pharma, Avexis, and Takeda. J.G. has research support from the NIH, ALSA, and the MDA, and clinical trial funding from Biogen, Genentech, Amylyx, Cytokinetics, and the Healy Center at Massacusetts General Hospital. N.M. has consulted for Orion, Apellis, Brainstorm Cell Therapeutics, and Clene Nanomedicine, and has received research support from the Department of Defense ALSRP, Answer ALS, the ALS Association, the NIH/NINDS, Biogen, and Clene. T.M.M. has licensing agreements with C2N and Ionis Pharmaceuticals, has served on advisory boards for and receives material support from Biogen and Ionis Pharmaceuticals, and is a consultant for Cytokinetics and Disarm Therapeutics. S.P. reports personal consulting fees for advisory panels from Orion Corp and reports research grant suppport from Amylyx Therapeutics, Revalesio Corporation, Ra Pharma, Biohaven, Clene, Prilenia, the ALS Association, the American Academy of Neurology, ALS Finding a Cure, the Salah Foundation, and the Spastic Paraplegia Foundation. J.R. has consulted for Expansion therapeutics and received research grants from the NIH/NINDS, the NIH/National Institute on Aging, the Department of Defense, the Chan Zuckerberg Initiative, the ALS Association, the MDA, Target ALS, F Prime, Travelers Insurance, American Airlines, ALS Finding a Cure, Answer ALS, Team Gleason, and Microsoft. Z.S. has consulted for Amylyx, Biogen, Biohaven, and Cytokinetics, and has received research support from Biogen, Biohaven, and Cytokinetics. M.W. has consulted for Biogen, Ra Pharma, and Argenx; is a speaker for Nufactor; and has received research support from ALSA and ALS Finding a Cure. R.B. has research support from ALSA and Orion, and consulting support from Amylyx, Alexion, ALSA, Biogen, Brainstorm Cell, ITF Pharma, Mallinkrodt, New Biotic, and Woolsey Pharma. N.C., B.D., and J.S. declare no potential conflicts of interest.

ETHICAL PUBLICATION STATEMENT

We confirm that we have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

REFERENCES

ORCID

Zachary Simmons https://orcid.org/0000-0001-8574-5332

REFERENCE

1. International MG/COVID-19 Working Group. Guidance for the management of myasthenia gravis (MG) and Lambert-Eaton myasthenic syndrome (LEMS) during the COVID-19 pandemic. *J Neurol Sci*. 2020; 412:116803 https://doi.org/10.1016/j.jns.2020.116803 Epub 2020 Mar 25.
2. Kassardjian CD, Desai U, Narayanaswami P. AANEM Quality and Safety Committee of the AANEM. Practical guidance for managing EMG requests and testing during the COVID-19 pandemic. *Muscle Nerve*. 2020; https://doi.org/10.1002/mus.26891.
3. Rajabally YA, Goedee HS, Attarian S, Hartung HP. Management challenges for chronic dysimmune neuropathies during the COVID-19 pandemic. *Muscle Nerve*. 2020; https://doi.org/10.1002/mus.26896.
4. Veerapandiyan A, Wagner KR, Apkon S, et al. The care of patients with Duchenne, Becker and other muscular dystrophies in the COVID-19 pandemic. *Muscle Nerve*. 2020; https://doi.org/10.1002/mus.26902.

5. Veerapandiyan A, Connolly AM, Finkel RS, et al. Spinal muscular atrophy care in the COVID-19 pandemic era. *Muscle Nerve*. 2020; https://doi.org/10.1002/mus.26903.
6. Northeastern ALS Consortium. *NEALS member sites*. https://www.neals.org/about-us/neals-member-sites. Accessed May 5, 2020.
7. Brooks BR, Miller RG, Swash M, Munsat TL. El Escorial revisited: revised criteria for the diagnosis of amyotrophic lateral sclerosis. *Amyotroph Lateral Scler Other Motor Neuron Disord*. 2000;1:293-299.
8. de Carvalho M, Dengler R, Eisen A, et al. Electrodiagnostic criteria for diagnosis of ALS. *Clin Neurophysiol*. 2008;119:497-503.
9. American Academy of Neurology. Telemedicine and COVID-19. https://www.aan.com/siteassets/home-page/tools-and-resources/practicing-neurologist–administrators/telemedicine-and-remote-care/20200326-telemedicine-and-covid-19-final.pdf. Accessed May 5, 2020.
10. Palese F, Sartori A, Logroscino G, Pisa FE. Predictors of diagnostic delay in amyotrophic lateral sclerosis: a cohort study based on administrative and electronic medical records data. *Amyotroph Lateral Scler Frontotemporal Degener*. 2019;20:176-185.
11. Pupillo E, Bianchi E, Poloni M, Beghi E, SLALOM Group. Is firstly diagnosed ALS really ALS? Results of a population-based study with long-term follow-up. *Amyotroph Lateral Scler Frontotemporal Degener*. 2017;18:221-226.
12. Geronimo A, Wright C, Morris A, Walsh S, Snyder B, Simmons Z. Incorporation of telehealth into a multi-disciplinary ALS clinic: feasibility and acceptability. *Amyotroph Lateral Scler Frontotemporal Degener*. 2017;18:555-561.
13. Kaufmann P, Levy G, Montes J, et al. Excellent inter-rater, intra-rater, and telephone administered reliability of the ALSFRS-R in a multicenter trial. *Amyotroph Lateral Scler*. 2007;8:42-46.
14. American Thoracic Society. Pulmonary function laboratories: advice regarding COVID-19. https://www.thoracic.org/professionals/clinical-resources/disease-related-resources/pulmonary-function-laboratories.php. Accessed May 5, 2020.
15. Andrews JA, Meng L, Kulke SF, et al. Association between decline in slow vital capacity and respiratory insufficiency, use of assisted ventilation, tracheostomy, or death in patients with amyotrophic lateral sclerosis. *JAMA Neurol*. 2018;75:58-64.
16. Miller RG, Jackson CE, Kasarkis EJ, et al. Practice parameter update: the care of the patient with amyotrophic lateral sclerosis: drug, nutritional, and respiratory therapies (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology*. 2009;73:1218-1226.
17. Rooney J, Byrne S, Heverin M, et al. A multidisciplinary clinic approach improves survival in ALS: a comparative study of ALS in Ireland and Northern Ireland. *J Neurol Neurosurg Psychiatry*. 2015;86:496-501.
18. Cui F, Sun L, Xiong J, Li J, Zhao Y, Huang X. Therapeutic effects of percutaneous endoscopic gastrostomy on survival in patients with amyotrophic lateral sclerosis: A meta-analysis. *PLoS One*. 2018;13:e0192243.
19. Pulley MT, Brittain R, Hodges W, et al. Multidisciplinary amyotrophic lateral sclerosis telemedicine care: the store and forward method. *Muscle Nerve*. 2019;59:34-39.
20. Selkirk SM, Washington MO, McClellan F, Flynn B, Seton JM, Strozewski R. Delivering tertiary centre specialty care to ALS patients via telemedicine: a retrospective cohort analysis. *Amyotroph Lateral Scler Frontotemporal Degener*. 2017;18:324-332.
21. van de Rijn M, Paganoni S, Levine-Weinberg M, et al. Experience with telemedicine in a multi-disciplinary ALS clinic. *Amyotroph Lateral Scler Frontotemporal Degener*. 2018;19:143-148.
22. Kwong M, Gutierrez M, Marcin J. Interstate licensure for telemedicine: the time has come. *Virtual Mentor*. 2014;16:1010-1013.
23. Center for Medicare Services. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. Accessed May 11, 2020.
24. Bloom B, Dorsey E, Okun M. The coronavirus disease 2019 crisis as a catalyst for telemedicine for chronic neurological disorders. *JAMA Neurol*. 2020; https://doi.org/10.1001/jamaneurol.2020.1452.
25. Federation of State Medical Boards. https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf. Accessed May 11, 2020.
26. Ryan C. Computer and Internet Use in the United States: 2016. American Community Survey Reports. US Census Bureau. ACS-39. August 2018. https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-39.pdf
27. Van den Berg L, Kalmihn S, Lindeman E, et al. Multidisciplinary ALS care improves quality of life in patient with ALS. *Neurology*. 2005;65:1264-1267.
28. Traynor BJ, Alexander M, Corr B, Frost E, Hardiman O. Effect of a multidisciplinary amyotrophic lateral sclerosis (ALS) clinic on ALS survival: a population based study, 1996-2000. *J Neurol Neurosurg Psychiatry*. 2003;74:1258-1261.
29. Haulman A, Geronimo A, Chahwala A, Simmons Z. The use of telehealth to enhance care in ALS and other neuromuscular disorders. *Muscle Nerve*. (to be published). 2020;61:682-691.
30. Geronimo A, Simmons Z. Evaluation of remote pulmonary function testing in motor neuron disease. *Amyotroph Lateral Scler Frontotemporal Degener*. 2019;20:348-355.
31. Ali S, O-Connell C, Kass L, Graff G. Single-breath counting: a pilot technique for measuring pulmonary functions in children. *Am J Emerg Med*. 2011;29:33-36.
32. US Food and Drug Administration. Use of electronic informed consent: questions and answers, guidance for institutional review boards, investigators and sponsors. December 2016. https://www.fda.gov/media/116850/download. Accessed May 5, 2020.
33. Panda N, Solsky I, Huang EJ, et al. Using smartphones to capture novel recovery metrics after cancer surgery. *JAMA Surg*. 2019;155:1-7. https://doi.org/10.1001/jamasurg.2019.4702.
34. Cote DJ, Barnett I, Onnela JP, Smith TR. Digital phenotyping in patients with spine sisease: A novel approach to quantifying mobility and quality of life. *World Neurosurg*. 2019;126:e241-e249.
35. Garcia-Gancedo L, Kelly ML, Lavrov A, et al. Objectively monitoring amyotrophic lateral sclerosis patient symptoms during clinical trials with sensors: observational study. *JMIR Mhealth Uhealth*. 2019;7:e13433. https://doi.org/10.2196/13433.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

How to cite this article: Andrews JA, Berry JD, Baloh RH, et al. Amyotrophic lateral sclerosis care and research in the United States during the COVID-19 pandemic: Challenges and opportunities. *Muscle & Nerve*. 2020;62:182–186. https://doi.org/10.1002/mus.26989

Statement for the
U.S. House Committee on Energy & Commerce, Health Subcommittee
Hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Thank you for holding this hearing to discuss the important role telehealth is playing during the COVID-19 pandemic and for allowing the National Safety Council (NSC) to submit these comments for the record.

NSC is America's leading nonprofit safety advocate and has been for over 100 years. As a mission-based organization, we work to eliminate the leading causes of preventable death and injury, focusing our efforts on the workplace, roadway and impairment. We create a culture of safety to keep people safer at work and beyond the workplace so they can live their fullest lives. Our more than 15,000 member companies, including federal agencies, represent 7 million employees at nearly 50,000 U.S. worksites.

The COVID-19 pandemic has taken a serious toll on the mental health of Americans, with 40% of U.S. adults reporting that they struggled with mental health or substance use in June 2020.[1] Studies show that from February to December 2020, the risk of having a general anxiety disorder increased by 80%. The risk of having depressive disorder has increased by 145%,[2] with women showing the largest increases in stress and anxiety. A snapshot of stress levels in January 2021 revealed that 84% of Americans are experiencing negative emotional states, including feeling sad, angry, scared and unsafe.[3]

Additionally, recently released data show the 2018 dip in both general and opioid-related overdose fatalities was reversed in 2019, with preliminary statistics indicating the number of opioid overdose fatalities surpassed 50,000 in 2019.[4] The U.S. reached a tragic new high in the 12-month period ending in June 2020, with over 83,000 opioid overdose fatalities reported.[5] Lastly, over 40 states are reporting an increase in opioid overdose fatalities since the beginning of the pandemic.[6]

Treatment for mental health and substance use disorders (SUD) is effective, but access to treatment, which was a significant barrier before COVID, has been strained further since the pandemic. Over 50% of adults with a mental illness go untreated and over 20% of adults with a mental illness reported not receiving the treatment they needed.[7] Additionally, only 10.3% of people with an SUD in 2019 received any treatment, and only 18% of people with an opioid use

[1] Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.
[2] https://connect.nationalalliancehealth.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=1b159a27-931e-6069-03b2-30e0ce570e32&forceDialog=0
[3] https://www.apa.org/news/press/releases/stress/2021/stress-snapshot-january.pdf
[4] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[5] https://emergency.cdc.gov/han/2020/han00438.asp
[6] https://www.ama-assn.org/system/files/2020-09/issue-brief-increases-in-opioid-related-overdose.pdf
[7] https://www.mhanational.org/issues/mental-health-america-access-care-data#adults_ami_no_treatmentt

disorder (OUD) received medications for addiction treatment.[8] The increase in telehealth services, along with other actions taken by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA),[9] helped address some, but not all, of these disruptions.

Given the increased need and decreased access to services across all medical fields, the telehealth service mechanism required additional support in 2020. Telehealth is an underutilized tool that is essential for reaching hard-to-reach populations, including rural and underserved communities. It can break down barriers to providing behavioral health services and care, and increase access and availability. In some cases, telehealth can allow for greater privacy, anonymity and avoidance of the stigma that can be attached to being a behavioral health patient.

Additionally, telehealth can improve care outside of traditional care sites such as doctors' offices and community health centers. This is particularly important for rural areas and people who are isolating (including those who are quarantining, abiding by stay-at-home orders, and those not comfortable with in-person visits, etc.) during the COVID-19 pandemic. It also enhances communication between patients and providers and extends a limited workforce.[10] Increased telehealth coverage and utilization can also increase the capacity to remotely monitor and improve the quality of remote monitoring of high-risk and hard-to-reach populations, which can help shape interventions and provide better population-level and individual care.

COVID-19 has forced a rapid expansion of telehealth services and utilization has risen accordingly, with one payer reporting an increase from 200 telehealth claims a day in February 2020 to 38,000 a day in May 2020.[11] Almost 50% of those claims were related to mental health. Maintaining increased access and availability of telehealth services after the COVID-19 pandemic will be critical to meeting the anticipated increased demand for services on an already overburdened workforce.

While telehealth has been a critical component of the COVID-19 response, increased telehealth access has been debated for years. Increasing careful programming and expanding funding are critical. Barriers exist to effective implementation of telehealth practices, including but not limited to:[12]

- Lack of patient internet or phone access;
- Lack of health care coverage;
- Lack of training on effective health care professional best practices;
- Reimbursement discrepancies that pay at a lower rate than in-person visits, effectively disincentivizing health care professionals to offer their services via telehealth;
- Disparate coverage models (both governmental and private) and payment mechanisms, with no standardization on funding sources and covered services across payers;
- Perceived lower quality care in comparison to in-person appointments; and

---

[8] https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

[9] https://www.healthaffairs.org/do/10.1377/hblog20200331.557887/full/

[10] https://www.mhanational.org/blog/tele-mental-health-now-and-now

[11] https://healthpayerintelligence.com/news/mental-health-visits-take-majority-of-1m-payer-telehealth-claims

[12] https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers

- Mistrust of technology, including privacy concerns.

While almost all state Medicaid programs reimburse for some level of telehealth services, coverage is inconsistent. This is also true for those with employer-sponsored coverage. In one 2019 survey, only 50% of employee respondents across the nation reported that their employer health care plan provided telehealth coverage.[13] While coverage for telehealth has been enhanced and expanded due to the COVID-19 pandemic, this is not necessarily permanent.

Given the great need for continued support for and expansion of telehealth services in the U.S., NSC offers the following recommendations:

- Continue to offer telehealth as an essential part of coverage
- Update licensing requirements to make it easier to provide telehealth services, including allowing providers to practice across state lines, and permission for pre-licensure providers to utilize telehealth services under supervision
- Improve and standardize coverage models, payment mechanisms and reimbursement practices for telehealth services across government (Medicaid, Medicare) and private payers
- Remove barriers to accessing telehealth services, including:
    - Covering technology and other services needed to ensure patient access to telehealth services
    - Allowing initiation of care virtually
- Increase telehealth capacity and remove barriers for providers of medications for addiction treatment (MAT) and other SUD treatment interventions
- Determine when telehealth is or is not a good stand-in for in-person care
- Develop standards of care for providing telehealth services
- Apply the developed standards of care to all telehealth providers to ensure quality of care is maintained and individualized to the specialty to avoid an overly general one-size-fits-all approach.

Thank you again for holding this hearing. The National Safety Council looks forward to working with you to increase access to this essential tool.

[13] http://dmec.org/2019/05/30/2019-dmec-mental-health-pulse-survey-results/

Ochsner Health

March 1, 2021

Chairwoman Anna Eshoo
House Energy & Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Brett Guthrie
House Energy & Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of Ochsner Health (Ochsner), our physicians, nurses, and other health professionals and the tens of thousands of patients and communities we serve in Louisiana and Mississippi, we thank you for this opportunity to submit to you and your Energy and Commerce Health Subcommittee colleagues comments regarding "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." We commend you for your recognition of the importance to take time now to hold a hearing to examine the impact of telehealth on COVID-19 response, and how those lessons learned may inform future federal policy decisions with respect to telehealth.

We thank you in advance for your attention to our recommendations and the comments that may be submitted by our colleagues from associations representing health and hospital systems. Making permanent a number of the current federal telehealth waivers and other policy changes, expanding coverage and payment for telehealth and digital medicine services and devices, and otherwise supporting and facilitating the utilization of virtual care will help ensure that more patients have access to care, not just during emergency circumstances. These much-needed changes will help facilitate access to care for individuals from underserved and/or rural communities, and enable better access for those with mobility, transportation, and other challenges.

In particular, we stand ready to share our lessons learned over the past year as we have addressed the myriad challenges associated with COVID-19 and how we have successfully deployed telehealth and digital medicine to care for patients with COVID-19 as well as maintain continuity of primary and specialty care for patients, families, and communities during this challenging and unprecedented time. We welcome the opportunity to be a resource to you, your staff, and Energy and Commerce Health Subcommittee and full committee members as you examine this critically important topic.

Summary of Policy Recommendations

We know that the topic of telehealth is an incredibly important and time sensitive issue and as such, wish to draw your immediate attention to our policy recommendations below, which can be found in further detail on pages 7-11 of this document. Background on Ochsner and our digital medicine and telehealth programs can be found on pages 2-5. Our COVID-19 telehealth and virtual care lessons learned are enumerated on pages 5-6.

The following provides a summary of the policy changes we urge you and your colleagues to support. These recommendations are informed by our experience in providing care throughout the public health emergency (PHE) and, in particular, being an early "hot spot" for the pandemic. With these changes, patients will have improved access to the primary, specialty, urgent, and emergency care they need and deserve.

