House Energy & Commerce Health Subcommittee Hearing
The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care

Tuesday, March 2, 2021 **|** 10:30 AM ET | Cisco WebEx

Key Take-Aways:

- There was disagreement amongst Subcommittee Members on the approach and timeline for adopting permanent telehealth reimbursement policies.
  - Some Members, including Subcommittee Chair Anna Eshoo, believe now is the time to act to permanently remove Medicare telehealth reimbursement barriers.
  - Others, including Subcommittee Ranking Member Brett Guthrie and Full Committee Chair Frank Pallone, would like more data to ensure proper guardrails are in place to protect against fraud, abuse, and overutilization and ensure equity.
  - For the most part, witnesses agreed that they do not support arbitrary restrictions – like requiring a patient to be seen in-person prior to a telehealth visit – as fraud, abuse, or overutilization guardrails.

- In addition to reimbursement barriers, many witnesses highlighted licensure reform as a critical need in removing barriers to care for both providers and patients. Laws that do not allow clinicians to practice across state lines are major barriers in access to care.

- Over the COVID-19 public health emergency period, telehealth has been a lifeline for many providers and patients.
  - Telehealth has seen a decrease in missed visits and "no shows" because it tends to be more convenient for patients.
  - Telehealth has the potential to lower cost of care because it can provide more timely access to care.

- Other key themes from witnesses and Subcommittee Members were payment parity and reimbursement for audio-only services.
  - Some witnesses stated that there is no evidence that suggests audio-only telehealth provides lower quality care when used appropriately and believe it has been a lifeline for many beneficiaries who do not have access to audio-visual technology and those who do have that technology but lack adequate high-speed broadband. While witnesses did not agree with that statement, some supported phasing out coverage of audio-only telehealth services over a period of time.
  - Overall, most witnesses supported payment parity between telehealth and in-person services; though some witnesses stated support for telehealth in value-based payment models vs. fee-for-service.

Witness Opening Statements:

Megan R. Mahoney, M.D., Chief of Staff, Stanford Healthcare
[View testimony here](#)

Ateev Mehrotra, M.D., MPH, Associate Professor of Health Care Policy, Harvard Medical School
[View testimony here](#)

Elizabeth Mitchell, President and Chief Executive Officer, Purchaser Business Group on Health
[View testimony here](#)

Jack Resneck, Jr. MD, Board of Trustees, American Medical Association
[View testimony here](#)

Frederic Riccardi, President, Medicare Rights Center
[View testimony here](#)

Member Opening Statements:

Chair Anna G. Eshoo
- Medicare reimbursement for telehealth services need to be made permanent.
- More than 10.1 million traditional Medicare beneficiaries has used telehealth during the early days of the pandemic.
- Telehealth can help address racial disparities and health outcomes.
- It is important to create innovative legislation that addresses the country's needs.

Rep. Matsui
- Telehealth has been critical in allowing for access to care during the public health emergency (PHE).
- The waivers issued by CMS were key in jump starting the widespread investment in telehealth.

Ranking Member Guthrie
- Broadband continues to be a limiting factor in patients' ability to access telehealth services.
- Congress has worked to resolve this issue via four COVID-19 relief packages.
- Infrastructure limitations to telehealth access needs to be addressed.
- There is a need to examine appropriate guardrails for telehealth services to combat bad actors looking to take advantage of this circumstance. Scammers and criminals are cold-calling Medicare beneficiaries and are using fraudulent, overseas providers to bill for services.
- The OIG is focused on 3 key areas of telehealth:
  - Quality of care and patient safety
  - Verification of services and patient consent
  - Infrastructure

Chair Pallone
- Most private insurers have followed Medicare's lead during the PHE in reducing barriers to accessing telehealth services by allowing coverage of more services and reducing cost-sharing for those telehealth services.
- Telehealth expansion has helped save lives and helped to keep providers afloat during a time where patients were hesitant to physically go in and seek care.
- The data shows that telehealth utilization has skyrocketed, not only in the Medicare program but among private insurers as well.
- Private insurance plans do not have the same statutory restrictions such as rural and originating site requirements.
- It is important that the data collected today informs decision-making going forward. There are several key areas to consider:
  - Value. Even though the expansion improved access, it could still cause over-utilization, or low-value care in Medicare fee-for-service.
  - Strengthen program integrity and prevent potential bad actors that are taking advantage of the system and consumers.

o Ensure equitable access to telehealth. Ideally, telehealth will ensure access to underserved communities. The data needs to show that these vulnerable populations are effectively being reached.

