HOUSE COMMITTEE ON WAYS AND MEANS, HEALTH SUBCOMMITTEE

Charting the Path Forward for Telehealth

Wednesday, April 28, 2021 at 2 p.m. EST via Cisco WebEx

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PURPOSE

The purpose of this hearing was to discuss the barriers and opportunities that exist with regard to telehealth after widespread adoption and implementation during the COVID-19 pandemic.

KEY TAKEAWAYS

- Telehealth should be treated as complementary to, rather than a substitute for, traditional in person care. It has more value in certain settings, such as rural areas, and for specific kinds of care, such as behavioral health, than others.
- Broadband access remains a fundamental barrier and necessary corollary to the expansion of telehealth.
- While telehealth can expand access to traditionally underserved populations, structures and systems built around telehealth expansion still need to be informed by best practices for culturally competent care.
- Fraud and abuse in telehealth is not fundamentally different than fraud and abuse in traditional settings and the technological nature of telehealth may make it even easier to mitigate.
- A fundamental divide has emerged between approaches going forward for telehealth in Medicare. Some believe that flexibilities should be permanently extended immediately to promote investment and predictability. Others believe that more reliable data beyond the pandemic is needed before permanent structures are put in place.

MEMBERS PRESENT

Subcommittee Chair Doggett, Ranking Member Nunes, and Representatives Thompson, Buchanan, Kind, Blumenauer, Adrian Smith, Higgins, Reed, Sewell, Kelly, Chu, Jason Smith, Evans, Schweikert, Schneider, Wenstrup, Gomez, Horsford, Larson, and Kildee.

WITNESSES

Sinsi Hernández-Cancio, JD
Vice President for Health Justice
National Partnership for Women and Families

Ellen Kelsay
President and CEO
Business Group on Health

Thomas Kim, MD, MPH
Chief Behavioral Health Officer
Prism Health North Texas

Joel White
Executive Director
Health Innovation Alliance

Ateev Mehrotra, MD, MPH
Associate Professor of Health Care Policy, Harvard Medical School

OPENING STATEMENTS

Subcommittee Chair Doggett (D-TX) stated that we need to avoid exacerbating health care disparities. Telehealth can be integrated into existing physician-patient relationships. Telehealth has found a path forward in the last year. This past year, 144 services were able to be provided via telehealth through a waiver from the Centers for Medicare and Medicaid Services (CMS). Depending on how we implement it, telehealth can improve or exacerbate health inequities. Telehealth can expand language access and culturally competent care and allow caregivers and family advocates to more easily participate. But barriers in access related to broadband and technology still remain for marginalized communities. We must avoid a two-tiered system where lower-income patients only get audio-only care. We need a plan in place to ensure no abrupt disruption of telehealth once the Public Health Emergency ends. The Medicare Payment Advisory Commission (MedPAC) recommended that Congress provide a limited extension to gather more data. A number of Members of Congress have submitted legislation on the issue and some have proposed a telehealth caucus. He will be introducing a bill of his own to extend waivers beyond the Public Health Emergency. This will allow Congress and MedPAC time to evaluate telehealth and make permanent changes. Additionally, this committee is the steward of Medicare. The Department of Justice (DOJ) has reported fraud in the amount of billions through schemes that are similar to those in traditional health care delivery. We can mitigate these scams by requiring in-person visits prior to durable medical equipment and lab tests at high rates and tracking these better with National Provider Identifiers. The committee looks forward to finding a blueprint for health equity and quality through telehealth.

Ranking Member Nunes (R-CA) stated that telehealth is a vital lifeline and critical health benefit. CMS data showed that 13,000 per week went up to 1.7 million in the early months of the pandemic. We removed originating site restrictions and expanded the range of services and provider types that could be used to deliver telehealth. We also expanded technology types, including audio-only visits, which allowed more people to access care. Republican believe telehealth is a powerful tool that can improve access to care and must be a component of value-based care. The pandemic has shown the positive benefits of telehealth. It would be a missed opportunity to turn back now. The Congressional Budget Office (CBO) has scored telehealth at cost, fraud and abuse issues require vigilance and not everyone has equal access.