- Make permanent the range of waivers associated with the provision of telehealth. Specifically, make permanent the flexibilities associated with: patient location, relationship between patient and provider, and the types of services that can be provided via telehealth. Further, maintain reimbursement for telehealth services at the in-person rate and permanently waive the application of copayments to remote patient monitoring services and other non-face-to-face services.
- Ensure that in the event of a PHE cross jurisdictional licensure can be automatic, presuming certain conditions are met.
- Modify the Emergency Medical Treatment and Labor Act (EMTALA) to allow for new types of medical screenings, such as employment of pre-screenings that use technology that can help divert non-emergent cases to other settings.
- Expand covered remote monitoring services to allow for beneficiary participation and Medicare coverage and reimbursement for more than one program, which will increase access, ease patient day-to-day care, and improve health outcomes.
- Provide digital medicine and telehealth tools/devices to Medicare patients at no cost to increase patient uptake of these services.
- Ensure patient access to TeleStroke services by establishing separate Medicare payment for providers giving both TeleStroke consult and same day inpatient care to Medicare beneficiaries experiencing acute stroke.
- Expand Medicare beneficiary access to non-stroke telehealth services for acute neurological conditions.
- Expand access to intensive care unit (ICU) telehealth.
- Provide payment to providers who are offering additional levels of remote monitoring for patients through programs such as TeleStork.

About Ochsner

Ochsner, headquartered in New Orleans, with sites of care throughout Louisiana and Mississippi, is one of the nation's leading health systems. Ochsner is Louisiana's largest not-for-profit health system and one of the largest independent academic health systems in the United States. Specifically, in an innovative approach with the Ochsner Health Network (OHN), Ochsner partners with other health systems to offer 38 owned, managed, and affiliated hospitals and specialty hospitals – a model that allows many communities to maintain local ownership and control of their hospitals, while bringing to bear the benefit of the scale, assets, and experience of the Ochsner clinical and operational teams.

With more than 100 sites of care among its health centers and urgent care clinics, each year OHN serves approximately 1 million patients – from every state in the nation and more than 70 countries. Ochsner offers clinical expertise in more than 90 medical specialties and subspecialties, and includes approximately 3,600 affiliated physicians, with more than 1,300 employed Ochsner physicians and another 26,000 employees. In 2020, Ochsner earned two "Best Hospital" Specialty Category Rankings in U.S. News & World Report.

Louisiana regularly ranks near the bottom of the United States in nearly all health indicators, with a population that has a high prevalence of a number of risk factors for poor health outcomes, including obesity, tobacco use, poverty, diabetes, and cardiovascular disease. A number of years ago, Ochsner leaders recognized that it would take innovative strategies and deployment of new technologies and interventions to tackle these myriad challenges.

In response to the demand for better care at a lower cost and greater convenience to patients, Ochsner created an innovation lab, innovationOchsner (iO) to improve health through innovation with the following quadruple aim:

improve the patient experience of care, improve the health of populations, reduce the per capita cost of health care, and improve the work life of the provider of care. The strategies to achieve these goals are: operational efficiency, differentiate product or service, create customer intimacy, and improve quality and safety. We are proud that our investment and focus in this area has resulted in ground-breaking innovations, which are measurably improving patient care and outcomes, and are reducing inefficiencies and costs.

iO has developed a number of digital medicine programs, particularly for those affected by chronic disease, in particular hypertension and diabetes, that are transforming the patient experience, enhancing health, and well-being, while reducing costs. More than 15,000 patients are enrolled in our digital medicine programs and we are currently onboarding an additional 1,033, representing a more than 100% increase in enrollments since 2019. In addition, Ochsner provides more than 100 telehealth services to more than 185 hospital and clinic partners. Further, Ochsner continues to innovate in the direct-to-consumer market, with offerings such as Ochsner Anywhere Care for primary and urgent care needs.

Ochsner's innovative digital medicine approach using wearable technologies, remote monitoring, and virtual provider visits is substantially improving patient health outcomes at a lower cost. Particularly for patients who are managing complex diagnoses and chronic disease we are easing the patient care experience by allowing them to receive the care they need, when and where they need it. And, critically, our pioneering telehealth program is meaningfully increasing patient access to medical services in rural areas of Louisiana and Mississippi where, in certain cases, no such access existed before. For many – and a growing population – of our patients, telehealth and digital medicine are the standard of care and a preferred way in which they interface with the health care system.

Examples of Ochsner Digital Medicine Offerings[1]

Ochsner's Hypertension Digital Medicine (HTNDM) program uses a connected blood pressure cuff to transmit blood pressure readings from the patient's home to be monitored by an Ochsner care team, which includes a pharmacist and health coach. This program has been shown to be three times more effective than traditional care at having patients achieve blood pressure control over 180 days, while also increasing patients' medication adherence and patient activation, and reducing the total cost of care.

An analysis by Blue Cross Blue Shield found that participants in the HTNDM medication adherence program led to an overall decrease in emergency department visits and inpatient hospital stays. The same analysis also found that the program saved $77 per member, per month, based on claims data and total cost of care.

Our Digital Diabetes Medicine (DDM) program uses a prescription, Bluetooth-enabled digital glucometer to monitor a diabetic patient's A1C and other health indicators. This program also has achieved results that are better than traditional care methods, including reductions in A1C, decreases in hypoglycemic events and diabetes distress, and increases in adherence to recommended health maintenance activities.

[1] To learn more about Ochsner's digital medicine programs see the following articles:
CNBC: https://www.cnbc.com/2019/03/04/ochsner-hospital-in-new-orleans-has-o-bar-like-apple-store.html, ***Modern Healthcare***: https://www.modernhealthcare.com/article/20180922/TRANSFORMATION01/180929992/the-internet-of-things-extends-healthcare-into-the-home
Washington Post: https://www.washingtonpost.com/business/economy/these-louisiana-physicians-can-monitor-your-blood-pressure--and-you-dont-even-have-to-leave-your-living-room/2018/07/11/6d57f198-7beb-11e8-93cc-6d3beccdd7a3_story.html

The Connected Maternity Online Monitoring (MOM) program allows expectant mothers to conveniently receive monitoring and care between scheduled in-person visits. Each participant in the program is provided with a wireless scale and blood pressure cuff, along with supplies for urine protein tests that can be read and sent remotely. This deployment of technology allows the care team to be more proactive and anticipate and treat issues that may arise sooner. Due to the more frequent at-home monitoring, patients need fewer in-person appointments, providing convenience for low-risk patients, while opening up greater clinic availability for higher-risk patients and those patients who need additional in-person care.

The use of digital and wearable technologies in these programs results in improved patient outcomes while lowering costs and increasing patient engagement.

Examples of Ochsner's Telehealth Offerings

Ochsner deploys telehealth to deliver specialty, primary, and urgent care to patients near and far. We are proud to have created a network of hundreds of physicians who reside out of state and who – through multi-state licensure and the telehealth licensure compact – can deliver high quality care to our patients via telehealth, helping to ensure better access to care for underserved communities.

Ochsner provides emergency virtual psychiatric services, cutting emergency room wait times for psychiatric care at our partner sites by 50%. Telehealth can meaningfully increase patient access to telepsychiatry and telebehavioral health services for many patients in rural and underserved areas who are currently without access to such care. Access to specialty care has been expanded through the utilization of physicians with multi-state licensure who can treat patients via telehealth. Our "hub" and "spoke" model allows us to leverage our specialty physician workforce and expertise located in New Orleans to locations throughout Louisiana and Mississippi.

Ochsner's TeleStroke program provides 24-hour/7-days per week coverage by vascular neurologists who – through telehealth – are immediately available to emergency department physicians in rural hospitals to help them quickly diagnose and treat patients presenting with symptoms of a possible stroke. The program has been instrumental in successfully treating thousands of patients (more than 300 patients per month) in a timely manner, and allows these facilities to remain open and successfully caring for patients in their own communities. ***Seventy percent of TeleStroke patients now stay local; prior to the program's implementation, nearly all patients were transferred.***

Ochsner's TeleStork program, using live streaming of maternal and fetal health records, provides 24/7 monitoring to laboring mothers. Rapid detection of labor distress and early intervention by our specialty care team is helping reduce poor birth outcomes. Since initiated in August 2016, there has been a 50% decrease in term unexpected Neonatal Intensive Care Unit (NICU) admissions in TeleStork facilities. ***The program has seen an 80% decrease in situations requiring intervention from TeleStork nurses, indicating an improvement in birth outcomes and overall improvement in health status of newborns within the program.***

We recently launched a partnership with Ready Responders (RR) to make house calls to Medicaid patients who are heavy users of the emergency department and have multiple comorbid conditions, including behavioral health and substance use challenges. Through RR, we are able to deliver high quality, compassionate, tailored care to in-need patients at their home via EMS and/or nurses, with telehealth hook-up with a physician as needed. Patients seen by RR have reported dental pain, suicide ideation, and altered mental state.

RR addresses urgent and acute medical needs while also working with patients on referrals to and support related to

social and behavioral issues, such as transportation, food insecurity, lack of a regular source of primary care, and addiction. ***RR has helped enrolled patients get needed urgent and longer term care while reducing overall emergency department visits by 42%, decreasing unnecessary emergency department visits by 58%, and lowering costs to the health care system.***

In 2019, we announced a partnership with Tyto Care, the health care industry's first all-in-one modular device for remote medical exams. This partnership expands Ochsner's current telehealth offering, a consumer-facing virtual visit platform called Ochsner Anywhere Care, which is powered by national telehealth leader American Well®. The Ochsner Anywhere Care Health Kit, powered by Tyto Care, is a portable health kit that enables patients to capture physical examination data at home using a handheld device with a digital camera and various attachments and then share it with a provider using the Ochsner Anywhere Care app. It is designed to replicate the exams performed during an in-office visit, by providing high-quality digital sounds of the heart and lungs, digital images and video of the ears, throat and skin, and body temperature. Special adaptors are included for examining the ears, throat, skin for taking body temperature, and listening to heart and lung sounds. To see a demonstration video visit: https://ochsner.tytocare.com/.

It is important to note that an Ochsner Anywhere Health Kit is not required for an Ochsner Anywhere Care or other telehealth visit, but it does provide tools to capture and share exam data, which can prove to be helpful for a provider making a diagnosis and treatment recommendation.[2] This offering has potential to expand access to care, particularly for individuals with mobility limitations, including disabilities and transportation challenges, as well as provide access to individual and families in rural and underserved communities.

Since the pandemic began, we have sold thousands of Ochsner Anywhere Care Health Kits and through their deployment expanded access to primary and urgent care, allowing these patients to have access to care from the safety of their own homes. Further, through funding we received through the Federal Communications Commission (FCC) COVID-19 Telehealth Program, we have been able to purchase and are actively disseminating – at no cost to patients – almost 12,000 devices to support patients in participating in our HTNDM, DDM, and Connected MOM programs.

Having additional resources allowed us to expand the reach of our digital medicine programs, which in turn, supported our ability to maintain continuity of care – and in some cases begin important health monitoring – of patients with hypertension and/or diabetes as well as support our patients during an important time during their pregnancy. We are particularly pleased with the growth of enrollment in patients covered by Medicare and Medicaid due to the FCC funding, where offsetting the costs of the devices removed a significant barrier for many new enrollees.

Lessons Learned from COVID-19

Prior to the COVID-19 PHE, Ochsner had long-advocated that Congress, the U.S. Department of Health and Human Services (HHS), and the Centers for Medicare and Medicaid Services (CMS) expand coverage and reimbursement for telehealth and digital medicine services and associated connected devices. We theorized that improvement in how these services and the associated devices are covered and reimbursed would accelerate their adoption, increase access

[2] The Ochsner Anywhere Health Kit, powered by Tyto Care, retails for $299 with $10 flat shipping if ordered online at www.ochsner.org/healthkit. It is also available for purchase at Ochsner pharmacy locations, O Bar retail stores, Ochsner Fitness Centers and Ochsner Total Health Solutions. Some insurance providers may provide a discount or partial reimbursement; it is recommended that consumers contact their insurance provider for more information.

to care, and in turn, leverage their potential in supporting patient engagement, expand provider access to more accurate and timely patient data, and enhance the patient experience.

Now, a year into the pandemic, we have real world experience and have seen this theory come to fruition. These technologies and care delivery modalities are making a difference in the lives of people diagnosed with COVID-19, those suspected as having COVID-19, and for patients who need access to non-COVID-related primary or specialty care. Fully deploying telehealth and digital medicine to our Medicare, Medicaid, and commercially insured patients has helped to maintain continuity and coordination of care, as well as allowed for expanded access to care to patients who previously had been underserved. In many cases, Ochsner has been able to reach patients who previously have had limited or no access to such services – particularly in rural and underserved areas where health care disparities persist.

Over the course of the COVID-19 pandemic, Ochsner has observed in patient reported data a significant increase in utilization of telehealth services by minority populations, particularly among African Americans, where the percentage of patients completing virtual visits doubled. At the height of the COVID-19 outbreak in the "hot spot" state of Louisiana, Ochsner delivered more than 60 percent of visits to patients via telehealth – making Ochsner the leading health care system in the South in the delivery of telehealth during the public health crisis.

From the March to December 2020 period, we are proud to have deployed virtual visits in a robust manner to sustain continuity of care and reduce the risk of COVID-19 exposure for patients, family members, and providers. Specifically, during this period Ochsner provided:

- An estimated 314,000 total virtual visits to adult and pediatric patients;
- Virtual visits across 20 different service lines, with the bulk of care being primary care, behavioral health, and other/non-specified;
- Approximately 60,000 virtual visits to Medicare Advantage beneficiaries;
- An estimated 39,000 virtual visits to Medicare fee-for-service beneficiaries; and
- More than 40,000 virtual visits to people with Medicaid coverage.

While Ochsner was able to quickly and adeptly expand our telehealth and digital medicine offerings due to our existing programs and infrastructure, other hospitals, health systems, and providers required significant time, resources, equipment, and training – of health professionals and patients – to scale up their remote care offerings, which in turn, caused some delay in patients receiving health care services and outpatient treatment. We feel strongly that the nation's health care system must maintain these advances during non-pandemic times to ensure that the infrastructure, practice, familiarity, and resources are in place so irrespective of what threat may emerge – natural disaster, bioterrorism, or infectious disease – that we have a strong, existing system so physicians, nurses, and hospitals can continue to provide health care services across the care continuum.

Ochsner Policy Recommendations

The telehealth waivers granted by HHS and CMS have been critical to Ochsner's quick expansion and implementation of telehealth and digital medicine services. Since the start of the pandemic and the advent of the waivers, in our telehealth program, we have seen an 89% increase in Louisiana patients from rural areas, as defined by the Health Resources and Services Administration. This increase is due to a number of factors, including a significant boost in patient interest in remote care and quick patient adoption to remote care.

We applaud and commend HHS and CMS for this work and respectfully request that the Congress work with CMS and HHS to enact legislation and modify regulations, as applicable, to make these waivers permanent and, ensure that the United States does not lose the gains made in telehealth.

Telehealth Waivers Prioritized for Permanent Change

While all of the telehealth waivers provided by HHS and CMS have enhanced our ability to serve patients throughout the COVID-19 public health crisis, Ochsner believes that the following waivers in particular have enabled and fostered successful deployment of telehealth services to patients and these policy changes should be maintained once the pandemic has abated so that more patients – especially those in rural and underserved areas – can access treatment and receive more comprehensive and coordinated care.

1. **Patient location**: The ability of patients to receive telehealth services from any location, including their homes, has given patients access to services where in many cases they could not have accessed care. Telehealth has reduced the need to travel for patients who are not as mobile and provides scheduled or on demand care and support through difficult stages of well-being. For example, telehealth has allowed patients in rural and remote areas without reliable transportation to more easily receive treatment by eliminating travel burden. For those patients with limited resources, telehealth has eliminated the cost of travel time and additional time away from work to receive an in-person visit. Further, for institutional-based patients such as those residing in skilled nursing facilities (SNFs), telehealth has given them the ability to remain in their care setting, minimizing both health risk and burden. Hence, making permanent the waiver permitting patients to receive telehealth from any location will eliminate a significant barrier for many patients who, before the telehealth expansion, were unable to access the services they need to get well and stay healthy.

2. **Reimbursement at the in-person visit rate**: Reimbursing for telehealth visits at the in-person rate has enabled Ochsner to offer services to patients in a financially sustainable and scalable manner. Adequate reimbursement for telehealth at the in-person visit rate ensures that providers receive appropriate payment for the full range of care they provide in the context of a remote visit. For example, often patients submit photographs, videos, and other medical information (e.g., blood pressure readings, blood sugar data, etc.) in advance that their providers take time to review and analyze prior to – or following – a telehealth encounter. In a face-to-face encounter this often is done in real time and is reflected in the in-person payment amount. Further, providing reimbursement at the same rate as in-person care recognizes that the provision of telehealth services requires resources, such as technology and other infrastructure.

3. **New services eligible for telehealth delivery:** The significant expansion in the types of health care services that can be delivered via telehealth has given Ochsner a way to reach patients previously not possible in many instances. For example, delivering occupational, speech/language, and physical therapy services via telehealth to patients in their homes or in nursing facilities has given patients new or increased access to care that improves quality of life and health outcomes. Pain Management and Palliative Care and hospice patients and families have also benefited from the ability to connect with their providers through telehealth.

4. **No required established relationship between practitioner and patient:** Without the requirement of an established relationship between the patient and provider, Ochsner has been able to immediately serve a wider population of patients and address their care needs. Many patients living in rural and underserved communities do not have a regular source of health care and therefore do not have an established relationship with a provider.

Making this waiver permanent will remove a significant barrier in access to treatment, especially for those many patients in rural and underserved communities who in many cases historically have received fragmented care.

5. **Waiver of Medicare remote patient monitoring and other non-face-to-face services copayments:** The HHS Office of the Inspector General (OIG)'s waiver of the Anti-Kickback Statute (AKS) for cost-sharing obligations for non-face-to-face services furnished through various modalities, including remote patient monitoring, remote monthly care management, virtual check-ins, and telehealth visits has eliminated a substantial barrier in patient access to care where, in many cases, patients simply do not have the resources to pay for services that are not immediate care needs but who could benefit from the care provided.

   For example, as noted earlier, primary and secondary preventive services like Ochsner's DDM and HTDM programs have reduced unnecessary emergency department visits, decreased inpatient admissions, increased medication adherence, and improved annual screening compliance, but unfortunately have been hindered by copayment barriers. Unfortunately, given the demographics of the Ochsner patient population, affordability of care is a serious impediment to our ability to manage chronic disease for too many of our patients. According to Kaiser Family Foundation, approximately 20% of Medicare beneficiaries in fee-for-service have no type of supplemental coverage, which makes paying out-of-pocket costs more challenging. Coinsurance often stands in the way of patients seeking and receiving the care they need, particularly for Medicare patients with limited resources.