Ranking Member McMorris Rodgers
   o Telehealth is particularly important in rural areas during the pandemic.

Q&A

Chair Eshoo
- There is a concern that telehealth will increase services utilization, and therefore, increase costs. What does the word utilization mean? Is all utilization the same? Will one reimbursement cover the costs? Is it possible to write that kind of clinical determination into law?
   o Mahoney: Utilization typically refers to patient consumption of healthcare services, including the clinician's time spent seeing the patient and any ancillary services that are provided such as lab tests. The clinician's time is usually the rate limiting factor. The fear is that telehealth will be additive not substitutive, but we have not seen that happen.
- Does the data show that telehealth can substitute for in-person care?
   o Mahoney: Telehealth can substitute for in-person care.
   o Mehrotra: It is difficult to use the data from the pandemic. It is important to look at the period prior to the pandemic to try to assess that. There is not enough research on this particular topic. One study shows that for one form of telehealth, it was primarily additive, and it did increase healthcare spending.
- Have any of you examined the CONNECT for Health Act ([HR 4932](#), 116th)? Do you think it accomplishes what Congress wanted it to?
   o Resnick: The Telehealth Modernization Act ([HR 1332](#), 117th) approach is preferred. Adding permanent repeal of the rural exclusion and the originating site exclusions would give certainty in clinician practices.

Ranking Member Guthrie
- The OIG highlights critical vulnerabilities that could exist within telehealth as Congress thinks about expanding these important benefits. The potential vulnerabilities need to be weighed. As Congress examines making some of these flexibilities permanent, how do you think Congress should address clinical appropriateness?
   o Mitchell: Research is necessary to determine clinical effectiveness. We need to measure both the quality and patient experience of telehealth service itself as well as the experience within the practice when telehealth has been integrated.
- How do we balance the accessibility of technology with patient privacy?
   o Riccardi: Some telehealth services should be expanded, but expansions must not exacerbate existing health disparities and it must go back to some of the pre-pandemic protections such as the HIPAA rules.

- Expand on the safeguards state legislatures and medical boards have put in place to ensure safe practice of telemedicine.
  - Resnick: States set the rules of the road for physicians through their state medical practice acts. Congress should not support federal licensing. State medical boards are what hold physicians accountable for the care of patients in their jurisdiction. And that is where their enforcement lies. There is no interstate policing of that.

Chair Pallone
- What does the data from before and during the pandemic say about whether telehealth services seem to substitute or add to in-person services? Could you discuss incentivizing high-value telehealth services and avoiding over utilization?
  - Mehrotra: Has not witnessed an increase in the utilization of telehealth overall in the number of visits physicians are receiving during the pandemic. But this cannot be generalized until after the pandemic. Payment reform has not been addressed so far.
- What does the research show in terms of cost effectiveness of telehealth services relative to in-person services? Are there any policy considerations that you would recommend with respect to cost effectiveness?
  - Mehrotra: Telehealth is not a monolith - there are certain applications where it would be cost effective and others where it is not.
- Is cost-effectiveness an important consideration for purchasers and are there other factors that warrant additional study?
  - Mitchell: It is necessary to move away from fee-for-service (FFS). Tossing in another service into the dysfunctional system will not make it better. Telehealth needs to be thoughtfully increased within the total cost of care or some other non-FFS model.
- Is there a need for additional data on cost, quality, and outcomes of telehealth services compared to in-person services?
  - Mahoney: We now have a 12-month, real-world data set on scaled telehealth implementation across the country. There is an opportunity to leverage the data to conduct a large-scale analysis and determine inclusively what is the association between clinical outcomes and telehealth. There needs to be continued access to telehealth to be able to answer those questions and the questions that are related to health equity.

