HEALTH **INNOVATION** ALLIANCE

Joel C. White, Executive Director

Testimony Before the House Ways & Means Subcommittee on Health
"Charting the Path Forward for Telehealth" Hearing

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Introduction

Chairman Doggett, Leader Nunes, and Members of the Subcommittee, thank you for inviting me to testify today. My name is Joel White, and I am the Executive Director of the Health Innovation Alliance, or HIA. HIA was started in 2007 as a diverse coalition of healthcare providers, patient advocates, employers, insurers, and technology companies who support the adoption and use of data and technology to make health care work better. Today our membership comprises more than 60 organizations who agree that one of our top priorities is to improve care by expanding telehealth.

We are witnessing the beginning of what I hope will be a digital health transformation. In this revolution, providers are brought directly to patients versus the other way around. Such a radical change in care can usher in a new age of consumerism that can reshape incentives to lower costs while also improving access to care.

COVID accelerated this adjustment by forcing consumers and providers to rethink how people receive care. Congress and the Centers for Medicare and Medicaid Services (CMS) waived government rules that held back use and provision of telehealth leading to an incredible natural experiment where patients are getting more access to care, care is more convenient to the patient, and costs may be lower.

This Committee is now wrestling with whether to continue the transformation and make the temporary waivers permanent, revert back to the old rules, or adopt a hybrid structure. If I can leave the committee with one suggested path forward, it is:

1. Permanently extend the temporary telehealth flexibilities to ensure Medicare beneficiaries can continue to receive care remotely once the public health emergency (PHE) ends.

2. Ensure appropriate tools and incentives are implemented to safeguard taxpayers and patients from fraud or overutilization while transitioning to value-based models of care delivery and reimbursement.

3. Remember that hundreds of millions of more Americans obtain health coverage outside of Medicare fee-for-service and are looking to Congress to eliminate roadblocks to progress, such as the outdated medical licensure system and limits on account-based plans.

Making these reforms is a common-sense approach to post-pandemic care. They rightly update Medicare by eliminating the statutory limitations that were developed decades ago on where providers and patients must be to deliver or receive remote care are simply archaic and nonsensical in 2021. In addition, these reforms will greatly expand access to care for all Americans. Congress should move quickly to solidify the gains already made and build a foundation for progress in the future.

The Context – Factors Influencing Telehealth During COVID

Out of necessity many turned to telehealth as a safe alternative to in-person and face-to-face visits once COVID hit U.S. shores. The quick onset of the COVID-19 pandemic in early 2020 brought about not only severe health challenges, but also problems delivering in person care for patients who contracted COVID-19 and for patients who needed routine medical care for other diseases and conditions. As emergency rooms, hospital ICUs, and inpatient beds started to fill, CMS issued a series of policies to guide "voluntary care" – or the care needed by non-COVID patients, such as dialysis, cancer care, and treatments for heart disease – that effectively restricted access to in person care. [1] Hospitals were turned into COVID-focused facilities overnight, and the CDC encouraged non-COVID care to be delivered via telehealth if possible whenever possible.[2]

To address these challenges, Congress passed legislation such as the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), and the Administration effectuated waivers of restrictions on telehealth delivery and reimbursement of care throughout the public health emergency. As a sample of the waivers in effect since the end of March 2020, CMS has:

- Allowed Medicare fee-for-service (FFS) patients to receive telehealth in their home, and regardless of whether they live in a rural area (with some exceptions). Previously, patients had to be from a rural area and go to a clinic, hospital, or doctor's office in order to have a telehealth visit with a provider who was in another facility.

- Allowed physical and occupational therapists and speech language pathologists to visit with patients through telehealth services and to bill Medicare where they previously could not.

- Allowed for the use of audio-only telehealth in certain circumstances, and

- Allowed for the use of technologies like cell phones and video calls to facilitate provider visits even though those technologies may not be in compliance with HIPAA or other federal requirements.

The confluence of these policies, especially the waiver of government rules, has effectively produced a year-long, nation-wide demonstration project from which we can garner much needed evidence on cost, usage, access, quality and outcomes, and technology gaps. This experience should guide Congress as you seek to answer the question of whether or not to extend or expand current policies.