   Remote monitoring, such as our hypertension program, typically involves a monthly "charge" to cover the costs of having the data reviewed by the health care team and additional involvement by the physician should any adjustments to treatment or the care plan need to be made. We know from our clinical experience that for many beneficiaries the cost of the monthly out-of-pocket fee caused them to decline the opportunity to enroll in a digital medicine program. Yet, over the past four months, with the copayments waived, we have noted a significant increase in enrollment and participation among patients who need these programs, which in turn will help improve their health and reduce costs over time.

   Permanently waiving the copayment requirement for these non-face-to-face services will meaningfully improve access and much better enable Ochsner to more effectively and comprehensively care for patients, especially for patients in rural and underserved areas where significant disparities in care remain and must be addressed.

Other Waiver Related Policy Recommendations

In addition to the telehealth waivers enumerated above, HHS and CMS have provided additional waivers during the PHE that have strengthened our ability to "continue to provide health care services and outpatient treatment during a pandemic." Based on our experience with these waivers, we recommend the following:

1. ***Cross jurisdictional licensure in the event of a PHE:*** In the event of a PHE, there should be automatic allowance of CMS physician or non-physician practitioner licensing requirements when the following four conditions are met: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state, which relates to his or her Medicare enrollment; 3) is furnishing services –whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area. This change would have no effect on state licensure requirements.

2. ***Modify the Emergency Medical Treatment and Labor Act (EMTALA):*** The 1135 emergency waiver authority has allowed the Secretary to waive enforcement of EMTALA. In response to the current PHE the Secretary allowed hospitals to redirect patients who present at the emergency department to an alternative screening site and to transfer individuals with an unstable emergency medical condition. To use these waivers, many health systems relied on technology to screen patients upon emergency department arrival. Outside of a PHE, such screening tools would not typically meet the medical screening requirements under EMTALA.

   While EMTALA is necessary to ensure that all patients have access to emergency medical care, **we urge Congress to revise the statute to allow for new types of medical screenings.** Specifically, many health systems hope to employ pre-screenings that use technology that can help divert non-emergent cases to other settings. The current medical screening requirements are so extensive that patients remain in the full queue of emergency department patients before it is determined that they could be diverted to another setting of care. More often than not, the patient is treated in the hospital after long wait times rather than being directed to nearby outpatient departments or physician practices, where the patient could have received appropriate care in a timelier manner and at lower cost to the patient and healthcare system. We envision appropriate guardrails could be put in place by requiring hospitals to have their pre-screening approaches approved by CMS and requiring additional data submissions on patient diversion.

Other Policy and Payment Change Recommendations

1. ***Expand covered remote monitoring services to allow for beneficiary participation and Medicare coverage and reimbursement for more than one program, which will increase access, ease patient day-to-day care, and improve health outcomes*:** Federal health programs should permit patients to participate in as many remote monitoring programs as their health needs dictate. A significant number of patients have more than one chronic condition (e.g., hypertension and diabetes) that would benefit from remote monitoring. Currently, Medicare only provides payment for one remote monitoring program/initiative, generally resulting in the provider receiving reimbursement for the program to which the patient consents first. Ochsner treats patients who would benefit from being enrolled in both our HTNDM and DDM programs because they have both hypertension and diabetes. For example, in Louisiana among Medicare beneficiaries aged 65 and older 65.63% have hypertension and 27.99% have diabetes.[3] Hypertension is twice as common among people with diabetes as those without it and an estimated two-thirds of people with diabetes have elevated blood pressure and/or are treated for hypertension.[4] Among the population we treat at Ochsner, an estimated 75% of patients with diabetes also have hypertension. Many chronic care Medicare beneficiaries have multiple comorbid conditions. The latest CMS data for Louisiana show that 28.63% of Medicare beneficiaries in the state have 2-3 chronic conditions and annual Medicare per capita spending for this group of patients is $5,999.[5] As such, the Medicare program and patients could benefit from allowing providers to offer a variety of remote monitoring services at the same time for all applicable

[3] https://portal.cms.gov/wps/portal/unauthportal/unauthmicrostrategyreportslink?evt=2048001&src=mstrWeb.2048001&documentID=69E5BACC452E9CC0D72D6DA872A90AF6&visMode=0&currentViewMedia=1&Server=E48V126P&Project=OIPDA-BI_Prod&Port=0&connmode=8&ru=1&share=1&hiddensections=header,path,dockTop,dockLeft,footer

[4] https://www.hopkinsmedicine.org/health/conditions-and-diseases/diabetes/diabetes-and-high-blood-pressure

[5] https://portal.cms.gov/wps/portal/unauthportal/unauthmicrostrategyreportslink?evt=2048001&src=mstrWeb.2048001&documentID=69E5BACC452E9CC0D72D6DA872A90AF6&visMode=0&currentViewMedia=1&Server=E48V126P&Project=OIPDA-BI_Prod&Port=0&connmode=8&ru=1&share=1&hiddensections=header,path,dockTop,dockLeft,footer

documented diagnoses. Federal health programs should permit providers to bill for all remote monitoring services applicable to a patient's diagnoses to foster increased patient access to more coordinated and more comprehensive care, ultimately, resulting in improved patient health outcomes at a lower total cost-of-care.

2. ***Provide digital medicine and telehealth tools/devices to Medicare patients at no cost to increase patient uptake of these services*:** Patients often need technology or tools to support their health and well-being and allow for better care management by their provider team. As explained above, Ochsner's successful digital medicine programs require the use of connected smart devices that communicate with the care team. Patients must purchase these devices – in some cases entirely out-of-pocket and in other cases with some cost-sharing and some coverage. Unfortunately, as noted above, out-of-pocket expenses often preclude patients from accessing to the care, services, and tools they need to stay healthy and prevent catastrophic episodes of care. In our experience, approximately 10% of patients decline to participate in our digital medicine programs when they learn they have to pay for the device out-of-pocket. Therefore, Congress should expand Medicare payment policy to include full coverage of digital medicine devices (e.g., Bluetooth-enabled blood pressure cuff, Bluetooth-enabled digital scale, Bluetooth-enabled digital glucometer) and telehealth devices (e.g., Tyto Anywhere Care kit) and do so without any cost-sharing requirements. The overwhelming response to the Congressionally-established COVID-19 Telehealth Program at the FCC has demonstrated the need for a funding mechanism for these devices. Ochsner has seen first-hand the willingness of patients to participate in these beneficial programs when they have affordable access to them. Expanding access to these important patient engagement and support tools will help providers leverage the full value and improved patient health outcomes that digital medicine and telehealth care can offer.

3. ***Ensure patient access to TeleStroke services by establishing separate Medicare payment for providers giving both TeleStroke consult and same day inpatient care to Medicare beneficiaries experiencing acute stroke:*** Ochsner commends the Congress for expanding Medicare beneficiary access to TeleStroke services as part of the Bipartisan Budget Act (BBA) of 2018. To foster further Medicare beneficiary access to TeleStroke services, Congress should permit Medicare to make two separate payments to a single provider for both a TeleStroke consult and the work of a subsequent stroke admission on the same day if the admitting hospital both provides the initial TeleStroke consult and later admits the patient after transfer due to the acuity level of the patient's stroke.

4. ***Expand Medicare beneficiary access to non-stroke telehealth services for acute neurological conditions:*** Patients in rural and underserved communities typically have significantly less access to treatment for acute neurological diseases. To build on the important expansion of TeleStroke care, Ochsner requests that Medicare provide unrestricted telehealth coverage for other non-stroke acute neurological conditions that typically require consultations with emergency departments to achieve optimal patient health outcomes. These include diagnostic questions of numbness, weakness, vertigo, confusion, headache, tremors and seizures, leading to treatment of complications of spinal cord injury, nerve compression, brain tumors, Multiple Sclerosis (MS), Parkinson's disease, Alzheimer's disease, epilepsy, Amyotrophic Lateral Sclerosis (ALS), and many other conditions. Similar to the request for TeleStroke above, Congress should allow Medicare to make two separate payments to a single provider for both a non-stroke telehealth consult of an acute neurological condition and the work of a subsequent inpatient admission on the same day related to that condition if the admitting hospital provides both the initial telehealth consult and later admits the patient after transfer due to the acuity level of his or her neurological condition. Patient access to acute neurological telehealth services should not be limited by geographic or originating site requirements in the original Medicare telehealth statute. All patients should be able to benefit from the availability of these services that in many cases can offer life-saving and life-sustaining care.

5. ***Expand access to intensive care unit (ICU) telehealth*:** In many cases, patients in rural and underserved areas have to travel significant distances to receive emergency care. Through Ochsner's innovative telehealth offerings, we can give telehealth ICU consults that save meaningful time to treatment in many instances where immediate access to care can result in the likelihood of significantly better patient health outcomes. Congress should provide unrestricted Medicare coverage for telehealth ICU consults (i.e., no originating or geographic site limitations) so that all beneficiaries can access the emergent care they need as quickly as possible.

6. ***Provide payment to providers who are offering additional levels of remote monitoring for patients through programs such as TeleStork***. Offerings like TeleStork provide an additional level of specialized monitoring and clinical support to providers who are caring for maternity patients who may be at higher-risk for poor maternal and fetal outcomes. Because the care is not delivered directly to the patient there is no reimbursement provided for the service, yet in our experience it is cost-effective and cost-saving.

Conclusion

The federal waivers outlined above have allowed Ochsner's telehealth programs to operate at their full potential, and in doing so, have demonstrated that telehealth is a high quality, efficient, and effective way to treat patients safely both inside and outside of the clinic and hospital settings. Ochsner urges the permanent extension of these critically important waivers; this essential policy change will allow us to continue providing care to patients that may otherwise go unserved.

Further, we thank you for considering our additional recommendations for ways to modify federal coverage and reimbursement policy to facilitate the provision of virtual care and patient monitoring in a cost effective and convenient manner and in a way that also reduces patients' unnecessary exposure to infectious disease, such as COVID-19. We believe that by strengthening our nation's telehealth and digital medicine infrastructure we will be able to maintain the access to care gains made over the past year and support hospitals and providers in continuing to provide care during the PHE and otherwise.

We thank you for your consideration of our recommendations and stand ready to serve as a resource. Should you need any additional information, please contact me at (662) 719-4969 or William.crump@ochsner.org.

Sincerely,

Will Crump
Director of Public Health Policy

cc: The Honorable Frank Pallone, Jr., Chairman
House Energy & Commerce Committee

Oncology Nursing Society
Statement for the Record
House Energy and Commerce Health Subcommittee
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
Tuesday, March 2, 2021

Chairwoman Eshoo, Ranking Member Guthrie, and members of the Subcommittee, the Oncology Nursing Society (ONS) would like to thank the House Energy and Commerce Health Subcommittee for the opportunity to provide input on the importance of expanded telehealth during the ongoing COVID-19 public health emergency and the need to preserve and expand these flexibilities in the future.

The Oncology Nursing Society (ONS) is a professional organization of more than 39,000 registered nurses and other health care providers dedicated to excellence in patient care, education, research, and administration in oncology nursing. ONS members are a diverse group of professionals who represent a variety of professional roles, practice settings, and subspecialty practice areas. As advocates for the nursing profession and our cancer patients, ONS welcomes the opportunity to inform the Subcommittee about the importance of the expanded use of telehealth services for oncology nurses and their patients.

Telehealth has helped oncology nurses maintain communication and protect vulnerable patients, ensuring the safety and well-being of both patients and staff, during the COVID-19 pandemic. Increased access to telehealth in recent months has also facilitated continued participation in clinical trials for many patients, which is often crucial to their care.

New models of ambulatory cancer care have helped ensure the safety and well-being of both patients and staff during the COVID-19 pandemic, providing a crucial method for oncology nurses to stay connected with patients. ONS is happy to share real-life examples of how oncology care has changed during the public health emergency.

At one cancer center, any clinic appointments that did not need to be in-person were converted to online visits. Oncology supportive programs, like social work, support groups, and nutrition, also transitioned to telehealth, and the team has been using social media and email to educate patients about safety, telehealth, and coping and stress management. Nurses lead virtual chemotherapy education appointments for patients and their caregivers, allowing for one-on-one teaching and a virtual tour of the infusion suite prior to their first visit.

Another ONS member shared the example of a newly diagnosed patient who needed to discuss their treatment options. A tele-video appointment gave the patient and their family the

opportunity to meet their doctor 'face-to-face,' learn about their diagnosis, ask questions, and facilitated the scheduling of additional testing to determine the extent of the disease.

A geriatric-oncology nurse practitioner has found that telehealth can be more valuable than an in-person visit in the clinic setting. This nurse described being able to complete a geriatric assessment, including a 'Get Up and Go Test', with her 82-year-old patient on long-term survivorship surveillance. She notes that the patient's daughter was able to be in attendance, and that the patient was fully engaged and focused. This nurse practitioner completed a medication review, virtually observed the patient's home setting, and provided real-time feedback on additional safety measures.

Virtual care and telehealth services have proven not only to be a viable solution to providing patient-centered care throughout the pandemic, but a tremendous value for patients, providers, and the health system broadly. As the Subcommittee continues to examine the impacts of the ongoing pandemic, ONS urges you to consider the positive effects that expanded telehealth flexibilities have had on patients, caregivers, and providers. ONS strongly supports making permanent the new flexibilities established in response to the public health emergency that expand the use of telehealth services and provide payment parity for telehealth and in-person visits.

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
ENERGY & COMMERCE COMMITTEE SUBCOMMITTEE ON HEALTH
HEARING ON
"THE FUTURE OF TELEHEALTH: HOW COVID-19 IS CHANGING
THE DELIVERY OF VIRTUAL CARE"
MARCH 2, 2021

The Partnership for Employer-Sponsored Coverage (P4ESC) appreciates the Energy and Commerce Committee's Subcommittee on Health holding this important hearing on the future of telehealth. No public health crisis has been more challenging in our nation's history than the current COVID-19 pandemic. P4ESC believes that the time is ripe to modernize laws to increase access to telehealth services as patients, health providers, and coverage plan sponsors continue to adapt to and comply with remote working and social distancing measures.

As an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and millions of Americans who rely on employer-sponsored health coverage every day, P4ESC is working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

P4ESC appreciates the COVID-related policies adopted over the last year to help employees and businesses, including expanding telemedicine availability to employees. Congress should build on this policy to provide employers with the ability to enhance employee coverage permanently. P4ESC is eager to work on bipartisan legislation to expand employee access to telemedicine, including enabling employers to offer a telehealth service plan to all employees regardless of their enrollment in the employer's medical coverage.

P4ESC supports: 1) treating telehealth services as an excepted benefit which would enable employers to offer this type of coverage to part-time and variable workforces, and other employees not enrolled in the employers' medical plan; 2) reforming licensure requirements to enable services to be offered across state lines; 3) establishing a national set of standards for telemedicine services to address state-based requirements that have not kept pace with technology, practice site and remote working advances, including eliminating originating site and prior provider relationship requirements; and 4) clarifying that CARES Act telemedicine provisions are effective for plan years on or after January 1, 2019 (employer plan years vary between non-calendar and calendar year basis).

The pandemic has offered employees the ability to receive mental and behavioral health services via telemedicine, and we strongly support making this access permanent. According to the Society for Human Resource Management's (SHRM) *Navigating COVID-19: Impact of the Pandemic on Mental Health*[1], "the COVID-19 pandemic has put unprecedented strain on workers' mental health… the research finds that a majority of employees are experiencing symptoms of depression, but very few are receiving care." Findings include:

- Two out of three employees report experiencing symptoms of depression sometimes amid widespread lockdowns
- More than two in five employees feel burned out, drained, or exhausted by work
- 37 percent of employees have not done anything to cope with depression-related symptoms and only 7 percent have reached out to a mental health professional

[1] https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/documents/shrm%20cv19%20mental%20health%20research%20presentation%20v1.pdf

In a statement for the record[2] for the Senate Health, Education, Labor, and Pensions (HELP) Committee's hearing on June 17, 2020, entitled "Telehealth: Lessons from the COVID-19 Pandemic," the ERISA Industry Committee (ERIC) wrote "[t]elehealth enables our beneficiaries to obtain the care they need, when and where they need it, in an affordable and convenient manner. It reduces the need to leave home or work and risk infection at a physician's office, provides a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages and improve choice and competition in health care."

Further, in an op-ed published in *THE HILL*[3] on May 28, 2020, SHRM's Emily M. Dickens, Chief of Staff, Head of Government Affairs & Corporate Secretary, wrote "[g]reater access to telemedicine, including telepsychiatry, will provide the resources for employees to navigate all health care options and privately seek the help that they need. The convenience of this offering will benefit employers and their employees because such services can be received at home and after work hours during a time when personal and professional schedules are anything but definite for so many workers."

In the employer benefits space, telehealth services come in different forms, such as: the ability for employees to be treated by a health provider or practice, with whom they already have a relationship, in a telemedicine setting instead of through a traditional in-office visit; and access to a telehealth service vendor which is included in a benefits package offering, similar to a dental or vision plan, that is separate from the medical plan but provides the ability to be connected to a physician or health professional for a consultation. In the later example, the separate telehealth vendor program can legally be provided to full-time employees enrolled in the employer medical plan but not to other groups of the workforce. Part-time and seasonal employees, and full-time employees who declined the employer medical plan cannot access the telehealth vendor program because this type of stand-alone benefit would violate the coverage rules under the Affordable Care Act's (ACA) employer mandate. P4ESC would like the availability of these telehealth services to legally be offered to all employees, regardless of their eligibility for or enrollment in an employer's medical plan.

The Partnership for Employer-Sponsored Coverage welcomes any opportunity to provide input and speak in further detail about expanding telehealth to Americans, especially during the pandemic. Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers themselves. There is no one-size-fits-all employer plan, and the functionality of a business is centered around a productive, thriving, and healthy workforce. As a coalition representing businesses of all sizes, we have the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family business to the largest corporation.

Sincerely,

American Health Policy Institute
American Hotel & Lodging Association
American Rental Association
Associated Builders and Contractors, Inc.
Associated General Contractors of America
Auto Car Association
Business Group on Health
The Council of Insurance Agents & Brokers
The ERISA Industry Committee (ERIC)
FMI – The Food Industry Association
HR Policy Association
National Association of Health Underwriters
National Association of Wholesaler-Distributors
National Restaurant Association
National Retail Federation
Retail Industry Leaders Association
Society for Human Resource Management

[2] https://www.eric.org/wp-content/uploads/2020/06/06-17-20-ERIC-Statement-for-HELP-Telehealth-Hearing-Final.pdf
[3] https://thehill.com/opinion/healthcare/500017-assist-mental-health-of-workers-by-increasing-access-to-telemedicine

PHYSICIAN ASSISTANT EDUCATION ASSOCIATION
655 K Street NW, Ste. 700, Washington, DC 20001
PAEAonline.org • 703-548-5538

Statement for the Record
Submitted to
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Hearing on "The Future of Telehealth: How COVID-19 Is Changing the Delivery of Virtual Care"
March 2, 2021

The Physician Assistant Education Association (PAEA), representing the 267 accredited PA programs in the United States, welcomes the opportunity to submit a statement for the record regarding the impact of COVID-19 on the future delivery of telehealth services.