Ranking Member McMorris Rodgers
- What does the data show on patient outcomes and satisfaction on mental and behavioral health treatment using telehealth? What can Congress do to make sure kids and adolescents get the care that they need?
  - Mehrotra: The research is consistent. Patients who receive care via telehealth vs in-person care average outcomes are generally the same and sometimes better for the treatment of mental illness. This is also true among adolescents and children. Licensure is something that can be addressed by Congress. Laws requiring patients to have an in-person visit before being able to receive mental health care via telehealth is another barrier that Congress can address.

- What do you foresee the future of telehealth being? What do you think telehealth should look like 10 years from now?
  - Mahoney: The office face visit will change. The need for an annual, in-person physical in primary care will also change. Specific indications for an in-person visit needs to be revisited because of the inconvenience on the part of the patient. The application of remote patient monitoring will also be increasingly utilized.

Rep. Matsui
- Expand on how new patient visits, by modality, has changed over the course of the pandemic. What has been the primary driver of these changes?
  - Mahoney: The in-person requirement is outdated. High quality care can still be provided, even at the initial visit. Additionally, there has been an uptick in number of patients who actually show up to their virtual appointments because of the added convenience.
- What is the clinical necessity of the in-person requirement for telemental health services?
  - Resneck: Each specialty needs to be examined in order to figure out the standard of care for a variety of conditions.
- CMS has said it may stop reimbursing for audio-only telehealth, how might that impact the 1/3 of Medicare beneficiaries who have used this method during the pandemic?
  - Riccardi: Audio-only has been a lifeline through this pandemic. A significant number of Medicare beneficiaries do not have access to audio/visual technology. Data suggests that audio-only visits are applicable and should be used for people who need behavioral health services.

Rep. Upton
- Does the OIG have the tools to stop people from cheating the system?
  - Resneck: The OIG has the tools needed. Telefraud has nothing to do with telemedicine. It is unscrupulous marketing companies that are reaching out to patients for free services and then will document it as a telehealth visit. But they are not billing for the "visit," they bill for the prescription or DME. This fraud existed before the pandemic.
- What are your thoughts on further expansion of mental health telehealth?
  - Mitchell: This is very important, but the concentration of mental health providers is often inversely related to the need. Telehealth can play a critical role in addressing access, but broadband and licensure issues still need to be addressed.

Rep. Castor
- Where would you prioritize additional research to build the evidence based on quality and outcomes for certain services to ensure that seniors are getting the services they need?
  - Riccardi: Geographic and site restrictions need to be removed. Systems that work for all people with Medicare need to be set in place.
- Where should the research be prioritized so that we have the data on patient outcomes and quality?

- o Mahoney: Peer-reviewed research to quantify the clinical quality, cost, and safety outcomes of telehealth compared to in-person needs to be completed. There also needs to be a better understanding of the association between access to internet, smartphone, or computer, and digital literacy and how that might affect clinical outcomes.
- o Mehrotra: There is not much data on the Medicaid side of things. The lack of evidence creates a dilemma on where to go. There are a number of states that have proposed or implemented trial periods after the end of the pandemic for up to two years for broader coverage. This also allows for more studies to be done to see where telehealth is most effective.

Rep. Burgess
- Is there any Congressionally directed research that might be useful in assessing the cost effectiveness of telehealth?
  - o Mitchell: Many of the PTAC models envisioned alternative sites of care. Patients need to be reached where they are. More research is needed to increase the amount of patient reported outcome measures.
- Is there anything that Congress can do on the front-end to ensure that telehealth does not become overly burdensome?
  - o Mitchell: Health data needs to be effectively shared.
- Are there any services that you provided via telehealth in the past year where you felt limited in treating a patient because of the virtual nature of the visit?
  - o Resneck: Yes, but that is part of the evolving evidence space.