Track Record Through COVID

The HHS Assistant Secretary for Planning and Evaluation (ASPE) issued a report in July 2020 highlighting the expanded use of telehealth by Medicare FFS beneficiaries during the first six months of 2020. The report shows that more than 40 percent of primary care visits for FFS beneficiaries were conducted via telehealth in April 2020, compared to less than one percent in February, prior to the

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[1] https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf

[2] Centers for Disease Control and Prevention (2020). Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html.

PHE.[3] As CDC data shows, reported patient encounters using telehealth rose sharply after the waivers went into effect in early March 2020.[4]
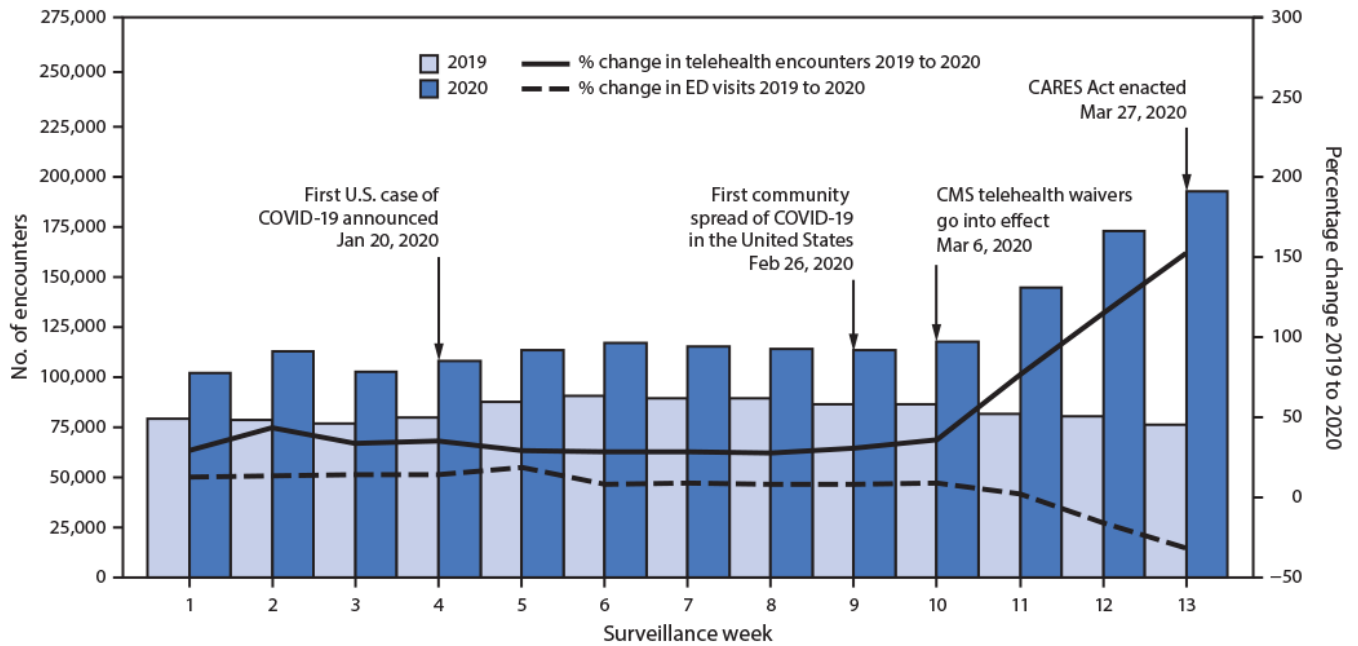
Source: Morbidity and Mortality Weekly Report, CDC (2020).

According to surveys from the CDC last year, an estimated 41 percent of U.S. adults were delaying or avoiding medical care during the pandemic because of concerns about COVID-19, and this was "more prevalent among unpaid caregivers for adults, persons with underlying medical conditions, Black adults, Hispanic adults, young adults, and persons with disabilities."[5] Telehealth helped fill those gaps, and the CDC recommended telehealth flexibilities to "help prevent delay of needed care."[6]

IQVIA data suggests that pre-pandemic telehealth visits represented less than one percent of total health care visits. As displayed in the chart below that number sharply increased with COVID-19 mitigation measures such as stay-at-home orders and restrictions on in person care took hold across the country. As proper precautions were implemented and patients grew more comfortable, telehealth