This hearing comes at a time of significant transformation for the traditional paradigm of health care delivery in the United States. As the pandemic has limited the ability or willingness of patients to receive in-person care, increased adoption of telehealth by health care providers has played a critical role in ensuring continued access to needed services. Less attention has been paid, however, to the role of telehealth in bolstering the pipeline of future providers and how lessons learned during the pandemic can be used to improve provider preparedness to meet anticipated high demand for telehealth services beyond the scope of the current public health emergency.

Since the inception of the profession in the 1960s, PA education has been based upon an intensive, modified form of physician training. Over the course of, on-average, a 27-month continuous program, PA students complete a rigorous curriculum divided almost evenly

2021 PAEA BOARD OF DIRECTORS
Michel Statler, MLA, PA-C
PRESIDENT
Kara L. Caruthers, MSPAS, PA-C
PRESIDENT ELECT
Howard Straker, EdD, MPH, PA-C
IMMEDIATE PAST PRESIDENT
Janie McDaniel, MS, MLS(ASCP)SC
SECRETARY
Carl Garrubba, DMSc, PA-C, CPA
TREASURER
Shalon Buchs, MHS, PA-C
DIRECTOR AT LARGE
Nicole Burwell, PhD, MSHS, PA-C
DIRECTOR AT LARGE
Reamer Bushardt, PharmD, PA-C
DIRECTOR AT LARGE
Shaun L. Grammer, DMSc, PA-C
DIRECTOR AT LARGE
Robert D. Hadley, PhD, PA-C
DIRECTOR AT LARGE
Linda Sekhon, DHSc, PA-C
DIRECTOR AT LARGE
Mary Ruggeri, MEd , MMSc, PA-C
STUDENT MEMBER AT LARGE
Mary Jo Bondy, DHEd, MHS, PA-C
EX OFFICIO MEMBER

between classroom-based/didactic and clinical education. During the clinical year, students complete a series of required rotations in family medicine, internal medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, and behavioral medicine in a variety of clinical settings with a heavy emphasis on in-person exposure to patients.

The onset of the pandemic in early 2020 resulted in a wave of clinical rotation suspensions mandated either by health care settings or by the sponsoring institutions of PA programs in an effort to protect students and conserve health system resources. According to PAEA's first survey of members related to the operational impact of COVID-19, a majority of programs reported either clinical site-mandated or institutionally mandated suspension of rotations - policies that were also instituted for medical, nursing, and other health professions students.[1] While these policies caused significant disruption to the ability of students to complete their required clinical education and graduate on time, many programs were able to limit this impact by supplementing traditionally in-person rotations with telehealth experiences. According to PAEA's most recent *COVID-19 Rapid Response Report*, 57.5% of responding PA programs reported increased adoption of telehealth for students' clinical year as a result of COVID-19.[1]

In spite of the success of many programs in rapidly increasing the use of telehealth for clinical year students, the realities of treating patients during the pandemic has revealed new opportunities to better prepare graduates to practice in a future environment with a significantly increased demand for telehealth services. Compared to in-person care, there are important nuances associated with preparing students to provide telehealth services such as special privacy and security considerations and modifications to traditional patient communication strategies. However, due largely to competing demands within a crowded curriculum, PAEA's most recent COVID-19 survey indicates that only 10.5% of programs provided their didactic year students with dedicated telehealth content prior to COVID-19.[2]

In recognition of increased demand for telehealth services , 37% of programs have signaled a desire to expand telehealth content in their didactic curriculum in the future.[2] **It is therefore crucial that any legislation designed to facilitate increased long-term utilization of telehealth**

---

[1] Physician Assistant Education Association. (2021). *COVID-19 Rapid Response Report 3*. https://paea.edcast.com/pathways/covid-19-rapid-response-reports/cards/8454047.

services include authorized funding to support the development of telehealth curriculum for PA programs to ensure students are as equipped as possible to provide the high-quality virtual services patients require.

PAEA stands ready to collaborate with the Subcommittee on effective legislative options to ensure workforce preparedness for the future of telehealth delivery. Should you require additional information or have questions, please contact Tyler Smith, Director of Government Relations, at tsmith@PAEAonline.org or 703-667-4356.

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

Free Markets. Real Solutions.
www.rstreet.org

The Honorable Anna G. Eshoo
Chairwoman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
272 Cannon House Office Building
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, D.C., 20515

Dear Chairwoman Eshoo, Ranking Member Guthrie and Members of the Subcommittee:

Thank you for the opportunity to discuss the future of telehealth in the wake of COVID-19. We at the R Street Institute commend the Subcommittee on Health for examining one of the most pressing topics today.

The R Street Institute is a nonprofit, nonpartisan, public policy research organization, and we engage in policy research that promotes free markets and limited, effective government. As such, we have conducted research on and written about telehealth regulations that limit access in harmful ways.

The COVID-19 pandemic fundamentally changed how millions of Americans access health care providers. Within days of the initial stay-at-home orders of 2020, governors, executive agencies and lawmakers across the country sought to bolster telehealth access by temporarily suspending some regulations that limit its use.[1]

These state and federal regulations—which dictate who can access telehealth, which telehealth platforms they can use, and where both patients and doctors must be physically located in order to engage in telehealth services—became particularly problematic as Americans suddenly faced closed doctor's offices, clinics and treatment centers. Virtual access through telehealth became a lifeline.

We now have a better understanding of how to bolster telehealth access permanently to more efficiently and effectively serve the needs of the American public. There are many things that state

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

lawmakers and Congress members can do to improve, simplify and expand telehealth access. Here, we focus on two main objectives on which Congress can act:

Eliminate originating site requirements for Medicare recipients.
The National Rural Health Association maintains that telehealth is a cost-saving measure because it enables earlier diagnosis and treatment, and better management of chronic conditions—particularly for those in rural areas. However, Medicare currently has geographic and originating site requirements that unnecessarily limit its use. Currently, a Medicare recipient keen on using telehealth services must live in a designated Health Professional Shortage Area (HPSA) and also travel to a health care facility to have a virtual consultation with a provider. At the onset of the pandemic in March 2020, the Centers for Medicare and Medicaid Services (CMS) temporarily waived these requirements.[2] Consequently, telehealth visits for Medicare recipients surged: fewer than 1 percent of Medicare primary care visits were via telehealth in February 2020, compared with almost half of Medicare primary care visits in April 2020.[3] Bipartisan legislation is currently in Congress that would permanently eliminate these requirements so that more Medicare recipients can access doctors via telehealth and not have to leave home to do so.[4]

Eliminate Medicare licensing requirements that inhibit doctors from seeing out-of-state patients remotely.
Even if Medicare recipients no longer have to be in a federally designated HPSA or travel to a health care facility to use telehealth, access may—in many states—still be hindered due to state and federal licensing requirements that limit health care professionals treating patients via telehealth unless the professional is licensed in the state that the patient is located. The CMS temporarily waived this requirement in 2020 so that doctors enrolled in Medicare could engage with Medicare patients, even if they did not reside in the same state.[5] This waiver should also be made permanent to ensure that enrolled doctors can see patients across the country, as long as they hold a license in good standing in one state. States often hold similar restrictions, but the pandemic is changing this; for example, the Arizona Legislature is currently considering legislation that would allow practitioners to see patients in Arizona via telehealth regardless of whether they are licensed in Arizona, so long as they hold a valid license in another state.[6] This type of forward-thinking reform will improve health care access, and federal reform will serve as a strong signal to states to follow suit.

Again, we thank you for your consideration of this crucial issue, and we stand ready to assist or answer any questions you may have.

Respectfully submitted,

Courtney M. Joslin, Resident Fellow
R Street Institute
cmjoslin@rstreet.org

1212 New York Ave. NW
Suite 900
Washington, D.C. 20005
202-525-5717

Free Markets. Real Solutions.
www.rstreet.org

---

[1] Center for Connected Health Policy, "Telehealth Coverage Policies in the Time of COVID-19," The National Telehealth Policy Resource Center, Sept. 15, 2020 https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies.

[2] Centers for Medicare and Medicaid Services, "President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak," U.S. Department of Health and Human Services, Mar. 17, 2020. https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak.

[3] Office of the Assistant Secretary for Planning and Evaluation, "ASPE Issue Brief: Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the COVID-19 Pandemic," U.S. Department of Health and Human Services, July 28, 2020. https://aspe.hhs.gov/pdf-report/medicare-beneficiary-use-telehealth.

[4] "Scott, Schatz, Shaheen Introduce Bipartisan Legislation to Increase Access to Telehealth in the Midst of the Pandemic," The Office of Sen. Tim Scott, Feb. 23, 2021. https://www.scott.senate.gov/media-center/press-releases/scott-schatz-shaheen-introduce-bipartisan-legislation-to-increase-access-to-telehealth-in-the-midst-of-the-pandemic.

[5] Centers for Medicare and Medicaid Providers, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, U.S. Department of Health and Human Services, Feb. 19, 2020. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

[6] Courtney M. Joslin and Shoshana Weissmann, "Arizona may become the model state for telehealth access," *Washington Examiner*, Feb. 24, 2021 https://www.washingtonexaminer.com/opinion/arizona-may-become-the-model-state-for-telehealth-access.

Statement for Hearing on: "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

Submitted to the House Energy & Commerce

Subcommittee on Health

March 2, 2021

Every American deserves access to the care they need, when they need it, in a way that is safe and convenient for them. That is why America's Health Insurance Plans (AHIP) appreciates the Subcommittee's focus on the role telehealth has played in safely delivering needed care throughout the COVID-19 crisis. Throughout the pandemic, Americans have increasingly relied on telehealth to receive care and manage chronic health conditions while reducing their risk of exposure to the virus. With continued spread of the virus across the country, many Americans still not vaccinated, and significant portions of the population in rural or underserved areas, it is critical that we work together to ensure all American have access to safe, affordable care when they need it.

The growth in use of telehealth since the beginning of the pandemic has been substantial. In fact, a year-over-year analysis of telehealth claims to private health insurance providers showed a roughly 4,347% in growth of telehealth services[1]. Research from CivicScience indicated that this growth in demand came across all ages and demographics, including traditionally hard-to-reach populations such as seniors and rural residents[2]. Among the those experiencing significant growth are [3]:

- CVS Health, which saw a 600% growth in telehealth and virtual visits through their MinuteClinics in the first quarter of 2020 compared to the first quarter of 2019.
- UPMC, which saw telehealth visits jump from approximately 250 encounters per day to 9,500 per day (3700%) by the end of April 2020.
- Blue Cross of Idaho which processed more than 90,500 telehealth claims between March and June of 2020 with telehealth now representing more than one-quarter of all claims.

While the exponential growth in telehealth during COVID-19 is the result of the unique circumstances created by the pandemic, use of telehealth services were increasing well before the COVID-19 crisis. In fact, a study published in the Journal of the American Medical Association

[1] https://www.fairhealth.org/states-by-the-numbers/telehealth
[2] https://ww2.frost.com/news/pres-releases/telehealth-to-experience-massive-grwoth-with-covid-19-pandemic-says-frost-sullivan
[3] https://www.ahip.org/telehealth-growth-during-covid-19/

found that telemedicine visits increased at an average compound growth rate of 52% per year from 2005 to 2014[4]. A report by Frost & Sullivan projected 7-fold growth in telehealth by 2025 due to deployment of more mature analytics, better adherence to cybersecurity and privacy regulations, and use of data to show return-on-investment[2].

Patients and providers understand and experience the value of telehealth. They accept – and often prefer – digital technologies as an essential part of health care delivery. Telehealth delivers convenient access to affordable, high-quality care.

Patients can and do take advantage of telehealth from wherever they are, making it a vital tool to bridge health care gaps nationwide. For patients in rural communities, or areas that are underserved and have fewer doctors practicing, telehealth programs and remote patient monitoring can make care more efficient and sustainable. Patients can connect with a doctor within seconds, rather than driving long distances for an office visit. Patients who can access care remotely can also avoid challenges associated with taking time off work or finding childcare. Those accessing behavioral health services can do so without stigma and from the privacy of their own homes. Telehealth is a tool that can connect patients with care in the most convenient, comfortable setting.

Additionally, telehealth costs less. Telehealth leads to better management of chronic diseases, reduced travel times, reduced emergency department visits, and fewer or shorter hospital stays. Patients are healthier and have better peace of mind by getting the right care at the right time and in the right setting.

Much of the expansion of telehealth has been made possible through flexibilities implemented during the COVID-19 crisis. For instance, COVID relief legislation temporarily authorized the Secretary of Health and Human Services (HHS) to waive originating site requirements with respect to telehealth services under Medicare, as well as allowing more services to be delivered by increasing telehealth and audio-only services for the duration of the COVID-19 public health emergency (PHE). HHS also expanded practitioner eligibility and licensure applicability, waived telehealth visit cost sharing for Federal health care programs, and waived penalties for non-compliance with HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the PHE[5].

The Centers for Medicare & Medicaid Services (CMS) issued guidance allowing health insurance providers in the individual and group market to amend plan benefits during the 2020 plan year to expand coverage for telehealth services[6]. Most health insurance providers have since reduced or eliminated cost-sharing altogether for telehealth for all services or for services related to COVID-19, and broadened coverage of telehealth benefits by allowing coverage of more

[4] https://jamanetwork.com/journals/jama/fullarticle/2716547
[5] 45 C.F.R. §§ 160, 164 (2020). See www.govinfo.gov/content/pkg/FR-2020-04- 21/pdf/2020-08416.pdf (accessed Feb. 23, 2021).
[6] www.cms.gov/files/document/faqs-telehealth-covid-19.pdf

services and expanding in-network telehealth providers. CMS issued guidance on remote supervision of nurse practitioners and physician assistants, which expands the capacity to treat patients without every elements of care to be physically present.

In addition, many State Medicaid and CHIP programs expanded benefits to increase access to telehealth services for their members. States alleviated geographic and originating site restrictions and expanded the list of providers eligible to deliver care virtually.

There is Still Room to Grow

Despite the tremendous advantages telehealth brings to providers and patients, telehealth can create or exacerbate disparities in access, leaving some populations behind. Research conducted prior to the pandemic revealed that older Americans, people residing in rural communities, racial and ethnic minorities, and those with lower socioeconomic status can be disadvantaged by the "digital divide", meaning disparities in access to broadband, technologies and resources necessary to fully leverage the promise of telehealth.[7]. Leveraging traditional telephone access whether through land lines or cell phones to deliver audio-only telehealth appointments have been especially critical to ensuring that individuals who don't have access to the technologies required for more advanced telehealth options can still get the care they need.

But these disparities could worsen because of the economic impact of COVID-19, as vulnerable populations may have reduced or lost income and dropped their Internet or data plans to save money, turned off smartphones they can no longer afford, and lost access to publicly available WiFi with the closing of schools and libraries.

America's health insurance providers embrace digital solutions that help increase access to care and want to ensure that the people they serve, regardless of where they live or their economic situation, can access high-quality, safe and convenient care. To that end, many health insurance providers are working with their provider partners to bridge the digital divide.

Health Insurance Providers are Committed to Improving Affordable Access to Quality Care through Telehealth

For years, America's health insurance providers have offered telehealth as an effective and efficient way to deliver care. Health insurance providers offer telehealth benefits to their members and provide access to a large network of providers from multiple specialties. In 2019, 97% of large employers offered telehealth to their members through their insurance providers, an indication of how widespread access was even before COVID-19.

---

[7] Yoon, Hyunwoo, Yuri Jan, Phillip W Vaughan, et al. 2018. "Older Adults' Internet Use for Health Information: Digital Divide by Race/Ethnicity and Socioeconomic Status ." Journal of Applied Gerontology 105-110. doi:10.1177/0733464818770772. Anderson, Monica, and Madhumitha Kumar. 2019. "Digital divide persists even as lower-income Americans make gains in tech adoption." FactTank, Pew Research Center. https://pewrsr.ch/2vK1HIo. Perrin, Andrew, and Erica Turner. 2019. "Smartphones help blacks, Hispanics bridge some – but not all – digital gaps with whites." FactTank, Pew Research Center. https://pewrsr.ch/2Z1PKPf.

During the COVID-19 crisis, health insurance providers supported policy changes made by federal and state policymakers to encourage telehealth use and speed its adoption. Our member plans also invested to scale up telehealth capabilities so providers could continue to see patients safely. Many of AHIP's member organizations significantly expanded telehealth provider policies to reduce barriers to care and to encourage the use of telehealth services. Additionally, a number of health insurance providers added virtual capacity so that patients can see providers more quickly.

Most notably, many health insurance providers ensured that their members had no responsibility for cost-sharing for telehealth services. To encourage social distancing and help reduce the risk of spreading COVID-19, many insurance providers are extending these cost-sharing waivers today. These waivers have been valuable in promoting expanded use of remote behavioral health services, which was a key driver in the significant spike in use of telehealth and in its sustained growth.

Health insurance providers are also addressing the social determinants of health and providing access to technology to expand access to care during telehealth. For instance:

- Centene has worked with Samsung Electronics America to supply providers with 13,000 Samsung Galaxy A10e smartphones to disseminate to patients who would not otherwise have the ability to receive their health care virtually.
- CareOregon is working with providers to supply flip phones and basic smartphones along with data plans for their members.
- Blue Shield Promise (the Medicaid Managed Care Organization of Blue Shield of California) and LA Care partnered to establish resource centers for local communities to provide members with wellness programs and to connect them with local resources to address socioeconomic needs. As their services and programs moved online due to COVID-19, Blue Shield Promise and LA Care offered technology and WiFi to help their members access virtual programs, services, and telehealth.
- The Humana Foundation, in partnership with Older Adults Technology Services, Inc. (OATS), are launching a new effort to close the technology adoption gap and stress the importance of digital health tools and social connectedness through *Aging Connected* – a national campaign to bring at least a million older Americans online with high-speed internet by 2022.

In short, AHIP's members have worked to expand and strengthen telehealth at a time when patients needed it most. But as we start a conversation about what a post-COVID health care system will look like, it is important that Congress considers what policy changes are needed to help sustain the positive changes and solutions created during the crisis. Through these policy solutions, we can ensure that telehealth continues to deliver efficient access to care, enhances outcomes, and creates new opportunities for lower health care costs.