Rep. Welch
- A fee-for-service system tends to encourage over utilization. How do we avoid this problem?
  - o Mitchell: Affordability is a crisis. Adding another service to the FFS is not optimal. There are ways we can utilize telehealth in our current system to reduce total costs. For example, expanded access to primary care can and does reduce unnecessary visits to the emergency room.
  - o Mehrotra: Too much emphasis is placed on being worried about whether telemedicine will be over utilized especially in comparison to services such as surgeries or endoscopies. Many people put specific concern on telehealth because the convenience creates a risk of over utilization higher.

Rep. Griffith
- CMS estimates about 30% of telehealth visits to be audio-only and a recent JAMA study of a California-based FQHC found that audio-only accounted for nearly half of all telehealth visits. When is it appropriate to use audio-only?
  - o Resneck: It is typically not a first-choice option, but it has been a lifeline, particularly for those in rural areas and disadvantaged patients. Audio-only can also be used as a backup especially if there are technological issues where the video component is no longer working.

- Do you believe it is appropriate for providers to receive a lower reimbursement rate for audio-only visits than audio-visual visits?
  - Resneck: The patient is just as sick on the audio-only visit as the patient seen during the audio-visual visit. The care is congruent. The audio-only visit is not a service to be valued differently. It is 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.

Rep. Schrader
- Are there any savings the system in terms of telehealth?
  - Mahoney: 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.
- What needs to be done from a policy perspective to help facilitate that transition from FFS to alternative payment models (APMs)?
  - Mehrotra: The next generation of ACO models need to be built upon what already exists. Need to consider how to accelerate their adoption and refine them so they are better accepted by providers.
  - Resneck: The AMA has been working on developing more APMs. But the massive innovation under telemedicine during the pandemic happened within the FFS model. So, innovation can happen in both spaces. Additionally, Medicare has only adopted so many of the APMs currently available and they are not available to many physicians. If telehealth becomes only available to patients that are in APMs, many Medicare beneficiaries may be stripped of their benefits.

Rep. Bilirakis
- Are there any ongoing concerns that you are aware of concerning programmatic fraud that may merit differences between traditional Medicare and Medicare Advantage or should certain guardrails be put into place if such policy was extended to Medicare Advantage plans? And if so, what should those guardrails be?
  - Riccardi: Medicare Advantage program should have these flexibilities. It is crucial that the expansion of telehealth benefits such as removing geographic site restrictions, is essential. It must also be applied to FFS original Medicare. Because millions of people could potentially be left behind. It is recommended to remove barriers to access and use data on the backend to detect any potential fraud, waste, or abuse. Audio-only has a role in helping people access the services that they need.
  - Mehrotra: Both private and public insurers and those in the Medicare Advantage plan are judiciously moving forward. Most are not planning on covering audio-only telemedicine visits in the future.

Rep. Cardenas
- What are some of the potential barriers to accessing telehealth that exist today and what can be done to take down those barriers?

- Riccardi: This is an opportunity to invest in telehealth, to improve health outcomes, and not exacerbate existing health disparities. Research shows approximately 1/3 of older adults ages 65 and over do not use the internet and half lack broadband. It is even worse for Black older adults - almost 70% do not have broadband access at home. This is why it is super important to invest in broadband and technology.
- Resneck: Commercial payers, before the pandemic, have been directly appealing to patients offering direct telehealth services and promising to waive co-pays but refused to cover coordinated care with the physicians who already knew those patients. This has actually worsened disparities for the working poor.