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[3] Office of the Assistant Secretary for Planning and Evaluation (July 2020). Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic. https://aspe.hhs.gov/system/files/pdf/263866/hp-issue-brief-medicare-telehealth.pdf.
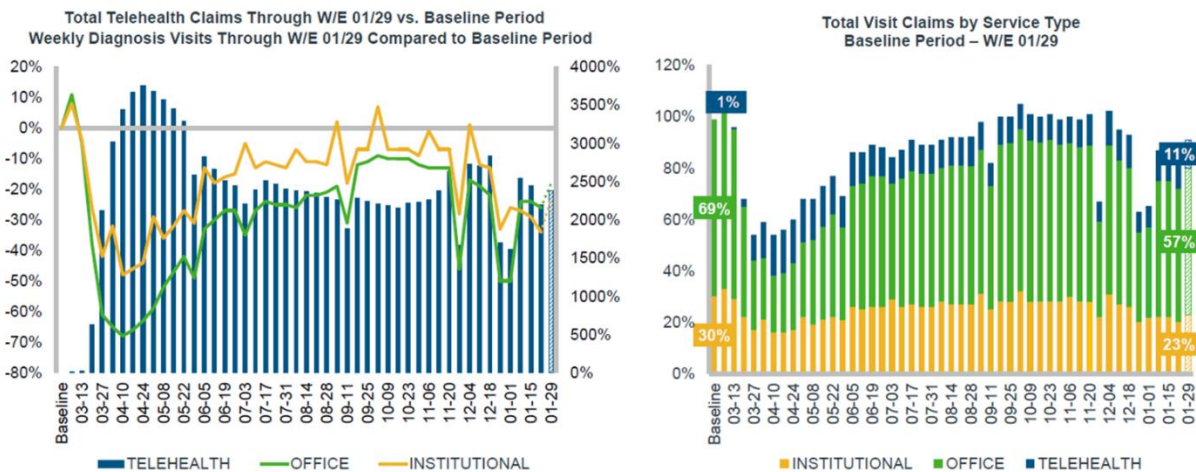
[4] Centers for Disease Control and Prevention (October 2020). Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic – United States, January – March 2020. https://www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm

[5] Koonin, L.M., Hoots, B., Tsang, C.A., Leroy, Z., Farris, K., Jolly, B.T., ... & Harris, A.M. (2020). Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. *Morbidity and Mortality Weekly Report,* 69(43), 1595-1599. https://www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm.

[6] *Id.*

medical claims reduced, and in-person visits resumed. However, telehealth visits have remained steady at about 10 percent reflecting, in part, provider and consumer preference for this mode of care. [7]

Weekly Medical Claims: Office, Institutional, Telehealth vs. Baseline

Total Telehealth Claims Through W/E 01/29 vs. Baseline Period
Weekly Diagnosis Visits Through W/E 01/29 Compared to Baseline Period

Total Visit Claims by Service Type
Baseline Period – W/E 01/29

Data for latest week date controlled against prior periods; estimates have been applied to reflect anticipated late-adjudicated claims based on historical rates

Source: IQVIA: Medical Claims Data Analysis, 2020; Baseline = Average of claims for period W/E 1/10/2020-2/28/2020;
Estimated amounts for latest weeks applied based on likely claims still to be received due to data latency or claim processing delays; See Appendix for further details

COVID-19 Market Impact - w/e Jan 29, 2021

≡IQVIA

According to IQVIA, telehealth billing claims show that telehealth was "almost exclusively used for mental health conditions" prior to the pandemic. During the pandemic telehealth services have expanded to conditions reflecting the broader population, including hypertension, diabetes, and hyperlipidemia.[8]

All told, the natural experiment data story shows improved care delivery, sustained access, fewer potential infections by keeping patients at home, and relieved stress on overburdened health care facilities. Moreover, concerns about overutilization and fraud seem to be localized instances of bad actors, just as in Medicare FFS face-to-face encounters. Importantly, patients who lacked access previously gained new opportunities to receive care in less expensive or more convenient settings.