Addressing the Gaps

The growth of telehealth usage, the high satisfaction among patients and providers, and the prevalence of waivers in the pandemic all indicate that telehealth is here to stay. Health insurance providers in the private market are developing real solutions that address the specific health care needs of Americans.

AHIP is ready to work with Congress and the Administration to strengthen telehealth and establish policies that ensure its long-term sustainability. Policymakers can further advance this work by embracing additional comprehensive, multi-stakeholder approaches:

1) Making permanent the flexibilities in benefit design implemented during the PHE. The Coronavirus Preparedness and Response Supplemental Appropriations Act allowed the HHS Secretary to waive certain Medicare telehealth payment requirements, and the CARES Act enacted flexibility for commercial health insurance providers to cover telemedicine. Congress should pass legislation to make these provisions permanent and redefine how Medicare and Commercial and Individual Market enrollees can access telehealth. To solidify several of the regulation implemented by CMS and HHS during the COVID-19 crisis, Congress should revise the Social Security Act, section 1834(m) to allow for flexibility in benefit design for originating sites, eligible geographies, eligible services, and eligible providers. While telehealth may be no more subject to fraud and abuse than other modalities, it will be important to monitor the impact of telehealth on outcomes including quality and costs.

2) Passage of the **Ensuring Parity in Medicare Advantage (MA) for Audio-Only Telehealth Act.** This bipartisan bill, led by Reps. Terri Sewell (D-AL) and Gus Bilirakis (R-FL) would reduce health disparities that result from unequal access in health technology, broadband service, and video telehealth platforms. It also ensures that the 26 million seniors and people with disabilities who receive their Medicare benefits through MA would continue to receive the high-quality care on which they rely. If enacted, the *Ensuring Parity in MA for Audio-Only Telehealth Act* would allow CMS to count diagnoses from audio-only telehealth services for risk adjustment in the MA program.

Without the accurate documentation of diagnoses for MA risk adjustment, health insurance providers and their provider partners will have fewer resources to ensure wide-spread access, choices for Americans, low premiums, and supplemental benefits for seniors.

However, the Energy and Commerce Committee can act and strengthen telehealth during the COVID-19 crisis and beyond, by ensuring that health insurance providers and medical professionals have these resources to provide needed care to patients at this crucial time. We urge Members to pass the *Ensuring Parity in Medicare Advantage for Audio-Only Telehealth Act* to sustain the growth of telehealth and help improve health equity.

Conclusion

Everyone deserves access to affordable and quality care, whether delivered in-person or virtually. Together with the Administration, Congress, and our provider partners, health insurance providers are working to ensure that patients continue to have access to health care when they need it, and that no community is left behind. Health insurance providers have taken innovative steps to ensure that their members can take full advantage of telehealth to access the care they need in safe and convenient ways. AHIP thanks the Committee for focusing on this important issue, and we look forward to working together on more initiatives to improve health care in every community.

JOHNS HOPKINS
UNIVERSITY & MEDICINE

Statement for the Record

Submitted by Brian Hasselfeld, MD
Medical Director, Digital Health and Telemedicine at Johns Hopkins Medicine

U.S. House Committee on Energy and Commerce Subcommittee on Health
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Chair Eshoo, Ranking Member Guthrie and members of the Subcommittee, I appreciate the opportunity to submit a statement for the record and share with you one institution's experience and reflections on the role telehealth has played as a lifeline for millions of patients during the pandemic. As you consider the future state of health care, I offer five recommendations for policy changes needed to support telemedicine in a post-pandemic environment and one bill you should pass as soon as possible to help support access to care for the duration of the pandemic.

As a practicing physician, I lead digital health strategy and the Office of Telemedicine for Johns Hopkins Medicine (JHM), an integrated system of six academic and community hospitals, four suburban health care and surgery centers, a home care group, and numerous patient care locations in the Baltimore-Washington region and Florida that collectively serve nearly 4 million patients annually.

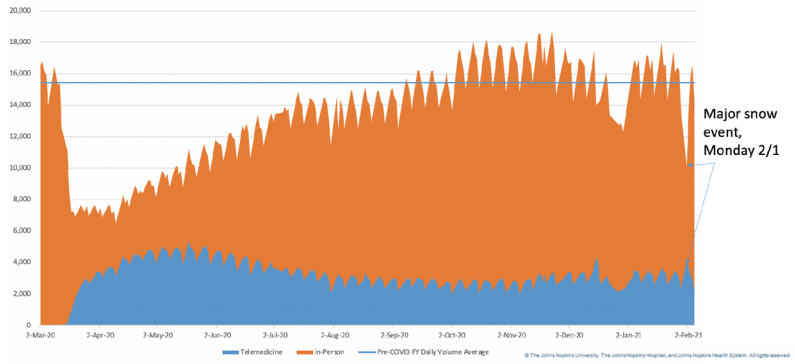
One year ago, in March 2020, Johns Hopkins recorded its first confirmed case of COVID-19. There is no question that during the course of the last 12 months, telehealth helped reduce the spread of the virus and saved lives. The critical flexibilities Congress and the Administration granted during the COVID-19 pandemic allowed providers, like those at Johns Hopkins, to be nimble and rapidly transform how we delivered care. Like other systems nationwide, JHM quickly scaled remote services to maintain vital connections to patients who otherwise would have delayed or skipped needed treatment.

JHM has been at the forefront of creating new and better ways to connect patients with providers for decades. Johns Hopkins also has embraced telehealth as a benefit within its managed care products where possible, including its Medicare Advantage offerings. While we will continue to do our part to leverage the benefits of technology-enabled care, we recognize that the most challenging work lies ahead as we strive to promote policies that will result in more equitable telemedicine delivery to patients already at risk of limited access to health care.

Telehealth Utilization During the Pandemic has been Substitutive, not Additive

Since March 2020, Johns Hopkins Medicine has conducted over 790,000 telehealth visits, or on average ~69,000 telehealth visits per month; before the pandemic hit, that number was fewer than 100 per month. When in-person visits fell precipitously in March 2020 due to a surge in COVID-19 cases in our region, Johns Hopkins providers were able to replace some of that care using telehealth modalities. Clinician and patient response to the new modality was impressive, given the relatively infrequent use before the pandemic. Initially, after a dramatic decline in healthcare engagement by patients, telemedicine has been a replacement option for many patients who prefer this modality, bringing our total volume back to our pre-COVID averages.

Total Ambulatory Volume (Video vs. In-Person Visits)



Note: Telemedicine and In-Person volumes are stacked (not overlapping).

Over time, as public health limitations lifted and patients began to feel more comfortable entering facilities for non-emergent care, we have seen a natural decline and leveling out in the use of telehealth, although it remains an important option for a number of our patients.

Ultimately, when selected as a clinically appropriate tool, telehealth requires similar skills, level of effort and training, history taking, and medical decision making as in-person care, and should be reimbursed similarly.

Audio-Only as a Tool for Promoting Health Equity

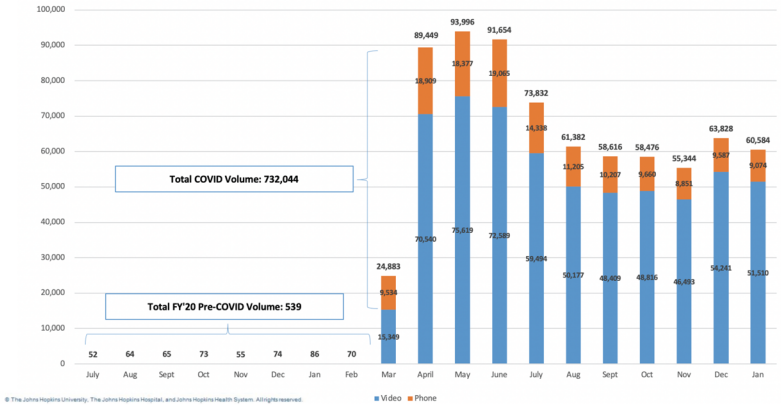
Researchers at Johns Hopkins have begun to explore how virtual care could be used to mitigate persistent disparities in U.S. health care. To best serve vulnerable patients, providers need to be able to continue to leverage all available tools, including audio-only care, after the expiration of the public health emergency (PHE). This will help ensure that telehealth's rapid expansion during the pandemic doesn't exacerbate inequities for some disadvantaged groups. Lawmakers should keep equitable access at the forefront of the discussion about permanent telehealth policy, particularly for patients enrolled in public insurance programs.

Telemedicine has played a key role in increasing access to care during the pandemic, but certain urban communities, like the neighborhoods that surround Johns Hopkins Hospital in downtown Baltimore, lack access to the broadband infrastructure to allow for video-based care. Compared to other cities, Baltimore has a higher proportion of households lacking both the hardware (laptop or desktop computer) and the wireline broadband for getting online.[1] The digital divide has adversely impacted disease monitoring and made it more difficult to fully evaluate the intersecting forces that contribute to racial disparities, including the underlying conditions and poverty that affect how the virus spreads across certain communities.

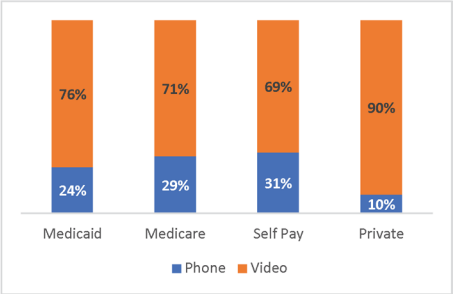
[1] "Baltimore's Digital Divide: Gaps in Internet Connectivity and the Impact on Low-Income City Residents," Abell Foundation, May 2020.
https://abell.org/sites/default/files/files/2020_Abell_digital%20divide_full%20report_FINAL_web%20(dr).pdf

JHM's experience demonstrates that clinically appropriate audio-only care can materially help health systems better meet the needs of underserved patients. On average, approximately 20 percent of JHM telemedicine visits systemwide used audio-only modalities, however, use of audio-only care is not distributed equally. JHM patients insured through Medicaid and Medicare relied on audio-only technology two and three times as often as commercially insured patients, and these trends remain little changed in 2021 compared to early in the pandemic.

Video and Phone Visit Volume Trends (Monthly)



Addressing Access Disparities: Audio-Only Care by Payor

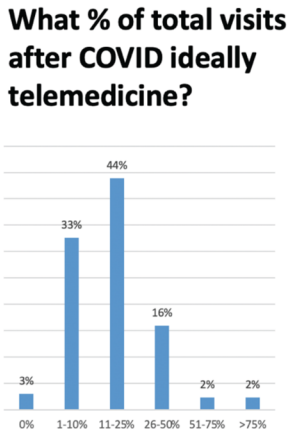


Some may argue that audio only care may not be as good as video care and so accepting audio only care for the vulnerable may worsen disparities. I encourage the committee to view audio only care as an option to promote more equitable healthcare access in the short term while long term access solutions are solidified. The long-term goal is that the digital divide will narrow and more people with have access to video-based care. But in the meantime, audio-only coverage is an essential stop gap measure to prevent a two-tiered system. Can you imagine, as a provider, if a video visit fails and having to say "sorry I can't help you today"? Often times, patients and providers may chose audio care because it is the only viable option given real world constraints (child care, time off work, transportation and parking, language and technology literacy); it is certainly preferrable to no care at all.

Being able to schedule audio only care for those who don't have video access, or convert to audio only in the moment for those who have unanticipated technical failure are important flexibilities to ensure providers can deliver care in this imperfect digital world. With appropriate rules to guard against improper use, audio-only should remain a critical tool to help address equity and access issues in a post-pandemic world.

Survey of Patients and Providers: Post-COVID

The Johns Hopkins Office of Telemedicine recently conducted a survey of patients' experience with, and providers expectations around, telemedicine. Out of 1,935 patients surveyed, 88 percent said having a video visit option would be very or extremely important for future care; 9 out of 10 respondents would recommend telemedicine to friends or family. In testimonials, patients expressed appreciation for the unique flexibility and efficiency of virtual care.



In a survey of 221 Johns Hopkins primary care providers, 64 percent stated that 11 percent or more of their total visits would ideally be conducted via telemedicine after the pandemic. Only 3 percent stated that they would conduct no telemedicine. Importantly, providers also note that telemedicine has increased their joy and satisfaction at work, pointing to flexible hours and the ability to work from home as major benefits of telemedicine.

With this background as context, the following are policy recommendations I offer on behalf of JHM as consideration for the Health Subcommittee.

JHM Telehealth Policy Recommendations

1. **Lift geographic and originating site requirements.** Section 1834(m) of the Social Security Act restricts the delivery of telehealth services to certain rural areas (geographic site restrictions) and certain physical locations, such as hospitals and physicians' offices (originating site restrictions). These outdated restrictions are the product of another era and should be modernized to keep pace with the future of health care. As we have seen in the pandemic, where restrictions were rapidly lifted, easing access in this space did not generally result in an overall increase in utilization. I urge Congress to permanently remove these restrictions from statute.

2. **Make provider enrollment flexibilities permanent.** Under 42 CFR 424.516, providers rendering services from a site other than their clinical practice must add each address to their CMS enrollment file. Fortunately, this requirement was waived during the PHE, permitting flexibility in provider location when delivering telehealth services. I urge Congress to ensure these flexibilities become permanent, thus permitting increased workforce efficiency in delivering care to patients.

3. **Permit telehealth services via audio-only communication.** CMS has interpreted statutory description of "services that are furnished via a telecommunications system" to mean that Medicare telehealth services must be furnished using video technology. Legislation is needed to permanently codify that telecommunications services can, in certain instances, include audio-only communication. It is vital that audio-only services remain available as an option to ensure access to services for the most vulnerable patients and prevent further exacerbating the digital divide.

4. **Reimburse for chronic disease management and monitoring in the home.** CMS established flexibility to allow professionals that provide home health and hospice services to do so via telehealth and bill accordingly during the PHE. Congress should create new statutory authority to allow all physician-ordered, clinically-appropriate home health services to be provided via telehealth. In addition, Congress should permit individuals to self-monitor (collect and document) their health and securely share the data with their providers, and permit inclusion of this information in important quality and outcome reporting.

5. **Encourage mutual recognition of state licensure post-COVID.** We have seen licensure limits substantially restrict access during this unprecedented COVID-19 emergency period. To maximize the utility of telehealth options and ensure provider accountability, state regulatory entities and officials (e.g., governors, state legislatures, medical boards and licensing agencies) should work together to implement durable solutions to facilitate and promote mutual recognition of health professional licensure, reduce duplicative paperwork and processes, and allow patients to see the provider of their choice regardless of their location.

Finally, as soon as possible, **I urge Congress to enact emergency legislation to establish temporary state licensing reciprocity as proposed in the Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168/H.R. 708).** The TREAT Act is narrowly tailored to address a critical need during the pandemic by maintaining access to care when travel is ill-advised and

facilitating efficient deployment of health care personnel where they are needed most. The bill enables providers licensed in good standing in one state (and not barred in any other state) to treat patients in any state. This short-term patch retains state-based licensing, but ensures uniform reciprocity to ease access during the crisis. Swift action on this important legislation is needed so that Americans can make the best use of telehealth technology and reduce exposure risk for patients and providers. For Johns Hopkins, this need became quickly apparent last Spring after students were abruptly sent home to other states and when patients from across our health system were suddenly unable to travel for cancer treatments and care for other rare conditions. Moreover, newly diagnosed patients were prevented from seeking second opinions or starting treatment with preeminent experts at Johns Hopkins and other leading institutions. Many of the needed services could be done remotely, but only if the clinician is licensed in the patient's state. After the pandemic, some patients will again be able to drive or fly across state lines to see their chosen provider but current recommendations to stay at home as much as possible highlight why the TREAT Act is desperately needed today.

Conclusion: Telehealth is an important tool in the toolbox

In my clinical practice and as a senior executive tasked with executing our institution's telehealth strategy in the midst of a pandemic, I have seen the intangible, un-"score"able benefits of telehealth. For my pediatric patient with poorly controlled asthma, I can spot home triggers such as pets, carpets, and tobacco via telemedicine, providing insight I would not gain in an office visit. My adult patient with the ever-changing medication regimen no longer has to worry about forgetting their long list of prescriptions at home. It is the modern equivalent of a "home visit" and another tool in the toolkit to enhance and facilitate care for my patients. I look forward to working with you to fulfill the promise of telemedicine in a thoughtful manner, and would be happy to make myself available for questions or follow up.

HOUSE COMMITTEE ON ENERGY AND COMMERCE
HEALTH SUBCOMMITTEE
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
Tuesday March 2, 2021
10:30AM
Statement for the Record
The American Pharmacists Association

The American Pharmacists Association (APhA) appreciates the opportunity to submit the following Statement for the Record for the March 2, 2021 U.S. House Energy and Commerce Health Subcommittee hearing "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care."

APhA is the largest association of pharmacists in the United States and the only organization advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health. Advancing pharmacists' role in providing patient-care services via telehealth is one of APhA's strategic priorities. To meet the telehealth demands of the COVID-19 public health emergency (PHE), APhA established a Telehealth Advisory Committee to guide our advocacy, practice, and educational efforts; developed telehealth practice resources;[1] included telehealth programming in our upcoming March 12-15th *APhA2021 Annual Meeting & Exposition*;[2] and organized an inaugural digital health summit, *DigitalHealth.Rx*, on March 11, 2021.[3]

The rapid shift to telehealth services during the PHE has illustrated the value of telehealth long-term, particularly for patients with mobility issues and those in rural and/or medically underserved areas. Prior to the PHE, pharmacists were already actively involved in virtual care delivery for Medicare beneficiaries through provision of Part B services such as Chronic Care Management (CCM), Transitional Care Management (TCM), Continuous Glucose Monitoring (CGM), Remote Patient Monitoring (RPM), and Behavioral Health Integration (BHI), as well as Medication Therapy Management Services in the Part D program. The onset of the COVID-19

[1] See "Telehealth During COVID-19," available at https://www.pharmacist.com/coronavirus/telehealth
[2] See *APhA2021 Annual Meeting & Exposition* Telehealth sessions, "Telehealth Part 1: Health Care's Answer to a Pandemic" and "Telehealth Part 2: Choosing the Best Technology for Virtual Care," available at https://apha2021.pharmacist.com/
[3] See *DigitalHealth.Rx* Summit, available at https://apha2021.pharmacist.com/agenda.asp?startdate=3/11/2021&enddate=3/11/2021&BCFO=&pfp=days

2215 Constitution Avenue, NW • Washington, DC 20037-2985 • 202-628-4410 • Fax: 202-783-2351
www.pharmacist.com

pandemic has brought about additional opportunities to leverage pharmacists in telehealth services, including medication management services, chronic disease management, education on healthy lifestyle interventions, interpretation of, and patient counseling on point of care diagnostic tests, and more.