Rep. Long
- How can telehealth deliver value to our healthcare system beyond just replacing a face-to-face visit? How can it lead to greater efficiency for both patients and physicians?
    - Resneck: The growth of telemedicine for chronic disease, where there is a huge ability to impact value of care and measure the financial benefits, is what will continue to be seen post-pandemic. Additionally, it is more convenient for the working poor so that they do not have to miss a day of work to come in physically to the office.
- How can telehealth help with the problem of physician shortages especially in rural areas?
    - Resneck: Telehealth is not a panacea for workforce issues. There are maldistributions of providers, particularly in rural areas.
- It will be difficult for providers to invest in the technology required to provide telehealth services and to incorporate telehealth into the workflows and its future is uncertain. What constitutes certainty?
    - Resneck: Payers need to understand that this is part of the future of healthcare delivery and that it is not going to suddenly disappear. Permanently removing the e restrictions is an important part of that. The big investments are not always in technology, but it is also about retooling your entire office.
- Why are concerns for fraud and abuse misplaced?
    - Resneck: The OIG and DOJ already have the tools. Telehealth fraud has very little to do with telemedicine and has more to do with using "sham" telemedicine that they are not even billing for in order to provide prescriptions and unneeded genetic testing.

Rep. Ruiz
- How can telehealth be used to expand and improve the use of home healthcare?
    - Mahoney: Skillful leveraging of the existing resources that are available and are also culturally sensitive and language concordant can overcome the barriers to access. There are number of licensed, non-physician practitioners that are instrumental in extending access to care, like pharmacists and physical therapists. Currently, these professionals are not able to bill for telehealth services.

Rep. Bucshon

- Do you believe that providers should be reimbursed for audio-visual visits at a same or similar rate as in-person visits? Can you elaborate on the provider concern expressed in the survey and share what you are hearing on the ground regarding provider reimbursement for telehealth services?
  - Resneck: Both telehealth and in-person visits should be reimbursed the same because telehealth is one mode of delivering a service. Coverage and parity rates allow physicians to provide this care to patients. Telemedicine is difficult work that should be paid equitably.
- Will a physician be held liable for mistakes made via telehealth? For example, if a patient sends a picture of a suspicious mole to a dermatologist who deems it to not be cancerous, but because of the poor photo quality, the doctor misdiagnosed the patient.
  - Resneck: Liability reform is on a lot of physicians' minds. Physicians should not be held accountable for what they were not shown or cannot see. However, the standard of care should be the same whether services are provided in-person or not.

Rep. Dingell
- In 2018, Congress allowed clinicians working with the VA to practice both in-person and telehealth across state lines as long as their license was in good standing in their home state. Congress did the same thing for DHS providers in the CARES Act. What is your view on a temporary, time-limited licensing proposal to address the current public health emergency?
  - Mehrotra: Licensure reform needs to be addressed and interstate practice of medicine needs to be facilitated.
- Do you have any suggestions on how we can strengthen Medicare program integrity to prevent cold calling and billing for unnecessary services, for example?
  - Riccardi: As we continue to move forward with telehealth, we need to draw upon previous experiences with fraud, waste, abuse, and privacy concerns. As we consider measures for combatting fraud and scams, we need to ensure we do not arbitrarily impose barriers onto people who need access to that care. We also need to consider other protections related to Medicare law, such as HIPAA. We can also draw upon supporting the community-based organizations that serve Medicare beneficiaries to help them combat fraud.

Rep. Mullin
- Is there more that can be done to provide providers in rural areas with the information needed to gain access to telehealth grants?
  - Resneck: The AMA and specialty societies have rolled out additional information about some of the grants to help with implementation in the last several months. CMS has been cooperative and supportive in helping the AMA improve that process.
- Would it be beneficial to have a "one-stop-shop" for opportunities to learn more about telehealth?
  - Resneck: This could be helpful.

- Would it be beneficial for there to be an elevated presence within HHS to coordinate these telehealth investment and policies across the government?
  - Resneck: AMAs observation is that HHS has made this a priority.

Rep. Kuster
- Please describe how the current flexibilities around prescribing medication assisted treatment has actually improved access to care.
  - Mehrotra: There has been some frustration with the changes that have been made to [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. This is a key area to be able to provide the flexibility and treatment.
- What can be done to encourage greater uptake among providers who might be hesitant for using some of these new flexibilities especially on new patients?
  - Mehrotra: There is wide variation in how providers who provide this treatment feel. On the clinical side, guidelines have been requested so that people feel more comfortable and this is a more reasonable way to treat opioid use disorder. This is the key to convincing providers to move in that direction.
- What are your thoughts on delivering telehealth across state lines to the nation's most vulnerable including behavioral mental health patients?
  - Mehrotra: It is difficult in areas like New Hampshire (with multiple state lines) for many people to receive treatment. A number of private companies are providing innovative new models to expand the use of telemedicine across all 50 states. The key is to provide licensure reform and broadband expansion.