TESTIMONY

Ms. Hernández-Cancio said she seeks to reduce health inequities. Our nation is plagued with inequities that affect minorities. One, our health care system makes care unaffordable, inaccessible and sometimes even biased. The pandemic has underscored the urgency of correcting these issues. Telehealth is integral to our future, especially for women and minorities who experience access issues. But telehealth cannot fix everything. We have to be vigilant for communities that are typically disenfranchised. Medicare can lead the way in equitable healthcare. We can build a virtuous health equity cycle and design health care delivery with equity at its center. We can identify barriers to proactively design better systems. We must first solve the digital divide, which was highlighted by issues in transitioning to remote learning. Reimbursement must support audio-only visits and patients should be able to choose how they access the care. Telehealth must also be an option that complements, but not substitutes, high-quality in-person care. We need disaggregated data that identifies impacted populations and measures these issue. Telehealth must also be made affordable for patients and providers. It requires up-front investment and predictable cost sharing. Next generation care should close gaps and our future depends on ensuring we all thrive together.

Ms. Kelsay said business groups have been at the forefront of telehealth adoption by integrating virtual care into their group health plans. She cautioned that virtual care and telehealth utilization are in early stages. There was a wide range of utilization rates across. There is room for much greater uptake of telehealth. The impact of large scale utilization remains to be seen. Long-term safety and quality impacts remain unknown. Rigorous study of health outcomes and experience needs to be undertaken to determine appropriateness of care that is administered virtually. We also need to pay attention to costs over time. Telehealth visits are often followed by in-person visits for the same reason, resulting in double costs and payments. Rigorous study of costs are also essential. Equity and uniform availability should also be considered. Disparity in availability of providers, access and broadband infrastructures contribute to health inequities. She recommended that the Congress and regulators permit interstate licensure, audio-only when appropriate and a national framework for telehealth for multi-state businesses. She also recommended permanently extending flexibilities to offer telehealth on a pre-deductible basis to individuals with High-Deductible Health Plans paired with a Health Savings Account. Flexibilities that allow employees not enrolled in group health plans to access telehealth services should be made permanent. The government is positioned to conduct large-scale studies to assess costs and benefits of telehealth expansion compared to in-person services. Finally, Medicare telehealth flexibilities under the COVID-19 pandemic should be extended to allow time for adequate data collection to inform permanent policies.

Dr. Kim stated that the path for telehealth is broadband. Broadband is important for commerce, education and more. Broadband need is more than access, however. It has bene suggested that telehealth can help with value-based care, but value-based care is more than one thing. Telehealth is about the right doctor with the right information at the right time. Delivery challenges usually relate to patients having to wait until a crisis to seek care. Telehealth is a skill to be mastered, and your doctor should be skilled. In his experience, they have seen telehealth visits organically settle to 20-30%. It is not a replacement solution, nor additive to general care. It has too long been viewed as "something else" outside of traditional health care. But the pandemic changed that, and we have to examine what is next. Texas provides a roadmap. A covered service should be paid at the same rate. Concerns around telehealth adoption, like fraud and utilization, are not exclusive to telehealth, and can be addressed with guardrails in place.

Dr. Mehrotra stated that we need to question why we even need telehealth specific policies. He asked how we can build upon the flexibilities in the pandemic. Value is the lens by which we should evaluate next steps. A high-value use of telemedicine could be a patient living in a rural community with untreated depression that gets to see a specialist they would not otherwise get to see. Audio-only telemedicine visits are a fancy name for a phone call. Poorer communities cannot access video visits due to technology barriers. We should pay for telemedicine visits at a lower-rate than in-person visits, and lower costs for telemedicine visits will ultimately not prevent physicians from pursuing telemedicine.