APhA would like to thank Subcommittee Chair Eshoo and Ranking Member Guthrie for holding this hearing and recommends that Congress take the following steps to enhance patient access to telehealth services:

- Make Permanent the Authority Allowing Direct Supervision to be Provided Using Real-Time Interactive Audio and Video Technology under Incident to Physician Services Arrangements
- Make Permanent the Authority Allowing Medicare-enrolled Pharmacies Offering Accredited Diabetes Self-Management Training (DSMT) Programs to Offer DSMT Services via Telehealth
- Designate Pharmacists as Practitioners (Providers) for the Medicare Telehealth Benefit, and Add Patient Care Services Provided by Pharmacists Using Telehealth to the Medicare Telehealth List
- Ensure Medicare Payment for Pharmacist-provided Telehealth and In-Person Services is Commensurate with the Time and Complexity of the Services Provided
- Make Permanent Medicare Coverage and Payment of Audio-Only Telephone Calls for Opioid Treatment Program Therapy, Counseling, and Periodic Assessments

Make Permanent the Authority Allowing Direct Supervision to be Provided Using Real-Time Interactive Audio and Video Technology under Incident to Physician Services Arrangements

In order to accommodate the provision of telehealth services during the COVID-19 PHE, the Centers for Medicare and Medicaid Services (CMS) relaxed its rule requiring physicians to provide "direct supervision" of auxiliary personnel, including pharmacists, in situations where direct supervision currently is required by regulation.[4] In these situations, during the PHE, physicians may provide direct supervision of pharmacists using real-time interactive audio and video technology. APhA urges Congress to make this flexibility permanent regardless of whether there is a declared PHE. Real-time "virtual" supervision of pharmacist services, where direct supervision is required, will help meet the growing demand for telehealth services and expand access to care.

Make Permanent the Authority Allowing Medicare-enrolled Pharmacies Offering Accredited Diabetes Self-Management Training (DSMT) Programs to Offer DSMT Services via Telehealth

Diabetes Self-Management Training (DSMT) programs teach essential skills to people with diabetes, including proper nutrition and physical activity, maintaining glycemic control, and other important selfcare tasks, such as blood glucose monitoring and insulin administration. The

[4] 85 Fed. Reg. 19230

provision of DSMT services via telehealth has improved rural/underserved populations' access to care during the PHE, and has provided a safe environment for patients to receive DSMT services remotely instead of the normally required group setting where social distancing would likely be problematic. APhA appreciates CMS' guidance[5] clarifying that accredited and recognized DSMT programs, eligible to bill Medicare Part B directly for DSMT services, may furnish and bill for DSMT services provided via telehealth during the COVID-19 PHE, and urges Congress to make this authority permanent. The addition of DSMT programs to the list of "professionals" eligible to provide telehealth services has allowed pharmacists in DSMT accredited pharmacies to furnish these services to Medicare beneficiaries via telehealth modalities and be reimbursed for them, thus enhancing diabetic patients' access to care.

Designate Pharmacists as Practitioners (Providers) for the Medicare Telehealth Benefit, and Add Patient Care Services Provided by Pharmacists Using Telehealth to the Medicare Telehealth List

The Coronavirus Aid, Relief, and Economic Security Act (CARES) Act (P.L. 116-136) under Sec. 3703. Expanding Medicare Telehealth Flexibilities eliminated requirements in the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123) and allows the Secretary of Health and Human Services to waive telehealth restrictions under 1834(m) to enable beneficiaries to access telehealth, including in their home, from a broader range of providers—including pharmacists. Given the significant burdens on the health care system posed by the COVID-19 PHE, APhA urges Congress to designate pharmacists as practitioners (providers) for the Medicare Telehealth Benefit in order to fully utilize their expertise both during and after the end of the PHE.

In addition, APhA urges Congress to add patient care services provided by pharmacists using telehealth, particularly services provided outside of inpatient settings, to the Medicare Telehealth List.[6] Many patient care services provided by pharmacists are clinically appropriate for telehealth, including medication management services, chronic condition management (e.g., diabetes, hypertension), pharmacogenomics, interpretation of point of care diagnostic tests and providing patient counseling on test results, and consultations with patients and health care providers.

Ensure Medicare Payment for Pharmacist-provided Telehealth and In-Person Services is Commensurate with the Time and Complexity of the Services Provided

To ensure telehealth services are financially sustainable, physicians and other non-physician providers (NPPs) must be able to bill for pharmacist-provided telehealth and in-person services at a level commensurate with the time and complexity of the services provided. However, the 2021 Medicare physician fee schedule rule[7] only allows payment to physicians and other NPPs for pharmacists' evaluation and management (E/M) services at the least complex services level

---

[5] CMS COVID-19 FAQs on Medicare Fee for Service Billing (pages 82-83). Updated 2/19/2021, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

[6] Medicare List of Telehealth Services, available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

[7] 85 Fed. Reg. 84472

(limited to 7 minutes). It is inconceivable that a pharmacist providing a 45-minute office visit to manage multiple chronic conditions and multiple medications for a Medicare beneficiary under an incident to arrangement with a physician is limited to having the service billed as a Level 1 visit (CPT Code 99211), that only has an anticipated time commitment of 7 minutes. Such a provision eliminates any incentive and/or ability for physicians/NPPs and pharmacists to partner to provide complex health care services. This misaligned Medicare payment policy for pharmacists' services performed in incident to physician services arrangements continues to be a significant barrier to broad use of pharmacists in team-based care models during the PHE and beyond.

Accordingly, APhA strongly urges Congress to ensure that physicians and other qualified practitioners can bill for pharmacist-provided "incident to" services provided both in-person and via telehealth to Medicare beneficiaries at higher E/M codes within their state scope of practice and training (CPT Codes 99212-99215) when the service provided meets the billing requirements for a specific E/M code.

Make Permanent Medicare Coverage and Payment of Audio-Only Telephone Calls for Opioid Treatment Program Therapy, Counseling, and Periodic Assessments

During the COVID-19 PHE, CMS revised its regulations[8] to allow audio-only telephone calls for the therapy and substance use counseling portions of the weekly bundles and the add-on code for additional counseling or therapy for beneficiaries with opioid use disorders, provided all other requirements are met. Providers may conduct the periodic patient assessments via two-way interactive audio-video communication technology or by telephone only in cases where the beneficiary does not have access to two-way interactive technology. Congress should make these authorities permanent. Emerging data is demonstrating that meeting people with their available technology expands care, counseling, and referral. This is a health equity measure to assist minorities and underserved communities and aligns with President Biden's Executive Order "On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," to "pursue a comprehensive approach to advancing equity for all."[9]

APhA would like to close by thanking the Subcommittee for its efforts to advance telehealth services in order to expand patient access to care. Please contact Alicia Kerry J. Mica, Senior Lobbyist, at AMica@aphanet.org or by phone at (202) 429-7507 as a resource as you consider telehealth legislation. Thank you again for the opportunity to provide comments on this important issue.

[8] 42 CFR § 410.67(b)(3) and (4)

[9] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

Telehealth: Addressing the Growing Demand for Behavioral Health Services During COVID and Beyond

When the COVID-19 pandemic began spreading through the United States, prompted immediate shutdowns across the country and a declaration of the Public Health Emergency (PHE); Centerstone, the nation's largest not-for-profit behavioral health healthcare organization, quickly transitioned from a traditional, in-person services model to one that was predominately virtual.

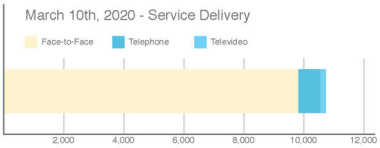
Following is a summary of this transition in terms of trends in utilization, clinical outcomes, and the patient experience that resulted from the pandemic – almost overnight – cutting decades of red-tape around virtual care delivery and launching the nation's largest ever trial period around digital care delivery.

Before the PHE

< 5% of our service encounters delivered via telehealth

< 3% of our services for MAT clients delivered via telehealth

Majority of our **3,500+** employees worked in an **office setting**

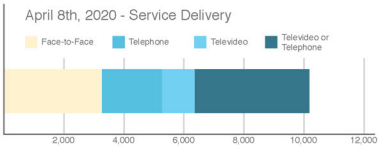


After the PHE

> 80% of our service encounters delivered via telehealth within one month of the PHE

> 45% of our services for MAT clients now delivered via telehealth

Majority of our **3,500+** employees moved to a **remote work environment**



Transitioning to Telehealth: Consumer Impact and Clinical Findings

"Grandmother who is caring for 3 preschool grandchildren so their mother can work often found it difficult to find someone to watch them so she could do in-office sessions to treat her mood disorder and prevent relapse to alcohol use. Because of audio only, she now never misses a weekly phone therapy session."

"Client who is care taking for a husband with Alzheimer's and a foster child. She found it challenging to get someone to care for her family members and drive the 45 minutes to my office. Doing telephone therapy has made life less stressful for and increased adherence in her own care."

Client satisfaction with outcomes, the ability to manage mental health, and depressive symptoms were on par with face-to-face outcomes at 6 months.

A Growing Need for Telehealth Access

Now more than ever, continuing access to mental health and substance use disorder services via telehealth is crucial to manage the growing need now and after the PHE.

Over 40 states have seen a **rise in opioid-related overdose deaths** since the start of the pandemic.

One in four young adults between the ages of 18 and 24 say they've **considered suicide** because of the pandemic.

From May to October 2020 Centerstone experienced a **44% increase in call volume** with more and more consumers reaching out for urgently needed help.

The pandemic ripple effects - social isolation, increasing unemployment, fear of becoming ill, the loss of loved ones - are projected to have lasting impacts on the rates of severe depression, anxiety, and substance use disorder for years to come.

As a nation we must take action now to ensure we are equipped for an emerging mental health crisis. Continuing the emergency telehealth waivers can play a critical role toward ensuring patient access.

CENTERSTONE

For more information, contact Lauren Conaboy, VP of National Policy, at Lauren.Conaboy@centerstone.org

MHLG | MENTAL HEALTH LIAISON GROUP
MENTAL HEALTH AND ADDICTION ADVOCATES ADVANCING POLICY, LEADING CHANGE

February 22, 2021

The Honorable Patty Murray
Chairwoman
Senate Committee on Health, Education, Labor, and Pensions
154 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Frank Pallone
Chairman
House Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, D.C. 20515

The Honorable Richard Burr
Ranking Member
Senate Committee on Health, Education, Labor, and Pensions
217 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Cathy McMorris Rodgers
Ranking Member
House Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Murray, Chairman Pallone, Ranking Member Burr and Ranking Member McMorris Rodgers,

The undersigned organizations are in support of the recent reintroduction of the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (H.R. 708/S. 168) led by Senators Murphy (D-CT) and Blunt (R-MO) and Representatives Dingell (D-MI) and Latta (R-OH). The legislation would increase access to health care services during the national COVID-19 public health emergency by allowing practitioners with valid licenses to provide services, including telehealth services, in all states for the duration of the public health emergency. We urge the Senate Committee on Health, Education, Labor, and Pensions and the House Committee on Energy & Commerce to consider the TREAT Act within committee and advance the legislation.

The health care system has been stretched thin during the COVID-19 pandemic, worsening pre-existing provider shortages. The United States needs a strong health care workforce to effectively combat COVID-19 and its accompanying conditions.[1] With fewer providers, rural and disadvantaged communities are left even further behind. Prior to the pandemic, 75% of U.S. counties experienced severe shortages of mental health providers.[2] The COVID-19 pandemic is exacerbating a health care issue that has plagued large portions of the U.S. for decades.

According to a Kaiser Family Foundation Tracking Poll conducted in early December of 2020, 51% of adults in the U.S. reported that their mental health had been negatively impacted by worry and stress over COVID-19. Only 39% of U.S. adults reported the same in May.[3] Many adults are also reporting specific negative impacts on their overall mental health and well-being due to worry and stress over the coronavirus, including difficulty sleeping (36%) or eating (32%), increases in

[1] New AAMC Report Confirms Growing Physician Shortage. (2020, June 26). Retrieved from https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage.
[2] Macher, D., Seidman, J., Gooding, M., & Diamond, C. (2020, May 11). *COVID-19 is Stressing a Fractured Mental Healthcare System in the US*. https://avalere.com/insights/covid-19-is-stressing-a-fractured-mental-healthcare-system-in-the-us.
[3] Lopes, L., Kearney, A., Kirzinger, A., Hamel, L., & Brodie, M. (2020, December 18). *KFF Health Tracking Poll – December 2020: COVID-19 and Biden's Health Care Agenda*. https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-december-2020/.

alcohol consumption or substance use (12%), and worsening chronic mental health conditions (12%).[4] In addition, the report stated that ongoing and necessary public health measures create conditions linked to poor mental health outcomes, such as isolation and job loss.[5] Last, 51.83% of all telehealth diagnoses in September were mental health conditions, a figure that continued to rise monthly indicating that many Americans were turning to telehealth for pandemic-related stress.[6]

The TREAT Act aims to increase access to crucial health services during this time by temporarily permitting health professionals to practice across state lines. The bill stipulates that a provider who holds a valid license in any state (and is not barred in another state) can practice in accordance with applicable state law in every state during the national public health emergency and during a 180-day transition period after the declaration is lifted. When the Secretary of Health and Human Services has declared a public health emergency, and when the president has declared an emergency under the National Emergencies Act or the Stafford Act for at least 12 states, the Secretary may invoke this authority, thus expanding lifesaving services during times of need.

The TREAT Act will improve access to providers of all kinds, including mental health providers, by allowing individuals in areas experiencing shortages to access care from across the country. The legislation will provide increased flexibility for providers, potentially raising the number of providers willing and able to work during this national crisis. For these reasons and the health of your constituents, we urge you to bring the TREAT Act forward for consideration in the Senate Committee on Health, Education, Labor and Pensions and House Committee on Energy and Commerce.

Thank you for your efforts to protect and expand Americans' access to important and necessary health services during this national emergency. We look forward to continuing to work with you to address mental health care needs throughout the country.

Sincerely,

2020 Mom

American Association for Marriage and Family Therapy

American Association for Psychoanalysis in Clinical Social Work

American Association of Geriatric Psychiatry

American Association of Suicidology

American Foundation for Suicide Prevention

American Group Psychotherapy Association

---

[4] Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., . . . Chidambaram, P. (2020, August 21). The Implications of COVID-19 for Mental Health and Substance Use. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.
[5] Ibid
[6] Gelburd, R. (2020, December 1). *Telehealth Claims Rise 2980% in One-Year Period Through September 2020.* https://www.ajmc.com/view/telehealth-claim-lines-rise-2980-in-one-year-period-through-september-2020.

Anxiety and Depression Association of America

Association for Ambulatory Behavioral Healthcare

Association for Behavioral Health and Wellness

Centerstone

Children and Adults with Attention-Deficit/Hyperactivity Disorder

Children's Hospital Association

College of Psychiatric and Neurologic Pharmacists

Consortium Representing Eating Disorders Care

Eating Disorders Coalition for Research, Policy & Action

EMDR International Association

Global Alliance for Behavioral Health and Social Justice

International OCD Foundation

International Society for Psychiatric Mental Health Nurses

The Jewish Federations of North America

Maternal Mental Health Leadership Alliance

Mental Health America

National Alliance on Mental Illness

National Association for Behavioral Healthcare

National Association for Children's Behavioral Health

National Association of County Behavioral Health and Disability Directors

National Association of Rural Mental Health

National Association of Social Workers

National Council for Behavioral Health

National Federation of Families

National Register of Health Service Psychologists

Postpartum Support International

Schizophrenia and Related Disorders Alliance of America

SMART Recovery

The Jed Foundation

The Kennedy Forum

The National Alliance to Advance Adolescent Health

The Trevor Project

Treatment Communities of America

Well Being Trust

To: Members of the Energy & Commerce Subcommittee on Health

From: Andrew Schwab, United States of Care Director of Policy, Federal Affairs & Partnerships

Subject: Background Info for March 2, 2020 Energy & Commerce Subcommittee Hearing "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

Date: February 26, 2021

As the Subcommittee considers the future of telehealth in the wake of the COVID-19 pandemic, USofCare wanted to provide members with what we have learned about people's experiences with telehealth -- what people have liked, as well as barriers they have encountered and concerns they have about telehealth -- in order to inform discussions from the perspective of people.

At USofCare, we approach our work by centering people's needs to drive action. To do this, we are leveraging our listening research to understand people's diverse experiences with virtual care, and identifying policies and approaches for health care leaders and policymakers that reflect people's priorities and close gaps in access.

On telehealth, we are examining the key question "Can virtual care be used as a tool to identify inequities and close gaps in access to care?" We define virtual care as: "health care services delivered remotely through digital technology including telehealth, telemedicine, remote monitoring, video, audio, and instant messaging (synchronous or asynchronous)."

Public Opinion Findings on People's Experiences with Virtual Care

To inform our work, USofCare fielded a national survey at the end of November 2020 of 1,000 registered voters where we asked questions about people's experiences with the health care system overall, as well as virtual care specifically. Our findings indicate:

- 44% of respondents overall had received virtual care, most doing so as a result of COVID-19.
    - About half of those who received it identified as Republicans and half as Democrats.
    - 59% of people with a disability said they had used it.
    - 73% of those who used it said they had a mental health disorder.

- Overall, there is wide support for the convenience of virtual care, especially during the pandemic. 87% had something positive to say about their virtual care experience, and 72% appreciated the convenience of not having to leave their place of residence to receive care and the ease of scheduling.
- However, many respondents had questions about the accuracy of care and concerns about the use of technology, which needs to be considered as virtual care policies are formalized.
- This aligns with what we have heard in our one-on-one interviews too. For example, one older adult we interviewed said:
    - *"I would NOT explore virtual care if I had to do it on a computer or any other way -- than a phone call -- because then I would need help from other people and I believe that health care appointments should be private."*
- Additionally, of the 53% who HAD NOT utilized virtual care, 16% had not done so because they felt it wouldn't be personalized or meet their specific care needs.
    - In our focus groups, we also had several participants question whether they would receive sub-par or more impersonal care if not done in person.