Charting the Course Forward - Reform Recommendations

    I.   Modernize Medicare Fee-For-Service

Beyond the PHE, beneficiaries should be allowed to continue to access their providers through telehealth. Medicare should not have archaic policies that require patients to travel to a doctor's office

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[7] Dolan, A. (2020). Telehealth Transformation: Moving from Crisis Response to Population Health Solutions. *IQVIA.* https://www.iqvia.com/-/media/iqvia/pdfs/us/publication/telehealth-transformation.pdf?_=1619231638835.
[8] Margolis, J. (2020). COVID-19 and Lasting Trends that are Redefining U.S. Healthcare. *IQVIA.* https://www.iqvia.com/locations/united-states/blogs/2020/09/covid-19-and-lasting-trends-that-are-redefining-us-healthcare.

to have a virtual visit with another doctor in another office, especially if that patient could easily conduct the same visit from the convenience and safety of their own home.

Permanently Expand PHE Flexibilities

Specifically, Congress should permanently:

- Remove the originating site restrictions in Medicare to allow beneficiaries to receive remote care regardless of their location, including their own homes. Congress should eliminate the originating site requirement altogether and allow patients to access care anywhere.

- Eliminate geographic requirements to expand telehealth services into suburban and urban areas.

- Allow more sites of service and providers to use telehealth to treat beneficiaries. Federally qualified health centers and rural health clinics, for example, should be able to provide remote care to their patients. Additionally, more care professionals, like physical therapists, speech pathologists, and occupational therapists, should be allowed to use and bill for telehealth services.

- Allow audio-only telehealth visits for patients who do not have the option of using video technology.

- Allow the remote authorization of dialysis care through telehealth technologies instead of requiring an in-person visit.

START Act

Another sensical proposal is the Safe Testing at Residence Telehealth (START) Act of 2021 (H.R. 318). This legislation requires CMS to cover at-home COVID testing. Considering available diagnostics and technology, Medicare should not require beneficiaries to leave their homes to be tested and potentially expose them or others to COVID infection. This bill would pay for an at home diagnostic test and provide a telehealth service to ensure patients get the advice they need about possible infection and next steps in their care. It is a simple way to limit COVID spread and promote a flexible, patient-directed pandemic response for those most susceptible to hospitalization or death from the coronavirus. We applaud Representatives Schweikert, Rush, and Kelly for their leadership on this measure and encourage the Committee to mark up the bill as soon as possible.

Mental and Behavioral Health Services

There is no doubt that the pandemic has exacerbated opioid and substance use disorder, stress, anxiety, and serious mental health conditions, including schizophrenia and bi-polar disorder. The CDC reported in December 2020 that for a 12 month-period ending in May 2020, 81,000 Americans had died of overdose, the most ever recorded in a single year.[9]

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[9] Centers for Disease Control and Prevention (December 2020). Overdose Deaths Accelerating During COVID-19. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html.

Many behavioral health providers responded to the COVID crisis by shifting outpatient services online through telehealth. For example, Temple University Health System in Pennsylvania transitioned to telemedicine quickly over the course of March 2020-April 2020. Patients responded positively, exhibiting a decrease in the no-show rate from 25.9% prior to telemedicine to 8.3% after telemedicine. This increased engagement has sustained due to an ability to provide virtual care. The flexibilities that allowed this progress include the ability to prescribe controlled substances via telemedicine and advance dispensing of certain medication-assisted treatments. **Congress should preserve these gains to ensure the vulnerable continue to have access to treatment.**

With the passage of the Consolidated Appropriations Act of 2021 (P.L. 116-260) Congress made permanent access to remote mental health services in Medicare. Unfortunately, the Omnibus language included a requirement that beneficiaries have an in-person visit every six months.[10] The Health Resources Services Administration (HRSA) numbers on the shortage of providers is astounding, especially for mental health services. According to HRSA, nearly 7,000 additional mental health providers are needed to meet the current needs of the population.[11] Telehealth allows more efficient and convenient access to care for patients in need of mental health services and given the lack of providers available to address current needs, there is even less of a possibility that every patient in need will be able to have an in-person visit with a doctor. Patients with acute anxiety disorder who have been receiving remote care and may be more reluctant to return to in-person visits should not lose access to medicines that help them perform their jobs and support their families just because a waiver expires. **Congress should remove the in-person requirement for mental health services.**