Mr. White stated that one of our top priorities is to improve care by expanding telehealth. The pandemic has changed consumer and provider perspectives on telehealth. The government's relaxation of policies has allowed telehealth to be used effectively. Several months into the pandemic, in-person care increased as restrictions around these visits relaxed. But we did see longstanding disparities laid bare, and we saw a clear need to invest in broadband. Overall, however, we did not see the total cost of care explode. According to some economists, they are estimating that 2020 health care costs will be lower than in 2019. He advocates for modernizing the Medicare program, permanently extending the flexibilities CMS has issued during COVID-19, including geographic and originating site restrictions. Medicare Advantage (MA) risk-adjustment should include audio-only visits. Telehealth enabled at-home testing should also be authorized. We know there are utilization and fraud concerns. Congress should provide more resources to the Office of the Inspector General to audit the top 5% of billers for telehealth. Care that is delivered remotely can be monitored with advanced analytics and artificial intelligence, and the Department of Health and Human Services (HHS) should use these tools for telehealth to predict and stop fraud before it happens. Outside of Medicare, workers should be allowed to use first-dollar services for telehealth services. Medical licensure laws also need to be updated.

QUESTIONS AND ANSWERS

Subcommittee Chair Doggett (D-TX) said that we are beginning to look at a post-pandemic America and delivery of health care services. He asked what the best way to deal with getting physicians to delivery culturally competent care to vulnerable populations. **Ms. Hernández-Cancio** said that the gaps in offices can extend into people's home. We need oversight and analysis of disaggregated demographic data. Medical professionals and their staff need to be educated on implicit bias and toxic stress. They first need to be taught how to care for diverse populations. We layer training on top of that for best practices in using telehealth with a nationally recognized curriculum with real consumer and community engagement to inform needs for specific populations. **Chair Doggett** said that some plans would want to fully replace in-person care with telemedicine. He asked what challenges exist in integrating telehealth in plans and ensuring that providers have complete health records. **Ms. Keslay** said telehealth should be incorporated into traditional care from a data and quality perspective. It should not be separate and distinct. The importance of coordination from a care and data perspective are critical. **Chair Doggett** asked how care differs in on-demand telehealth and whether establishing patient-physician relationship requires an in-person visit. **Dr. Kim** said that telehealth can inform all models of care, but its success rests on aligning the right doctor with right information at the right time. **Chair Doggett** asked what we still need to know about telehealth to pursue permanent legislation. **Dr. Mehrotra** said that we do not yet know what the impact of telemedicine will be on total utilization, and the pandemic may not provide the best answer to that and we need to see how it is used after.

Ranking Member Nunes (R-CA) asked what some of the issues are about making them permanent, whether Congress needs a temporary extension to study the issue more, and what some specific policies around licensure would be needed. **Mr. White** said that we need to move quickly to make flexibilities permanent, as some of them have been around for decades. Consumers clearly relied on this when it became available. We have less information on cost, but we have not seen a cost explosion as expected. We do not know what the quality issues might be, especially subpopulations. MedPAC did not make a recommendation, but simply formed a policy approach for consideration that has not been voted on. It would reverse the flexibility around cost-sharing for beneficiaries, which is a cost increase and is counter to concerns about equity. Congress needs to permanently authorize this, and if there are problems, Congress can adjust the law. The TREAT Act addresses the interstate licensure issues. While there are different norms and cultural competencies, the science is the same, and providers should not have to get duplicate licenses.