Older Adults' Experiences with Virtual Care

USofCare also conducted targeted research on older adults (age 50+) and their experience with virtual care, including mixed method research through national surveys, public opinion scans, and focus groups, and a review of older adult care models that have integrated virtual care into their care delivery. Through this work, we found that:

- During the pandemic, virtual care has proven critical to maintaining the health of older adults. To access virtual care, older patients have had to adapt to online platforms.
- *Older adults who have participated* and have the resources to do so strongly support using virtual care. *Older adults who have not participated* primarily say they have not needed it.
- If given a choice, older adults would not replace in-person visits with virtual care. Instead, they would utilize a combination, or else return to in-person visits altogether.
- Barriers and concerns that older adults encountered when utilizing virtual care include:
    - Lack of Comfort Using Technology and Digital Literacy, meaning:
        - Lack of comfort or unfamiliarity with technology including computers, tablets, and remote monitoring devices
        - Lack of comfort or unfamiliarity with online platforms including

downloading software and online forums
- Reliable and Accessible Internet, meaning:
  - Limited, inconsistent, or no access to internet service
- Quality and Personalization, meaning:
  - Concerned there will not be a personal connection to a provider via virtual care
  - Concerned their unique health care needs will not be met
- Accurate Assessment, meaning:
  - Concerned their provider would miss something in an exam
  - Concerned their provider could not conduct a thorough physical exam

What E&C Members Should Know

- Our data shows that getting people the care they need when they need it, rather than waiting until it's an emergency, is critical. Whenever clinically appropriate, patients must have the flexibility to choose how they would like to receive their care whether it is in-person or through virtual modalities. Policymakers and health care providers should create a blend of in-person care alongside permanent virtual care policies that address barriers people experience in accessing virtual care so that virtual care is a viable option for everyone.

Statement of the California Hospital Association for the

Subcommittee on Health of the Committee on Energy and Commerce

of the U.S. House of Representatives

"How COVID-19 is Changing the Delivery of Virtual Care"

March 2, 2021

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) thanks the Subcommittee on Health of the Committee on Energy and Commerce for holding a hearing on "How COVID-19 is Changing the Delivery of Virtual Care," and for the opportunity to provide written comment for inclusion in the record.

During the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) extended significant regulatory flexibilities that allowed hospitals and health systems to greatly expand the use of telehealth and other virtual services. These flexibilities include the removal of geographic, originating site, and provider type restrictions; the ability to see both new and established patients via telehealth; and equivalent provider reimbursement for services provided via telehealth and in-person. They have been critical to maintaining access to care for patients while preventing the spread of COVID-19.

As we begin to look beyond the PHE, it is clear from the expansion of these innovative modes of virtual care to new patient populations that telehealth will continue to be an important method for improving access to care and reducing barriers to entry for some of our most vulnerable populations. After a year of experience with increased telehealth utilization, clinicians have become comfortable with telehealth and virtual visits as an additional tool to evaluate patients, manage chronic conditions, and provide follow-up care. Patients — including a significant number of Medicare beneficiaries — have also come to expect telehealth visits as an option for care, and Congress must act to ensure they continue to have that option long after the COVID-19 PHE ends.

In particular, CHA recommends Congress address legislative and regulatory barriers in the following ways:

- **Eliminate geographic and originating site restrictions.** While CHA continues to believe that telehealth services are extremely important to addressing the unique challenges of rural communities, we also support access to telehealth for patients who reside in suburban and urban areas of the state. Expanded access to telehealth in these communities is particularly important for vulnerable patients who do not have reliable access to transportation, and for whom a virtual follow-up visit could be key to managing a chronic condition. The COVID-19 PHE telehealth waivers have also significantly contributed to an expansion in access to critical behavioral health services — a segment of our health care system where patients in all geographic locations often experience provider shortages. In addition, originating site

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 • *Telephone:* 202.488.3740 • *Facsimile:* 202.488.4418
1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

restrictions must be lifted to ensure that patients can continue to utilize telehealth services from their homes.

- **Allow telehealth services for both new and established Medicare patients without a prior face-to-face visit.** Telehealth services can greatly expand access for both new and established patients. Clinicians are well trained to determine whether a telehealth or face-to-face visit would be more appropriate for every patient in any specific situation. Allowing clinicians the option to evaluate a new patient via telehealth is an important step to expanding access to these services.
- **Ensure appropriate reimbursement for telehealth services.** Telehealth services require significant investments in technology, as well as the time and expertise of clinicians providing the services. In addition, telehealth will never replace the need for in-person care, and hospitals must always maintain the infrastructure to support necessary in-person care. Reimbursement policies must recognize the costs associated with providing telehealth services and maintaining technology, and ensure that telehealth and virtual services provide payment equitable to in-person care.

We look forward to working with the Subcommittee on Health of the Committee on Energy and Commerce to advance initiatives that continue to improve access to care beyond the pandemic. If you have any questions, please do not hesitate to contact Anne O'Rourke, senior vice president of federal relations, at aorourke@calhospital.org.

Quality, Safety, Value: Impact of sudden shift to telehealth due to COVID-19 within Nurse-led care models located in Colorado rural and urban communities (Barton)

This research project will examine the impact of the sudden shift to telehealth due to the pandemic on vulnerable patients seeking nurse-led care within behavioral health, primary and prenatal care, and home visitation models in urban and rural communities across Colorado. Using the state's innovative collaboration network, the study will examine within- and between-group telehealth innovations and challenges by using uniform and patient-level claims data, surveys and interviews based on an observational, time series design. The research will provide evidence on the consequences of the rapid shift to using telehealth on healthcare utilization, patient outcomes (intended/unintended), and provider/patient experience.

University of Colorado-Denver ($933,299)

People Are Primary Survey: Primary Care and Telehealth (Etz):

This research project will examine findings from a weekly primary care clinician-based national survey initiated at the start of the pandemic that monitors the response, challenges, and capacity of US primary care practices, and includes a complimentary patient survey. The primary aims of this project are to assess the impact of this rapid adoption on access to primary care during the pandemic, with special attention to vulnerable practices (rural, small, independent) and patient populations (minority, low SES, living with multiple chronic conditions). As well as to describe the positive, negative, and unintended consequences of rapid adoption of digital health on patient-clinician relationships and patient and clinician experience of care delivery during the pandemic.

Virginia Commonwealth University ($996,002)

Evaluating and Enhancing Health Information Technology for COVID-19 Response Workflow in a Specialized COVID-19 in a Medically Underserved Community (Kaufman):

This research project will identify whether current health information technology (HIT) meets decision-makers' needs regarding workflow integration and data access for responding to COVID-19 challenges. This will be done by analyzing applications, roles, tasks, information needs, communication, interfaces, decisions, and the sequence of activities for the emergency management response team. The project will develop a set of HIT prototypes that will include the use of dashboards, visualizations, and data integration tools to address information needs and enhance decision-making.

SUNY – Downstate Medical Center ($910,684)

Improving Safe Antibiotic Prescribing in Telehealth: A Randomized Trial (Meeker):

This study will conduct a randomized trial to identify variations in antibiotic prescribing and patient satisfaction at qualifying visits by testing the CDC Core Elements of Outpatient Antibiotic Stewardship in a representative telehealth setting that includes and evaluate the impact of behavioral variations to

interventions. Using a mixed methods approach, the study will generate a better understanding of prescribing practices in the rapidly growing telehealth sector, including what factors are most associated with antibiotic overuse. In addition, the research project will adapt interventions tested in outpatient clinics that are consistent with CDC Core Elements to telehealth, so that the findings will facilitate judicious use of antibiotics.

University of Southern California ($482,844)

A Multi-Site Evaluation of Primary Care Accessibility and Utilization during COVID-19 (Ratwani):

This research project whether patients were able to access primary care during the pandemic, and if certain subpopulations were disproportionately affected and if any were completely barred from accessing primary care. Based on , based on rich patient encounter data and administrative data and semi-structured interviews of providers, patients, IT experts, and operation managers, the study will assess the experiences of three large integrated healthcare systems (one in the east, one in the west and one in the middle of the country) by examining primary care responses to Covid-19 pandemic and the issues around innovative use of telemedicine technologies and different modalities (in-person, telehealth [video or phone], asynchronous communication, or multiple modalities]) to care vulnerable populations.

MedStar Health Research Institute ($999,380)

Florida Telehealth Shift Impact on Health (Shenkman):

The purpose of the study is to quantify the effects of ceasing in-person outpatient visits, and the resulting increased use of telehealth modalities, among patients with differing social vulnerabilities on their disease control (e.g. HbA1c, systolic blood pressure), and health care use (inpatient admissions and emergency department visits) with a study population of 14 million Floridians. The study is based on a mixed methods design that pair clinical data with interviews and surveys of health system leaders and patients, and leverages the natural experiment that occurred with the rapid transition to telehealth, and for some health systems, the transition back to in-person visits.

University of Florida ($999,840)

Leveraging Health System Telehealth and Informatics Infrastructure to Create a Continuum of Services for COVID-19 Screening, Testing, and Treatment: A Learning Health System Approach (Simpson):

This study will examine how the urgent COVID-19 requirements modified the standard telehealth or health systems processes, and describe changes to the characteristics of programmatic interventions in screening, testing, and treatment across a number of telehealth programs in a health system with a patient population that is 33% African American and at least 32% rural residents. The project will accomplish this by measuring and comparing pandemic-based changes to patient volume, service uptake, delivery learning curves, and safety/quality indicators as they changed over time. There will be

special emphasis on differences observed for underserved and high-risk populations, and specific issues emerging in rural locations and in broadband "digital deserts."

Medical University of South Carolina ($999,845)

Written Testimony of Nicole Lamoureux, President and CEO,
National Association of Free and Charitable Clinics

On behalf of the NAFC Board of Directors, our membership and the 1,400 Free and Charitable Clinics in the United States, thank you for the opportunity to share our few thoughts about how telehealth has impacted our ability to serve the uninsured and medically underserved patients in the country.

The mission of the National Association of Free and Charitable Clinics is to ensure the medically underserved have access to affordable health care. Many people do not realize that there are approximately 1,400 Free and Charitable Clinics throughout the nation who since the 1960's have been filling in the gap for those who "fall through the cracks" in our current health care system. Our clinics receive little to no state or federal funding, we do not receive HRSA 330 funds, and we are not Federally Qualified Health Centers or Rural Health Centers. Therefore, our clinics rely heavily on the generosity of individual donors, foundations, and grants as funding sources.

Annually, 2 million patients through 6.9 patient visits receive health care at America's Free and Charitable Clinics. This is done with the help of over 200,000 volunteer providers. 94% of the Free and Charitable Clinics workforce is composed of volunteers, which led to a unique challenge during the pandemic as social distancing and stay at home orders were issued.48% of our clinics had to modify their hours of operations due to concern for high-risk volunteers and staff.

Since the start of the pandemic, Free and Charitable Clinics and Pharmacies have been adapting their normal business to ensure that their patients and communities are cared for and not left behind. They have been making decisions on how to continue providing needed services while protecting their staff and volunteers, trying to get needed PPE, facing decreasing donations and increasing patient demand.

91% of Free and Charitable Clinics nationwide see patients with chronic diseases like Diabetes and/or Hypertension. They have been working hard to ensure that the treatment and chronic disease management among patients was continued as access to medications, provider visits, health foods and health education classes quickly decreased.

Free and Charitable Clinics have pivoted during this crisis and adapted their normal business protocols. They have been providing patients with needed medications and food –sometimes creating drive-throughs, curbside pickups and even making home deliveries, developing telehealth programs to keep connected while social distancing and to help address transportation issues, conducting COVID-19 education, screening, testing, and much more.

During COVID -19, over 90% of our member organizations have implemented telehealth programs, none of which are reimbursed by the federal government. 75% of those who implemented telehealth are going to continue with these programs. Telehealth services have

The National Association of Free & Charitable Clinics (NAFC)
1800 Diagonal Road Suite 600 • Alexandria, VA 22314
Phone 703-647-7427 • Fax 866-875-3827 • Email info@nafcclinics.org • Web www.nafcclinics.org

allowed our providers to help patients remain compliant with their medication and treatment protocols. Telehealth services have allowed both our high-risk providers to continue to practice medicine and for many of our patients to receive needed care.

As much as telehealth is a huge victory for patient access to providers during COVID, it cannot be ignored that telehealth services make a great deal of assumptions when it comes to patient's accessibility to healthcare. Telehealth assumes that patients have access to computers, internet, broadband, cellular plans that allow for video chatting, and are comfortable utilizing technology as well as comfortable with speaking to someone about their personal health issues over audio or telephone rather than in a closed exam room.

For many patients, Free and Charitable Clinics have also had to address the challenge of availability of hours for providers, as well as language and health literacy barriers. For example, Free and Charitable Clinics have had to rewrite directions to read at a 4th grade reading level and in the patient's native language for how to login to a telehealth system. Another challenge is that many people do not feel comfortable speaking to a provider not in their native tongue, so enlisting the help of medical translators to be on the phone or on virtual calls with the provider and the patients is something else that has been needed to serve the medically underserved and racially diverse patient populations.

It is imperative that Congress address the need for broadband access for all so that this way of care can be more readily available for all people. While Telehealth has dramatically shifted the way that health care is provided to frankly white populations, it should not be ignored that we need more research, effort, and understanding of how to serve the medically underserved, as well as racially diverse patient populations.

It has become necessary for us to find providers who look like the patients we are serving and who speak in their language or vernacular. Telehealth is a wonderful asset, but it is not the only solution especially given the high cost of care and the limited access to phone systems, internet, and broadband. Additionally, for providers who serve the medically underserved, specifically Free and Charitable Clinics who serve uninsured populations and do not have a reimbursable model telehealth programs, telehealth can be cost prohibitive and time consuming.

Free and Charitable Clinics during COVID-19 as well as during non-pandemic times are an excellent partner to the federal government. Our clinics work hard every day to keep people out of the emergency rooms, so that emergency rooms can be reserved for emergencies.

It has become apparent throughout this pandemic, however, that the federal government needs to recognize that there are more providers working to provide access to healthcare then those who are Medicaid and Medicare reimbursable providers and/or federally qualified health centers.

We thank you for this opportunity to express to the committee how telehealth has impacted our ability to care for our patients during this pandemic.

The National Association of Free & Charitable Clinics (NAFC)
1800 Diagonal Road Suite 600 • Alexandria, VA 22314
Phone 703-647-7427 • Fax 866-875-3827 • Email info@nafcclinics.org • Web www.nafcclinics.org

TESTIMONY ON BEHALF OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH SUBMITTED BY KATHRYN G. SCHUBERT, PRESIDENT & CEO

Prepared for the House Energy & Commerce Committee, Subcommittee on Health "The Future of Telehealth: How COVID-19 Is Changing the Delivery of Virtual Care"

On behalf of the Society for Women's Health Research (SWHR), I am pleased to submit testimony for the record to the House Energy & Commerce Committee, Subcommittee on Health. SWHR is dedicated to improving women's health through science, policy, and education. For over 30 years, SWHR has brought attention to diseases and conditions that disproportionately or differently impact women and provided recommendations to improve access and quality of care for women in the United States.

Women and men have different health needs and utilize the health care system in unique ways. For instance, women are more likely than men to have a regular clinician they visit for primary care, to have recently visited a care provider, and to be recommended for preventative screening services. They also are more likely to report financial barriers to care.[1] Women are frequently in charge of health care decision-making for both themselves and for family members. They are often unduly inconvenienced by in-person health care appointments due to caregiving responsibilities.

As is the case with many aspects of health care in the U.S., the COVID-19 pandemic has provided insight into women's health and well-being. Although the majority of people dying from COVID-19 are men,[2] women are more likely to be diagnosed with long-term symptoms.[3] Women also make up the majority of essential workers and are taking on more responsibility with regard to increasing caregiving and domestic work. Women are disproportionately dealing with the effects of worsening mental health and growing rates of domestic violence related to stay-at-home orders.[4]

As we know, women serve as crucial decision-makers in their family's health care planning as well as their own. Women are regular consumers of health care and are more likely to face challenges in accessing health care. Because of this, telehealth is an opportunity for women to maintain routine care during the pandemic. Some studies suggest that women have been more likely to utilize telemedicine than men during the current public health emergency and that more women have presented as new telehealth patients during this time period.[5]

Moreover, telehealth offers a way to reduce burden of care for women — and other individuals facing barriers to care — even after the public health emergency ends. Pre-pandemic, women were more likely to choose telemedicine compared to men,[6] suggesting that even post-pandemic, expanded access to telehealth will significantly benefit women.

---

[1] Salganicoff, A. et al. (2014). Years of the ACA: Key findings from the 2013 Kaiser Women's Health Survey. Accessed from: https://www.kff.org/womens-health-policy/report/women-and-health-care-in-the-early-years-of-the-aca-key-findings-from-the-2013-kaiser-womens-health-survey/

[2] Global Health 5050 (2020). COVID-19 sex-disaggregated data tracker. Accessed from: https://globalhealth5050.org/covid19/

[3] Davido B, Seang S, Tubiana R, de Truchis P (2020). Post-COVID-10 chronic symptoms: A postinfectious entity?

[4] Erickson, L (2020). The disproportionate impact of COVID-19 on women of color. *SWHR*. Accessed from: https://swhr.org/the-disproportionate-impact-of-covid-19-on-women-of-color/.

[5] Tingle, C. (2020). Women found more likely to utilize telehealth vs men. Accessed from: https://www.healio.com/news/orthopedics/20201207/women-found-more-likely-to-utilize-telehealth-vs-men

[6] Mensik, H. (2020). Female, younger patients more likely to choose telehealth visit pre-pandemic, study finds. Accessed from: https://www.healio.com/news/orthopedics/20201207/women-found-more-likely-to-utilize-telehealth-vs-men

TESTIMONY ON BEHALF OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH SUBMITTED BY KATHRYN G. SCHUBERT, PRESIDENT & CEO

On behalf of SWHR, I would like to present three broad ways to build on recent telehealth successes and preserve access to these crucial services into the future.

Maintain expanded access to telehealth services under Medicare post-pandemic
The federal government and private insurers took immediate steps to make telehealth more accessible during the earliest stages of the pandemic. The Centers for Medicare and Medicaid Services (CMS) quickly broadened access to telehealth for beneficiaries[7] and expanded regulations to ensure providers can receive reimbursement for patients who only have access to an audio connection.[8] Private insurers quickly followed suit.

Reversing course in the aftermath of the global pandemic would be a setback for patients and health care providers. Congress and the federal government must consider how to preserve these changes in a way that is workable for the long term. SWHR considers the following provisions crucial to maintain after the end of the pandemic:

(1) Removal of geographic and originating site restrictions.

(2) Coverage and reimbursement of audio-only visits.

(3) Removal of unduly burdensome billing requirements, such as those that require patient co-pays to be collected for virtual check-ins.

(4) Ensuring parity with regard to telehealth reimbursement. Telemedicine encounters should be reimbursed at rates equivalent to their in-person counterparts.

(5) Ensuring parity with regard to which types of telehealth services are covered. All specialties able to provide remote care, including mental and behavioral health services, should be able to bill and receive appropriate reimbursement for telemedicine visits.