Underserved Populations and Equity

Underserved populations in rural, suburban and urban communities lack access to care, sometimes for very different reasons, that can be addressed via telehealth. For many, the closest doctor or hospital could be hours away. Connecting to a caregiver through telehealth provides a much more convenient means of care delivery. Two-way, interactive video technology allows providers to reach patients who may not have the time or ability to get to a medical facility. However, these connections often rely on high-speed internet, or broadband, which unfortunately is not prevalent in many rural and underserved urban areas. **Congress should fund nationwide access to broadband.**

Another way to address disparate access is through audio-only care delivery, which has proven to be an incredibly useful tool during the pandemic. In many circumstances, a simple telephone call is all that is necessary for a provider to assess and discuss options with a patient or to simply refill a prescription that requires a provider sign-off. Many providers have been successful in switching to SMS communication through mobile devices such as cell phones which allow for communication in areas without sufficient broadband coverage.[12] Additionally, asynchronous technology that allows providers and patients to interact through automated forms are an excellent means of delivering care when more

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[10] Lacktman, N.M. (2021). Is this the Worst Medicare Telehealth Law of 2020? Foley & Lardner LLP.
https://www.foley.com/en/insights/publications/2021/02/is-this-the-worst-medicare-telehealth-law-of-2020.
[11] Health Resources and Services Administration (2021). Health Professional Shortage Areas. Accessed at
https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[12] National Center for Chronic Disease Prevention and Health Promotion (2021). Telehealth in Rural Communities. Centers for Diseases Control and Prevention.
https://www.cdc.gov/chronicdisease/resources/publications/factsheets/telehealth-in-rural-communities.htm.

robust technologies are unavailable. The Telehealth Equity Coalition, a multi-stakeholder effort to which HIA belongs, is seeking to address barriers to equal access to telehealth services and technologies. **Congress should codify audio-only policies and risk-adjust MA payments for audio only care.**

Finally, Medicaid and employers are expanding the use of telehealth as a key strategy in preventing disease progression while keeping people safe and well. Rather than being a leader, Medicare is quickly becoming a telehealth follower. Seniors and the disabled in FFS will be at a major disadvantage in terms of access to care via telehealth if Congress continues to delay making permanent upgrades to the program.
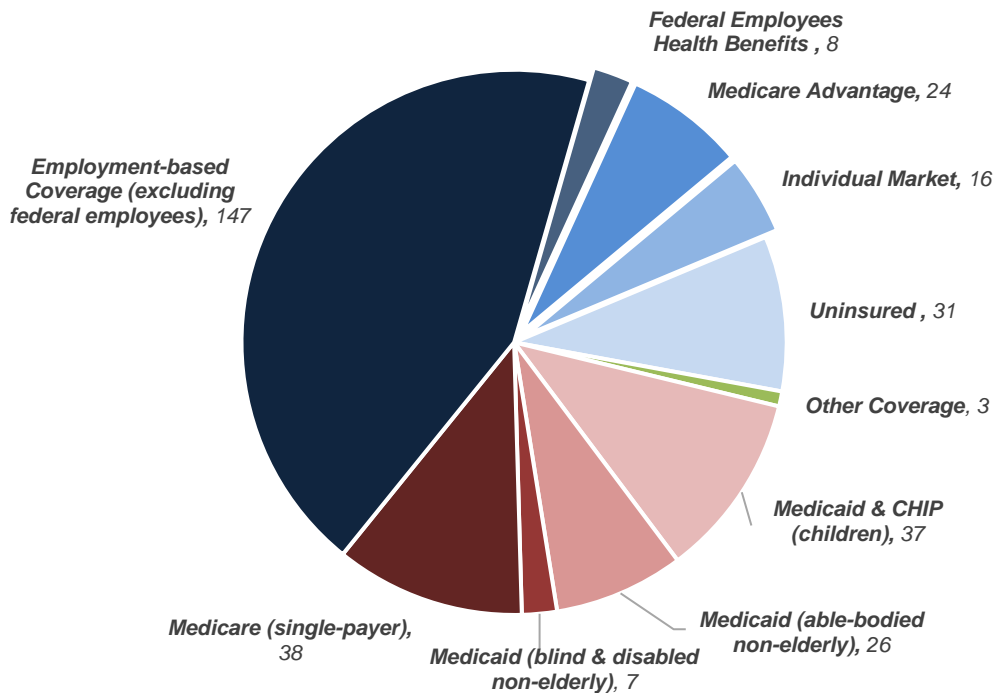
II.   Program Integrity Safeguards