Rep. Thompson (D-CA) noted that telehealth is one of the few silver linings of COVID-19. Millions of beneficiaries have been able to see providers safely and millions of providers have been able to stay afloat. He is proud to have written Protecting Access to Post-COVID-19 Telehealth Act. The trust fund must be protected. Telehealth equality must be protected. It cannot become another division. We need to monitor the quality of care if we spend tax money on it. This is about patients. He asked Dr. Mehrotra to talk more about how Congress can balance permanence of flexibilities while incentivizing high-value care. **Dr. Mehrotra** noted how substance use disorder, stroke and mental

illness have all been specifically addressed in terms of telemedicine through legislation. He stated that chronic illness presents an opportunity for high-value applications. **Rep. Thompson** asked whether it is fair to say that well-served areas could benefit as well. **Dr. Mehrotra** said that if a visit via telemedicine can save time and resources, it is an important benefit.

Rep. Buchanan (R-FL) said telehealth is a lifeline for his constituents. He asked what we can do to ensure standards of care remain uncompromised. **Mr. White** said that protections we have in place in Medicare are respected and need to be listened to. We do not need bureaucracy to determine what is clinically appropriate. **Rep. Buchanan** said that he has seen costs go up for small businesses and is sometimes pushed through to individuals. He asked about how telehealth could help with costs. **Mr. White** said telehealth saves money and that is borne out by adoption. One of the challenges is that these rules applies to Medicare fee-for-service, which carries incentives to overprescribe or utilize. Letting the doctor decide the appropriate mode of care can save a lot of money.

Rep. Kind (D-WI) said we have to find a path forward. There is no going back. He asked for clarification around audio-only telehealth and the digital divide with respect to a 1-2 year study period. **Dr. Mehrotra** said the clear distinction is between urban and rural areas, where the latter has been shown, during the pandemic, to use telehealth less, even though they used it more before. We should consider whether we should create telemedicine hubs in rural communities with remote patient monitoring and other tools. **Rep. Kind** asked whether congregate care settings, which were hit hard by COVID-19, will benefit from telehealth. **Dr. Kim** said that they can absolutely benefit telehealth. We can do better with the resources we have. **Rep. Kind** asked if there is a concern that when people get comfortable with telehealth that they will overuse it and if fraud is a concern. **Mr. White** said we should always be vigilant, especially with telemarketing-type fraud. We can use tools to stop that, like artificial intelligence and machine learning. Congress needs to direct the HHS Office of the Inspector General to direct existing programs to exercise oversight of telehealth. They need to make permanent moves, no matter what.

Rep. Adrian Smith (R-NE) said he believes this can expand primary care to rural and underserved areas and that we have seen this happen in real time. There are still gaps in coverage and access for communication, however, in urban and rural areas. He asked if there has been large-scale fraud from audio-only. **Mr. White** said that the Inspector General has raised issues about schemes used to bill for durable medical equipment. It is more akin to telemarketing scams. One company has applied machine learning to reduce fraud by 80%. These solutions exist and companies are sophisticated and can already do it. As we expand telehealth, we need to have this tool in the toolbox. But we are confusing telehealth fraud with telemarketing scams. On the audio-only side, there is a concern that it is easier fraud to commit. **Rep. Smith** asked about the risk adjustment for audio-only impact on MA beneficiaries. **Mr. White** said that they will face increased costs and it is a critical change to get audio-only parity for MA beneficiaries.

Rep. Blumenauer (D-OR) discussed the Patient Choice and Quality Care Act for patients with serious illness. He asked whether CMS should proactively target patient populations for telehealth and how a capitated model could enhance equity. **Dr. Mehrotra** said that we can two-way communication between patients and providers. We do not want a bureaucracy to choose between them. To the degree we use alternative payment models, like capitation, it is going to be a better system for patients and providers. Select populations could particularly benefit because they would have more flexibility in their care.

Rep. Reed (R-NY) asked how we drive efficient utilization for someone like an unmanaged diabetics patient and make sure that services are dovetailed. He also asked how we maximize the next generation of telehealth for Medicare and Medicaid. **Mr. White** said that CMS authorized remote management of diabetes care. We need to move to value-based care. For example, the PREVENT DIABETES Act leverages virtual care and remote patient monitoring. These can have a dramatic impact on cost. We are also getting good technology on remote labs and bedside diagnostics, which can be lifelines for people who cannot go into office visits. That should be integrated into Medicare.