Rep. Dunn
- Remote patient monitoring (RPM) can help resolve issues such as no-shows and missed appointments. It can also decrease the cost of chronic disease, reduce "frequent flyer" emergency room visits, and it is almost office style care without exposure to communicable diseases. Is there data now to determine the degree to which RPM can generate savings and how should we be thinking about accounting for the costs and the savings?
  - Mitchell: Telehealth will enable innovative and patient-friendly models of care in the home and in the community. The payment barriers to this need to be removed. There is not sufficient data that quantifies the savings from telehealth at this point. However, if it is deployed correctly, there can be significant savings. There is more research needed on the outcomes and cost.

Rep. Kelly
- Can you discuss what states have done before and during the pandemic to increase care across state lines?
  - Resneck: There are a couple of things that help with the licensure issue, one being an interstate compact, which makes it easier for physicians who are in good standing with their own state medical board to get licensed in multiple states. State medical boards need some ability to create unique, local reciprocity solutions around state boarder areas. Additionally, there are a set of codes which CMS has

approved called interprofessional consultation codes. These codes recognize a consulting physician with the main physician or specialist. One physician is giving advice while the other carries the responsibility of the daily care of the patient.

- Can you expand on how already existing disparities are made worse in a virtual environment and how can we address and remedy these inequities in virtual services provided through Medicare?
  - Resneck: The last year as ameliorated some of that. Broadband issues effect patients of color and low-income patients more than others. Fixing this issue will help the country go along away in health equity.

Rep. Curtis

- How important is it for HHS to work with Congress to obtain better health data? Contrast that to academia or another industry looking for data. What is the role for Congress?
  - Mehrotra: More data is needed on what is happening during the pandemic and the post pandemic period. HHS should work to gather more data on Medicaid programs.
- What metrics should Congress be using to help make better decisions?
  - Mehrotra: The key is that telemedicine will improve health. In recent research 1/3 of US hospitals have introduced telestroke which has led to a decrease in mortality.

Rep. Barragan

- What can Congress do to make sure underserved communities are not left behind? What should Congress keep in mind?
  - Mahoney: Tremendous progress can be made using the phone alone. The medical decision-making and the clinical effort required by the practitioner should be reimbursed and compensated in the same way other modalities of care are compensated. Additionally, broadband access needs to be expanded to all communities so that all communities can enjoy the benefits that come along with that technology. The phone is a vital backup. High quality care can be provided via audio-only means and should be reimbursed accordingly.
- At the beginning of this Congress, Barragan reintroduced the Improving Social Determinants of Health Act (HR 739, 117th). This legislation empowers public health departments and community organizations to address socioeconomic and societal barriers to health access in underserved communities. Internet connectivity is a social determinant of health. Can you discuss ways community organizations and community healthcare providers are leveraging telehealth to address SDOH and how can Congress better support these efforts?
  - Resneck: Everybody on the care team is needed in order to help with the disadvantaged patients. Broadband has been an issue. Getting previous grants for broadband expansion would be instrumental.

Rep. Carter

- Is there enough data to review the success of expanded telehealth services?

- o Resneck: These are not new services that are being provided. There is enough data to move ahead with making the expansion for visits permanent. There is a lot of data on the standard of care level but not the coverage level.
- Would you agree that telehealth increased access to care and decreased costs?
  - o Resneck: It is cost effective and has increased access to care.
- I sponsored The Telehealth Modernization Act (HR 1332, 117th), which would make the flexibilities from the pandemic permanent.