Concerns about overutilization and fraud in telehealth are as well founded as they are for in-person care. Congress has included program integrity provisions in prior laws that have added new benefits or expanded existing services. HIA's members have been working on several approaches to ensure concerns about overutilization or fraud are addressed. They include:

1. **Audit top billers:** Require CMS to audit the top five percent of billers for telehealth services and identify any outliers for additional scrutiny. Not only would this identify problems, but it would also deter potential overutilization and fraud. The OIG already has the authority to do this, but Congress could direct it. If OIG needs more resources to target telehealth specifically, give them the funding they need to conduct proper program oversight.

2. **Expand the Right Incentives:** Allow all Alternative Payment Models (APMs) flexibility to use telehealth to advance value-based, virtual care. Currently, Medicare Advantage and Medicare Shared Savings Program participants (ACOs) are allowed to provide telehealth care without FFS restrictions. Value-based care gets past incentives for overutilization by holding the provider accountable. Allowing all current and future APMs telehealth flexibility will also help accelerate the transition to value-based care. This is a nimble approach that would allow doctors to treat based on what is best for the patient, not the reimbursement rate.

3. **Use the Technology to Full Effect:** Use data inherent to telehealth technologies to improve program integrity in telehealth. Many telehealth platforms, including EHRs, already document data points (location, participants, timestamps, etc.) to validate services and reduce fraud. In 2019, HHS announced it would explore the use of advanced analytics and Artificial Intelligence (AI) to detect, prevent, and prosecute fraud and overutilization. Based on successful deployment in other industries (financial services, banking, insurance, travel services), Congress should direct the OIG to expand its use of advanced analytics and AI/ML to prevent, detect and end fraud and overutilization.

III.   Eliminate Policy Barriers to Telehealth in the Job-Based Insurance Markets

The issues and solutions we have outlined apply to one segment of the population – those covered by Medicare FFS, or about 38 million people out of a U.S. population of about 330 million. Most people in the U.S. receive coverage through job-based coverage, whether that coverage is employer sponsored or a union health plan. Based on an accounting in 2020, and detailed in the chart below,147 million Americans received coverage through employment, with another 24 million enrolled in coverage through Medicare Advantage and 70 million enrolled in Medicaid of some form.

Health Insurance Enrollment in America, 2020 (Millions)

Federal Employees
Health Benefits , 8

Medicare Advantage, 24

Employment-based
Coverage (excluding
federal employees), 147

Individual Market, 16

Uninsured , 31

Other Coverage, 3

Medicaid & CHIP
(children), 37

Medicare (single-payer),
38

Medicaid (blind & disabled
non-elderly), 7

Medicaid (able-bodied
non-elderly), 26

Source: HIA analysis of Congressional Budget Office March & September 2020 Baseline
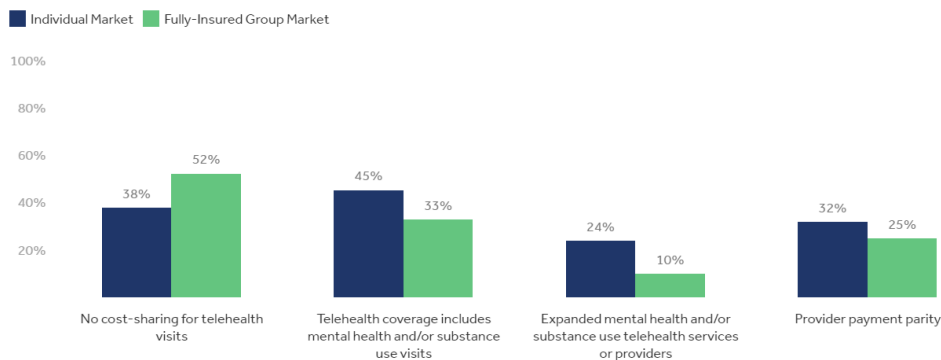
The restrictions the Committee is considering making permanent – access in urban and suburban areas, audio-only visits, and in home services – simply do not apply in these markets. In fact, Medicare FFS is the laggard in use of modern digital tools. For example, Massachusetts allows providers to treat patients they have never seen before via telehealth, Texas allows audio-only encounters to establish a patient-provider relationship and California removed an in-person visit requirement in the state's Medicaid plan for any service provided by asynchronous telehealth technology. Some have eliminated cost-sharing during the pandemic, and Congress has allowed first dollar coverage of telehealth services through account-based plans.