Rep. Higgins (D-NY) stated that COVID-19 accelerated telehealth and it demonstrated the benefits in terms of cost, access and outcomes. Telehealth, in its accelerated mode, has been a positive thing on all the measures we value health care delivery on. But we need to even the playing field. He asked **Ms. Hernández-Cancio** about investment in broadband to promote equitable access and what percent of health care is provided by nurses versus doctors as a measure of good utilization. **Ms. Hernández-Cancio** said that we saw how remote schooling highlighted access issues to broadband. It is important to understand that broadband presence alone is not enough. Rather, the number of users, reliability, affordability, hardware and ancillary aspects that affect the ability to use broadband also need to be considered. Telehealth has a lot of potential benefit for caregivers as well, who can be advocates connected through telehealth. That need will continue. There is still a lot of data we do not know however, and we need disaggregated data to help identify particular populations and geographies.

Rep. Kelly (R-PA) stated that some beneficiaries do not have the skillset needed to interface with telehealth. He asked whether providers have risen to the challenge of helping patients engage with it. **Mr. White** said they have, and that there are islands of excellence for helping patients use telehealth. The federal government has some standards around electronic health records interface. But we also have to focus on digital literacy in health. Broadband, literacy and user interface are primary barriers here. **Rep. Kelly** said the government has to go in to areas where there is not incentive for private business to enter the market there. He said we should look at whether the government should put more money into broadband in those areas and how we can educate people in ways that prepare them to use these resources.

Rep. Sewell (D-AL) asked how we can ensure we do not create a two-tiered system and still delivery high value. **Dr. Mehrotra** said that it takes a lot of guidance for older adults

to build confidence in telemedicine. One-on-one education will build familiarity over time. **Rep. Sewell** said the digital divide is real, and she sees it in her district. She asked Ms. Hernández-Cancio to talk about equity in maternal health. **Ms. Hernández-Cancio** said maternal health can benefit from telehealth, especially those with access issues to specialty care. Part of the challenge of maternal health is the racial bias. Cultural congruency and competency are antidotes to this issue. Better and closer monitoring can also be helpful. The other missing part of the equation is patient choice. **Rep. Sewell** said that cultural competency and implicit bias training should be available for telehealth providers.

Rep. Chu (D-CA) stated that she is interested in telehealth's impact on expanding mental health services. She asked why behavioral health services are well-suited to telehealth, especially with regard to equity and access. **Dr. Kim** said that behavioral health does not require a physical touch, which makes it particularly well suited. It provides a good model to other forms of care to evaluate how to maximize the therapeutic relationship. A good relationship often uses multiple forms of communication, and audio-only is one key part of that. **Rep. Chu** asked what guardrails are the most important for mental and behavioral telehealth. **Dr. Kim** said he has had success across all vulnerable populations he can think of to reach those who typically do not have access.

Rep. Jason Smith (R-MO) had technical difficulties and his responses will be entered as part of the record.

Rep. Evans (D-PA) asked what the most important lessons are from this year. **Ms. Kelsay** said that we have seen how we can mobilize and reach people quickly. People have accepted and embraced virtual care, including traditionally marginalized populations. **Ms. Hernández-Cancio** said that essential workers have been treated as dispensable workers, especially because these are disproportionately people of color. The pandemic has driven more attention to the system that drives these inequities.

Rep. Schneider (D-IL) stated that crises provide opportunities to advance. The health industry will not be the same. Our health system should allow people to receive care in their own home. He asked what metrics we should be using to evaluate improvements of telehealth. **Dr. Kim** said we need to ask whether we are conducting a high-value intervention and provided examples of how telemedicine can help de-escalate care. **Rep. Schneider** said that check-ins and compliance could be supported by telehealth as well.