Rep. Blunt Rochester
- Is there anything that you want to add about making the flexibilities permanent? Can you expand on the impact on patients if they were to lose the benefits provided during the pandemic?
  - o Resneck: Beneficiaries have become comfortable with the technology. It would be difficult to take away the benefits provided for during the PHE.
- Could you talk about how this opportunity intersects with broadband, transportation challenges, and other challenges beneficiaries might face?
  - o Resneck: This issue with lack of access to broadband is incredibly widespread. Affordability of broadband needs to be improved.

Rep. Crenshaw
- How do we properly regulate telehealth? What should Congress focus on?
  - o Mehrotra: A major barrier for providers using telemedicine is confusion. This becomes an impediment to providing telemedicine care. When making limitations on telemedicine, the key is to focus on only one dimension.
- How much would we save in telehealth? What are some of the best practices that you might suggest businesses could use to incorporate telehealth and pass these savings onto patients?
  - o Mitchell: Our members are self-insured, so the savings go back to the business immediately. But they are looking for ways on passing these savings on to employees. Barriers that are currently being faced are in the payment models.

Rep. Schrier
- Would you be able to take telehealth a step further and take the primary care doctor and the entire care team in one room, hearing and sharing information in real time? How might this improve medicine?
  - o Mahoney: We have experimented with having multiple providers, the patient, and family. The major barrier is the coordination of scheduling all of the individuals. Asynchronous communication through the electronic health record has been helpful.
- Can you talk about the good, bad, and the ugly with pediatric care specifically?
  - o Mehrotra: While healthcare visits have returned to baseline, one of the areas that has not is pediatrics. Kids are now less exposed to illnesses. However, there is a concern that there is a deficit in immunizations and preventative health visits.

Rep. Joyce
- Do you foresee any long-term consequences for "visual" fields like dermatology, given the shift to telehealth?
  - Resneck: Every specialty has identified areas where telemedicine can be useful.
- Should training in telehealth be included in training for medical students and residents?
  - Mahoney: Medical students and residents should be trained in telehealth and different modalities of care. They need to be empowered with all of the knowledge to be able to provide care effectively.
- Do you recommend this as a requirement to complete residency training?
  - Mahoney: I am enthusiastic about the idea while not an expert in that area.

Rep. Craig
- How do we best expand the reach of our existing healthcare workforce, especially for services like mental health and at the same time, balance the appropriate use of care, and guard against overuse?
  - Mehrotra: Rural patients are receiving less care, specialty care in particular, in comparison with their urban counterparts. States are grappling with how to address the balance of increasing access while also addressing overuse. Many states do not have enough data from the pandemic and have chosen to temporarily expand telemedicine for 1-2 years and use this time to understand what the impact is and whether this overuse concern is valid.
- In expanding access to telehealth, what additional policy tools should Congress consider in addressing the digital divide and ensure health services reach these underserved communities?
  - Riccardi: There is only early 2020 Medicare claims data that has not been publicly released yet. However, it is known that about 30% of beneficiaries who receive telehealth services were located in urban areas. 22% of beneficiaries were in rural areas.

Rep. Latta
- In light of the immense stress and pressure that has been placed on our hospitals, mental health providers, and addiction counselors, do you believe temporarily waiving state licensure requirements would help ensure patients can receive the quality care they need?
  - Mahoney: The TREAT Act ([HR 708](#)) will ensure continuity and access to care for patients nationwide during the pandemic. The issue of specialty care and behavioral health care access across state lines will persist beyond the pandemic. The system needs to be re-evaluated with this in mind. Providers who are in good standing should be allowed to practice in any state.
- Can you provide examples of licensure challenges faced by providers and why the current patchwork of state laws is making providing care for patients more difficult, especially during the pandemic?
  - Mahoney: After lockdown started, (our) providers received request for care from all 50 states. They were able to provide that care in states that did not have

subspecialty providers. Academic medical centers are able to provide subspecialty services that are not available throughout certain states.
- Would you agree that the severity of this crisis demands that Congress address the licensure issue and expand deployment of care during the duration of this public health emergency?
    o Mehrotra: We need to go beyond the TREAT Act by allowing any Medicare beneficiary to receive care from a physician who is licensed.