As shown in the chart below, insurers are adopting innovative plan designs to cover telehealth services, with more than half of the traditional, fully insured group market offering no-cost sharing for telehealth services and a third of that same group including mental health and substance use in telehealth coverage.[13]

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[13] Hudman, J., McDermott, D., Shanosky, N., & Cox, C. (2020). How Private Insurers Are Using Telehealth to Respond to the Pandemic. Peterson Center on Healthcare-Kaiser Family Foundation. https://www.healthsystemtracker.org/brief/how-private-insurers-are-using-telehealth-to-respond-to-the-pandemic/.

Private insurance plans have taken a variety of steps to expand telemedicine uptake and access during the pandemic

Share of enrollees affected by specific telehealth policies enacted due to the COVID-19 pandemic

■ Individual Market ■ Fully-Insured Group Market

Policy	Individual Market	Fully-Insured Group Market
No cost-sharing for telehealth visits	38%	52%
Telehealth coverage includes mental health and/or substance use visits	45%	33%
Expanded mental health and/or substance use telehealth services or providers	24%	10%
Provider payment parity	32%	25%

Note: Group market enrollment does not include enrollment in self-funded plans. Individual market enrollment may contain trace amounts of CHIP and Medicaid enrollment.

Source: KFF analysis of AHIP insurer response report (as of July 13th) and data from Mark Farrah Associates Health Coverage Portal TM.

Peterson-KFF

Many large employer plans operate in multiple states and have vast contracted networks of doctors, nurses and pharmacists to supply care to their employees. Because of archaic medical licensure requirements, care cannot be delivered via telehealth to employees of the same employer without licensing the provider in multiple states. Federal programs - the Department of Defense (DoD) and the Veterans Administration (VA) - have effectively implemented a national telemedicine framework to facilitate the delivery of care to patients. Congress expanded the Department of Defense (DOD) state licensure exemption to allow credentialed health care professionals to work across state borders without having to obtain a new state license. It also expanded the definition of an exempt health care professional to include qualified DOD civilians and contractors, while removing the service location requirement to allow for care regardless of where the health care professional or patient is located. This is not true in Medicare or the commercial market where doctors, nurses and pharmacists are required to obtain multiple state licenses and adhere to multiple state rules in order to provide telemedicine services to patients across state lines. Patients are restricted from receiving remote medical services by physicians unlicensed in their own state, even if that same physician is licensed, credentialed, privileged, and providing quality health care in other states. Congress should work to modernize licensing to allow more telehealth access across state lines.

The committee should pass legislation to address long standing challenges and barriers to access to care in these markets, including by:

1. **Making Telehealth Account Based Programs Permanent.** Allowing first-dollar coverage for telehealth under high deductible plans with a health savings account. This temporary change expires on December 31, 2021.

2. **Strengthening Existing Provider-Patient Relationships.** Easing licensure issues by allowing providers with existing patient relationships to provide virtual care when the patient is in another state and encouraging the use of virtual care through employer plans by allowing delivery of care to employees in other states.

Conclusion

Telehealth is a life-saving technology as amply evidenced during the pandemic. HIA urges Congress to harness its full potential. Absent making the PHE waivers permanent, we risk millions of Americans losing access to care they have come to depend on, pushing them off of the "telehealth cliff". As stated in a letter sent late last year by HIA and more than 300 other organizations, "Now is the time for Congress to take the lessons learned in the past year, analyze the data, and pass permanent policies to ensure this type of technology-enabled care is available for years to come." [14] Any outlier problems that arise can be dealt with through the natural course of legislative refinement and program oversight. Not acting and reverting back to the old rules would show Medicare beneficiaries Congress learned little from the COVID-19 natural experiment.

Again, thank you for the opportunity to share my testimony with you this afternoon. I, and the members of the Health Innovation Alliance, look forward to working with the Committee to improve health care through technology for all Americans.

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[14] https://health-innovation.org/press-releases/2020/6/29/340-organizations-send-letter-to-congress-urging-action-on-telehealth