Rep. Schweikert (R-AZ) stated that we are not being forward leaning enough in asking "what is telemedicine?" We do not do a good job leveraging technology to help manage chronic illness or using at-home diagnostics and remote patient monitoring. He requested for a group of the "health futurists" and data experts to come together to discuss how they are eliminating the cost, equity and access barriers. He asked what telemedicine would look like without the regulations in place. **Mr. White** said that we need to eliminate the

immediate barriers first, but technology-enable, consumer-driven care is the way of the future.

Rep. Gomez (D-CA) said that moving to digital settings for things like the census and vaccine registration did not adequately serve areas with low broadband connectivity and marginalized populations**.** He asked about the digital divide and how it impacted the COVID-19 vaccine rollout. **Ms. Hernández-Cancio** said that there have been issues with the vaccine rollout using digital registration, and that door-to-door work ended up being more successful for outreach for minority communities in some areas. Even machine learning, health care evidence and other informational inputs have racial bias systematically built-in. We have to look at disaggregated data to identify the issues.

Rep. Horsford (D-NV) noted that mental health services have had some of the best outcomes with telehealth. Communities, however, still struggle with the cost of getting high-speed internet. Language barriers also need to be addressed and patients should get care in their primary language. He asked how telehealth can integrate translation services to make primary care more accessible. **Ms. Hernández-Cancio** said that telehealth will make language access easier by allowing bilingual providers extend their reach, alongside diversifying workforce. Additionally, three-way communication with a culturally competent translator is a game-changer for these communities struggling with language access. Even English fluency does not necessarily mean it is the best language to communicate needs.

Rep. Wenstrup (R-OH) said that rural and underserved urban areas have similar barriers. We need to signal that there is going to be stable reimbursement for the investment. Alternative payment models that incentivize health is a good approach. Telehealth can play a vital role as one tool in the toolbox to increase health span and reach more people. He asked what the consequences could be of not signaling that there will be stable reimbursement, especially in rural areas. **Mr. White** said people will likely not invest in telehealth and make it a part of a long-term strategy. Telehealth needs to be a supplement and not something that supplants in-person care. **Rep. Wenstrup** said that with telehealth, it does not matter where your license is, because with telehealth, their home becomes your office.

Rep. Larson (D-CT) said he is concerned about changes at Social Security Administration regarding hearings for beneficiaries. In these scenarios, Administrative Law Judges are essential to making impartial and fair rulings. The previous administration allowed Staff Attorneys to hold these hearings, which compromises the fairness and integrity of the hearings. They are introducing a joint resolution to overturn this practice.

Rep. Kildee (D-MO) is working on the Rural Behavioral Health Access Act, which expands access to behavioral therapy and increases audio-only care flexibilities. He asked how telehealth with adequate reimbursement expand patient access while ensuring more financial stability in underserved areas. **Ms. Hernández-Cancio** said we

need to ensure guardrails are in place to ensure the right things are being measured. It needs to be the choice of the patient and not what bureaucrats want. **Rep. Kildee** asked how Congress should be delivering the quality of behavioral health through telemedicine. **Dr. Kim** said that providers can "spread out" through telehealth and not concentrate in urban areas. Telehealth is a big tent and will include pure telehealth services and the skills exhibited by specific types of providers.

Rep. Panetta (D-CA) said he is a co-sponsor of the Telehealth Modernization Act to eliminate geographic and originating site restrictions. He asked whether there was support for eliminating barriers. **Mr. White** said it was essential. **Rep. Panetta** asked what else needed to be done. **Mr. White** said there was a critical need for broadband expansion. **Rep. Panetta** asked what role telehealth plays in combatting health disparities. **Ms. Hernández-Cancio** said that there is enormous promise. But there are literacy issues, access issues and patient choice issues. We know the same communities are continuously left behind. There are so many other measurements—like respect and cultural competency—that inform patient-centered care.