Rep. Trahan
- Research has shown that compared with clinic visits, telehealth visits had significantly lower "no-show" rates among Latinx and non-English speaking patients. Studies have shown that tele-dermatology may play a large role in mitigating "no-show" rates and improving access to care. Have the findings been consistent with your medical experience?
    o Resneck: Some of the highest "no-show" rates are from patients who are already suffering from health disparities. The decrease in "no-show" rates have had an impact in improving care for the disadvantaged populations.
- Data suggests individuals are more inclined to visit a medical professional who share their same race or ethnicity. Is telehealth making the case for investing in a more diverse medical workforce?
    o Mahoney: Access to telehealth, or any modality that improves access to care is going to improve the trust and connection a patient will have with a provider.

Rep. Johnson
- Telehealth can make a huge impact in improving access to mental health treatment. Why is it so important to address issues early and can you provide some more examples on how telehealth can be used to achieve this?
    o Mehrotra: Before the pandemic, in some rural communities 30-40% of mental health services were provided via telehealth. During the pandemic, rural patients are using telehealth at a lower rate than people in urban areas. In another example using skilled nursing facilities (SNF), if telehealth could be provided as after-hours coverage, it would allow patients to be treated within the SNF without having to be transferred to the local ER and be hospitalized.
- As policymakers, why is it so important that we consider permanent telehealth policy changes but that we also keep working to build out adequate broadband infrastructure?
    o Riccardi: We need to invest in the infrastructure so that all communities have access to broadband and the technologies patients can use to receive care from home. It is important to ensure there is no disruption in care once this PHE comes to an end.

Rep. Fletcher
- Can you speak to these behavioral health issues, namely pediatric behavioral health issues?
    o Mahoney: Children are experiencing more isolation and sometimes can be overlooked. They have not been able to get the most evidence-based treatments for their conditions. Regarding reimbursement, this is an issue of Medicaid law.

Having interstate restrictions waived has been beneficial in providing access to subspeciality services across state lines.

- Are there particular issues that Congress should be thinking about to ensure more people with disabilities or complex medical conditions are able to access these services?
  - o Riccardi: The pandemic has allowed more people to access services. However, there is still a lack of transportation and/or access to facilities that meet ADA compliance. As we move forward with telehealth, we still need to ensure these physical facilities are meeting ADA requirements. Telehealth should not become a barrier to those with disabilities that may need to physically go to a doctor's office for follow-up care.

Rep. Pence
- Movement disorders typically require in-person interaction to properly diagnose and treat. How can we blend telehealth services with traditional care to better impact rural America and patients with chronic health conditions?
  - o Mehrotra: Patients in rural communities need to be able to access care from anywhere in the country. Licensure is in need of critical reform to allow for patients in rural communities to be able to access the care that they need.

Rep. O'Halleran
- Without access to high-speed broadband, are there certain specialists who may be difficult to see and treatments that are more difficult to obtain? What is the future with broadband?
  - o Resneck: There are certain specialties that require more bandwidth than others. All patients need to have the option to be able to speak with any provider electronically.

Rep. Sarbanes
- How has the expansion of telehealth services helped doctors and medical staff reach younger patients, particularly in underserved populations? What opportunities exist to help broaden access to these populations?
  - o Resneck: Barriers to access can often be multiplied for children. But there are improvements on both sides of the age spectrum. It is very important that in-person visits are still made available to children when they are appropriate as well as having the telehealth tool as an option.
  - o Mahoney: School-based health centers have the potential to significantly improve telehealth access for children because it helps to overcome the digital divide issue.
  - o Mehrotra: School-based health centers could also allow for teachers to get involved in behavioral health issues such as attention deficit disorder which adds additional value.
- What is telehealth going to look like post-pandemic?
  - o Mehrotra: New models of care that push boundaries in what traditional care is supposed to look like. These new models of care that fall under remote patient monitoring is where we are headed post-pandemic, but it does further complicate how payers will pay for these types of visits.