Incorporate policies that ensure equitable telehealth access
While telehealth offers exciting opportunities to expand access to care, it is important to ensure services are being delivered equitably and that certain groups of patients do not face undue barriers. From January to June 2020, while telemedicine visits increased substantially, use of telehealth services was lower in communities with high rates of poverty.[9] Some groups — including women, Black and Latinx patients, and those with low incomes — were less likely to participate in video services. Older patients, Asian patients, and non-English-speakers had lower telehealth participation overall.[10]

---

[7] CMS (2020). Medicare telemedicine health care provider fact sheet. Accessed from: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
[8] CMS (2020). Trump administration makes sweeping regulatory changes to help U.S. healthcare system address COVID-19 patient surge. Accessed from: https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19
[9] Patel, S.Y. et al. (2021). Variation in telemedicine use and outpatient care during the COVID-19 pandemic in the United States. Accessed from: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01786
[10] Jercich, K. (2021). Women are less likely to use video for telehealth. Accessed from: https://www.healthcareitnews.com/news/women-are-less-likely-use-video-telehealth-care

TESTIMONY ON BEHALF OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH SUBMITTED BY KATHRYN G. SCHUBERT, PRESIDENT & CEO

SWHR supports policy provisions that not only expand access to telehealth, but ensure no community or patient is left behind during the expansion process. Legislation must be intentionally crafted to mitigate inequality. Screening patients for digital access and skills has been suggested as an important first step.[11] Without full understanding of the barriers, there is no way to craft efficient solutions.

Another method of addressing equity issues is to provide support services for patients most in need — for example, those dealing with health conditions that make it difficult to access or understand telehealth software, non-native English speakers, and those unaccustomed to using internet-based technologies. Integrating language interpretation services with health care delivery models may also ease burden.

Consider telehealth as a model to expand the reach of government-funded research
While direct delivery of care is key, telehealth and digital technology also present a useful model for expanding federal research capabilities. The immediate impact of COVID-19 caused most ongoing research to be paused, except for work on life-saving treatments and research on the disease itself. As the pandemic progressed, clinical trials have been modified to allow for ongoing participation.[12] However, expanding efforts to increase alternate approaches for trials will help to support broad research needs during the pandemic and beyond.

Traditional clinical trial models involve frequent, and at times lengthy, site visits to receive a therapeutic or engage in routine patient monitoring. Low participation in trials may be in large part due to difficulties accessing in-person clinical sites.[13] Decentralized and siteless trials may improve participation rates and increase diversity within research by improving comfort and increasing convenience for research participants.[14]

SWHR encourages Congress to view the current environment as an opportunity to reconsider the conventional trial model. Policy aimed at supporting virtual, siteless, and direct-to-patient trials, as well as hybrid approaches, should be considered. Congress and federal agencies can play a major role in shepherding this transition and providing guidance on best practices for moving to more innovative trials models. We must apply lessons learned from COVID-19 not only to increase the use of telehealth for direct care, but also to expand our research capabilities.

CONCLUSION
The majority of clinicians and patients in SWHR's community have benefited from telehealth during the COVID-19 crisis. The message is the same across providers: Women are relieved telehealth is an option.[15] Patient satisfaction has increased.[16] The need to expand telehealth beyond the pandemic is clear.

---

[11] Center for Care Innovations (2020). Telemedicine for health equity: Considerations for reaching and engaging diverse patients. Accessed from: https://www.careinnovations.org/resources/telemedicine-for-health-equity-considerations-for-reaching-and-engaging-diverse-patients/
[12] Weiner, D.L. et al. (2020). COVID-19 impact on research, lessons learned from COVID-19 research, implications for pediatric research. Accessed from: https://www.nature.com/articles/s41390-020-1006-3
[13] Spears, P.A. (2020). Patient barriers to participation in breast cancer clinical trials. *Breast Cancer Management, 9*(1).
[14] NASEM; Shore C. et al., editors (2019). Virtual Clinical Trials: Challenges and Opportunities: Proceedings of a Workshop. Accessed from: https://www.ncbi.nlm.nih.gov/sites/books/NBK548971/
[15] Laitner, M. (2020). Coronavirus is driving a telehealth evolution. Accesed from: https://swhr.org/coronavirus-is-driving-a-telehealth-evolution/
[16] Laitner, M. (2020). Your counselor will see you now: How genetic counselors are leading the way on telehealth. Accessed from: https://swhr.org/your-counselor-will-see-you-now-how-genetic-counselors-are-leading-the-way-on-telehealth/

TESTIMONY ON BEHALF OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH SUBMITTED BY KATHRYN G. SCHUBERT, PRESIDENT & CEO

I would like to thank the Chair, Ranking Member, and the Subcommittee for the opportunity to provide comment on the impact of COVID-19 in expanding telehealth services for patients. SWHR appreciates your attention to this topic. If you have questions, please contact Melissa Laitner, PhD, MPH, Director of Public Policy & Government Affairs, at melissa@swhr.org.

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Megan R. Mahoney, M.D., Chief of Staff, Stanford Health Care

The Honorable Lisa Blunt Rochester (D-DE)

1. How can Congress best support state Medicaid programs in their efforts to expand telehealth? Are there supports, incentives and learnings that federal policymakers could provide?

The Honorable Gus Bilirakis (R-FL)

1. Do you support retaining HHS authority to more robustly allow services delivered through telehealth after the COVID-19 public health emergency ends? Should that authority include waiving restrictions that exist outside the PHE on the types of providers who can furnish those services?

2. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020 – signifying an almost 20% increase year over year, with no indication that this trend is reversing.

    a. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

3. Should HHS consider expanding the types of audiology, speech-language pathology, physical therapy, and occupational therapy services that can be provided during the PHE if they are clinically appropriate and can be delivered with the same efficacy as in-person visits?

4. Do you believe Congress should consider allowing audiologists and members of the therapy professions to provide telehealth services under Medicare permanently when clinically appropriate, especially since they are currently doing so during the public health emergency and patients appear satisfied to receive services in this manner?

5. I think you would agree that the earlier the identification of deteriorating patient condition, the better the chance of a positive outcome, and that we need to find a way to harness the spread of disease, especially in vulnerable patient populations such as the elderly and those with chronic medical conditions.

    a. Chronic diseases place immense strain on the operation of our health system. Could you discuss how remote monitoring is used today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?
    b. Do you support the use of remote patient monitoring that enables the early identification of physiologic changes in patient conditions in time to prevent catastrophic injury or death?
    c. Would you agree that the recent use of remote patient monitoring tools that have helped clinicians, nursing homes and hospitals respond to COVID-19 should be continued with appropriate Medicare coverage and reimbursement even when this current crisis is over?
    d. Do you agree that by bringing the healthcare to the patient at home will increase access to affordable and quality healthcare for vulnerable patients and those in rural areas?

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Ateev Mehrotra, M.D., M.P.H., Associate Professor of Health Care Policy, Harvard Medical School

The Honorable Lisa Blunt Rochester (D-DE)

1. How can Congress best support state Medicaid programs in their efforts to expand telehealth? Are there supports, incentives and learnings that federal policymakers could provide?

The Honorable Gus Bilirakis (R-FL)

1. During the COVID-19 pandemic, CMS has made very clear its support for remote patient monitoring and has urged commercial payers to do the same.

    a. Beyond the question of 'should coverage and reimbursement be made permanent' what additional questions should this committee consider?

2. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020 – signifying an almost 20% increase year over year, with no indication that this trend is reversing.

    a. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

3. Should HHS consider expanding the types of audiology, speech-language pathology, physical therapy, and occupational therapy services that can be provided during the PHE if they are clinically appropriate and can be delivered with the same efficacy as in-person visits?

4. Do you believe Congress should consider allowing audiologists and members of the therapy professions to provide telehealth services under Medicare permanently when clinically appropriate, especially since they are currently doing so during the public health emergency and patients appear satisfied to receive services in this manner?

5. I think you would agree that the earlier the identification of deteriorating patient condition, the better the chance of a positive outcome, and that we need to find a way to harness the spread of disease, especially in vulnerable patient populations such as the elderly and those with chronic medical conditions.

    a. Chronic diseases place immense strain on the operation of our health system. Could you discuss how remote monitoring is used today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?
    b. Do you support the use of remote patient monitoring that enables the early identification of physiologic changes in patient conditions in time to prevent catastrophic injury or death?
    c. Would you agree that the recent use of remote patient monitoring tools that have helped clinicians, nursing homes and hospitals respond to COVID-19 should be continued with appropriate Medicare coverage and reimbursement even when this current crisis is over?
    d. Do you agree that by bringing the healthcare to the patient at home will increase access to affordable and quality healthcare for vulnerable patients and those in rural areas?

The Honorable Richard Hudson (R-NC)

1. Dr. Mehrotra, it is my understanding that research has shown that telehealth has benefits for patients. For example, telehealth may increase access to mental health providers, improve outcomes in integrated care settings, and be at least as effective as an in-person visit for some psychiatric services. Given what we have seen about the increase in the need for mental health services during the pandemic, what do you recommend to build on what we've learned about from this experience?

The Honorable Neal P. Dunn, M.D. (R-FL)

1. Should Congress be evaluating all-payer claims data when considering reimbursement for in-home remote patient monitoring to identify gaps in coverage? Right now, some states cover it through Medicaid and commercial payment policies vary widely.

    a. What is the biggest obstacle to adopting remote patient monitoring right now?

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Ms. Elizabeth Mitchell, President and CEO, Purchaser Business Group on Health

The Honorable Michael C. Burgess, M.D. (R-TX)

1. Ms. Blunt Rochester and I just reintroduced the TIKES Act. This bill requires the Centers for Medicare and Medicaid Services to issue guidance and best practices to states on the use of telehealth in Medicaid. It also includes a MACPAC report to assess gaps in access to telehealth.

    a. Has COVID-19 led any states to be particularly innovative in utilizing telehealth in their Medicaid programs that might inform these best practices?
    b. Has COVID-19 exposed any gaps in access to telehealth for Medicaid or other populations?

The Honorable Gus Bilirakis (R-FL)

1. What conclusions have private payers that have expanded telehealth drawn from their experiences over the past year regarding utilization of services, patient satisfaction, and program integrity?

2. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020 – signifying an almost 20% increase year over year, with no indication that this trend is reversing.

    a. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

3. Should HHS consider expanding the types of audiology, speech-language pathology, physical therapy, and occupational therapy services that can be provided during the PHE if they are clinically appropriate and can be delivered with the same efficacy as in-person visits?

4. Do you believe Congress should consider allowing audiologists and members of the therapy professions to provide telehealth services under Medicare permanently when clinically appropriate, especially since they are currently doing so during the public health emergency and patients appear satisfied to receive services in this manner?

5. I think you would agree that the earlier the identification of deteriorating patient condition, the better the chance of a positive outcome, and that we need to find a way to harness the spread of disease, especially in vulnerable patient populations such as the elderly and those with chronic medical conditions.

    a. Chronic diseases place immense strain on the operation of our health system. Could you discuss how remote monitoring is used today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?
    b. Do you support the use of remote patient monitoring that enables the early identification of physiologic changes in patient conditions in time to prevent catastrophic injury or death?
    c. Would you agree that the recent use of remote patient monitoring tools that have helped clinicians, nursing homes and hospitals respond to COVID-19 should be continued with appropriate Medicare coverage and reimbursement even when this current crisis is over?
    d. Do you agree that by bringing the healthcare to the patient at home will increase access to affordable and quality healthcare for vulnerable patients and those in rural areas?

The Honorable Neal P. Dunn, M.D. (R-FL)

1. Remote patient monitoring can help with the issues of "no-shows," or missed appointments, which can be problematic and ultimately costly for chronic disease patients. It also has shown to reduce "frequent flyer" ER visits. Remote monitoring can allow for *almost* office-style care without exposure to communicable diseases. These are all savings in my book. Clearly there are decrements in physical examination and testing remotely, but technology continues to improve. Is there data to help us determine the degree to which remote patient monitoring can generate savings?

    a. How should we be thinking about accounting for costs and savings in regard to remote patient monitoring?

2. Some payers are exploring remote monitoring to incentivize health habits. How can payers build trust with patients who may be wary of continuously sharing their data with payers?
3.
    a. Please share your thoughts regarding the privacy considerations we will face to ensure patient data is safe when using remote patient monitoring technology.

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Jack Resneck, Jr., M.D., Board of Trustees, American Medical Association

The Honorable Lisa Blunt Rochester (D-DE)

1. How can Congress best support state Medicaid programs in their efforts to expand telehealth? Are there supports, incentives and learnings that federal policymakers could provide?

The Honorable Gus Bilirakis (R-FL)

1. Currently, CMS requires that all Medicare patients be monitored for at least 16 out of 30 days as a condition of payment, except for COVID patients during the PHE. As an aspect of telehealth, do you believe that device-driven remote patient monitoring in the home, as CMS now describes and reimburses for it, is too strict in terms of the required time of monitoring and limits use cases or provider discretion and should be more flexible; and, if so, what guardrails, if any, should remain for care quality and program integrity?

2. Do you support retaining HHS authority to more robustly allow services delivered through telehealth after the COVID-19 public health emergency ends? Should that authority include waiving restrictions that exist outside the PHE on the types of providers who can furnish those services?

3. According to a Pew report, 15 percent of the American population own a non-smartphone cell phone and that number jumps to 24 percent in rural areas. Additionally, many seniors or those with disabilities struggle with video platforms and access to stable broadband. Do you support audio-only telehealth and as a physician, are you able to deliver high-quality care via a phone call? Shouldn't there be equal recognition of information gleaned from a video call and an audio call?

4. We've heard excellent testimony about how telehealth aided by the internet has helped bring doctors to patients wherever they are located during the pandemic. Of course, these doctors must be licensed to practice medicine in the state in which they reside. Before the

pandemic and outside of DOD and VA health care, doctors also had to get and pay for a license where the patient was located, even though the science of medicine is the same.

a. How has easing of licensure rules expanded access to care for patients? As barriers came down, how have costs for doctors been reduced? Is there a reason to have a multiple-state licensure system?

5. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020 – signifying an almost 20% increase year over year, with no indication that this trend is reversing.

   a. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

6. Should HHS consider expanding the types of audiology, speech-language pathology, physical therapy, and occupational therapy services that can be provided during the PHE if they are clinically appropriate and can be delivered with the same efficacy as in-person visits?

7. Do you believe Congress should consider allowing audiologists and members of the therapy professions to provide telehealth services under Medicare permanently when clinically appropriate, especially since they are currently doing so during the public health emergency and patients appear satisfied to receive services in this manner?

8. All – I think you would agree that the earlier the identification of deteriorating patient condition, the better the chance of a positive outcome, and that we need to find a way to harness the spread of disease, especially in vulnerable patient populations such as the elderly and those with chronic medical conditions.

   a. Chronic diseases place immense strain on the operation of our health system. Could you discuss how remote monitoring is used today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?
   b. Do you support the use of remote patient monitoring that enables the early identification of physiologic changes in patient conditions in time to prevent catastrophic injury or death?
   c. Would you agree that the recent use of remote patient monitoring tools that have helped clinicians, nursing homes and hospitals respond to COVID-19 should be continued with appropriate Medicare coverage and reimbursement even when this current crisis is over?

d. Do you agree that by bringing the healthcare to the patient at home will increase access to affordable and quality healthcare for vulnerable patients and those in rural areas?

The Honorable Michael C. Burgess, M.D. (R-TX)

1. Ms. Blunt Rochester and I just reintroduced the TIKES Act. This bill requires the Centers for Medicare and Medicaid Services to issue guidance and best practices to states on the use of telehealth in Medicaid. It also includes a MACPAC report to assess gaps in access to telehealth.

    a. Has COVID-19 led any states to be particularly innovative in utilizing telehealth in their Medicaid programs that might inform these best practices?
    b. Has COVID-19 exposed any gaps in access to telehealth for Medicaid or other populations?

2. While it does not fit into the technical definition of telehealth, remote patient monitoring offers much promise for chronic disease patients. You mentioned in your testimony how access to real-time information related to a patient's social determinants of health can lead to better health outcomes and reduced care costs. Are there any patient populations that can particularly benefit from remote patient monitoring paired with in-person or telehealth visits?

3. Dr. Resneck, in your written testimony you say that concerns over fraud, waste, abuse and over-utilization are "misplaced," but that the digital nature of telemedicine creates built-in monitors to protect against fraudulent practices. What are you and other physicians seeing in practice when it comes to tracking and billing for telehealth services?

    a. Are there differences in the experiences of physicians in value-based payment relationships compared to those reimbursed in a traditional fee-for-service?

The Honorable Richard Hudson (R-NC)

1. Dr. Resneck, there are unique considerations for children with complex medical conditions who must travel out-of-state to receive specialized care. These children and their families face several hurdles ranging from delays in treatment, administrative burdens, and financial and logistical issues associated with travel and lodging. Telehealth may be a valuable tool for these families to access care with fewer obstacles, but current policies are not always clear and vary by state. Can you speak to how telehealth policies can be improved to support these children and families, as well as their providers?

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

Mr. Frederic Riccardi, President, Medicare Rights Center

The Honorable Gus Bilirakis (R-FL)

1. Currently, CMS requires that all Medicare patients be monitored for at least 16 out of 30 days as a condition of payment, except for COVID patients during the PHE.

    a. As an aspect of telehealth, do you believe that device-driven remote patient monitoring in the home, as CMS now describes and reimburses for it, is too strict in terms of the required time of monitoring and limits use cases or provider discretion and should be more flexible; and, if so, what guardrails, if any, should remain for care quality and program integrity?

2. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020 – signifying an almost 20% increase year over year, with no indication that this trend is reversing.

    a. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

3. Should HHS consider expanding the types of audiology, speech-language pathology, physical therapy, and occupational therapy services that can be provided during the PHE if they are clinically appropriate and can be delivered with the same efficacy as in-person visits?

4. Do you believe Congress should consider allowing audiologists and members of the therapy professions to provide telehealth services under Medicare permanently when clinically appropriate, especially since they are currently doing so during the public health emergency and patients appear satisfied to receive services in this manner?

5. I think you would agree that the earlier the identification of deteriorating patient condition, the better the chance of a positive outcome, and that we need to find a way to harness the spread of disease, especially in vulnerable patient populations such as the elderly and those with chronic medical conditions.

    a. Chronic diseases place immense strain on the operation of our health system. Could you discuss how remote monitoring is used today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?
    b. Do you support the use of remote patient monitoring that enables the early identification of physiologic changes in patient conditions in time to prevent catastrophic injury or death?
    c. Would you agree that the recent use of remote patient monitoring tools that have helped clinicians, nursing homes and hospitals respond to COVID-19 should be continued with appropriate Medicare coverage and reimbursement even when this current crisis is over?
    d. Do you agree that by bringing the healthcare to the patient at home will increase access to affordable and quality healthcare for vulnerable patients and those in rural areas?

○