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

TUESDAY, MARCH 2, 2021

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m. via Webex, Hon. Anna Eshoo [chairwoman of the subcommittee], presiding.

Present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

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

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

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

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

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

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

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

I think it is time to make Medicare reimbursement for telehealth service permanent. Over the last several months I

have talked to many health care professionals and providers in my district, and I think the members of the subcommittee have, as well, including Dr. Mahoney, of Stanford Health, who I am so pleased to have on our expert panel today. I have heard how the wide adoption of telehealth has been a bright spot during a very dark time in our country.

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

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

a doctor of the same race, or who speaks the same language.

I know that telehealth isn't the silver bullet for the deeper problems that exist in our health care system, but it has demonstrated great promise for high quality, innovative care if we intentionally create legislation that fits our nation's needs. Now that Medicare beneficiaries and Americans are receiving this important benefit, we need to find a way to continue affordable telehealth access for seniors and other Americans.

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

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

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

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

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

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

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

emergency.

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

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

[The prepared statement of Ms. Matsui follows:]

**********COMMITTEE INSERT**********

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

And remember to unmute.

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

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

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

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

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

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

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

Additionally, we must examine appropriate guardrails for

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

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

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

We need to examine ways to continue to allow telehealth. But there are several factors we need to consider and improve on as we move forward. Telehealth can't replace all in-person business, and we need to ensure quality of care is still given by the provider, no matter the setting. Additionally, we need to make sure telehealth isn't being used for fraud and abuse.

I look forward to hearing from our witnesses in

examining solutions today in order to ensure Americans have access to valuable telehealth services.

I yield back.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

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

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

Good morning.

*The Chairman. Good morning. Thank you, Chairwoman Eshoo.

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

Medicare is also now covering an expanded list of telehealth services that beneficiaries across the country can

access without ever leaving their homes. Most private insurers have also acted to expand coverage of telehealth benefits by allowing coverage of more services, and reducing cost sharing for those telehealth services.

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

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

In each of these examples, Congress expanded access

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

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

The first is value. While the convenience of telehealth can help provide critical services to hard-to-reach populations, it can also lead to overutilization or low-value care. So it is important to consider how future policies can encourage the use of high-value care, while at the same time discouraging potentially low-value care and over-utilization in Medicare fee for service.

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

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

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

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

quality of care for all Americans.

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

I yield back.

[The prepared statement of The Chairman follows:]

**********COMMITTEE INSERT**********

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

Good morning to you.

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

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

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

Physicians across Washington State have leverage telehealth technology to reach more patients, save lives, and

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

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

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

Now is the time for us to plan for the future of telehealth. Thanks to the groundwork we laid with 21st Century Cures, leadership by the private sector, and Operation Warp Speed, the third vaccine for COVID-19 was just

authorized for emergency use. Also, this past weekend, more than two million shots made it into people's arms each day.

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

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

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

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

We need to be aware of the cost to the health care system of changes that we make permanent. The Medicare Hospital Trust Fund is projected to go bankrupt in 2024, less

than 5 years from now. We need to make sure we expand telehealth and maintain our commitment to our nation's seniors to provide a top-notch level of care.

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

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

Thank you, and I yield back.

[The prepared statement of Mrs. Rodgers follows:]

**********COMMITTEE INSERT**********

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

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

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

First, Dr. Megan Mahoney, chief of Staff of Stanford Health Care. I am so pleased to welcome her, she is my constituent. She has dedicated her career to developing innovative, compassionate approaches to health care that empowers patients.

Welcome to you, and thank you.

Dr. Ateev Mehrotra, associate professor of health care policy at Harvard Medical School, thank you and welcome, Doctor.

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

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

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

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

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

STATEMENT OF MEGAN MAHONEY

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

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

We learned that virtual care is broadly adopted as a clinically effective tool, even after we return to offering

in-person care across all specialties. In rheumatology, endocrinology, gastroenterology, and cancer care, well over 50 percent of our visits are now being conducted virtually. Across all Stanford clinics we have stabilized at around 30 to 40 percent of visits being conducted virtually, and we believe this is our new normal.

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

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

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

There is a perception that telehealth may be overused,

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

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

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

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

Third, we need recognition that visits provided via video require the same effort and medical decision-making by

the provider. Reimbursements should be equivalent for clinically-equivalent services.

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

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

Thank you.

[The prepared statement of Dr. Mahoney follows:]

**********INSERT 1**********

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

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

STATEMENT OF ATEEV MEHROTRA

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

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

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

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

How do we build upon this enormous success that we have

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

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

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

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

The point to emphasize is that neither of these low-value applications is malicious, but in aggregate they may greatly increase the amount of care that Americans receive, without substantially improving their health. In my written testimony I emphasize a number of ways to encourage high-value uses of telemedicine.

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

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

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

access to video visits.

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

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

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

[The prepared statement of Dr. Mehrotra follows:]

**********INSERT 2**********

*Ms. Eshoo. Thank you, Dr. Mehrotra. That was fascinating testimony.

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

STATEMENT OF ELIZABETH MITCHELL

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

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

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

However, we see enormous promise for telehealth. By making care more accessible, telehealth can function as a highly useful tool in providing care to under-served areas,

like we have heard today, particularly in rural communities, and expanding care to sectors like behavioral health, which is a top priority for my employer members.

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

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

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

But even better news is that people like it. We recently completed research among California-based HMOs and Medicare, and nearly nine in ten people report that they

would recommend telehealth, and nearly three quarters wished to continue using it. So, from a patient perspective, this is a positive change.

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

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

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

We need to rapidly expand the effective use of telehealth or, as we heard this morning, do it with intentionality as part of a broader shift to a long-overdue transition to value-based care. And the key to getting the right -- this right is to adopt payment models and hold health care systems accountable for quality, patient

experience, equity, and total cost of care. We believe in a system where accountability for outcomes and total cost is present. You will see rapid adoption of these patient-centered innovations.

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

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

[The prepared statement of Ms. Mitchell follows:]

**********INSERT 3**********

*Ms. Eshoo. Just in time to answer the phone.

[Laughter.]

*Ms. Eshoo. Thank you to Ms. Mitchell for your important testimony.

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

STATEMENT OF JACK RESNECK, JR.

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

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

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

This rapid expansion has made millions of patients comfortable with the technology, and it has advanced our knowledge in, frankly, every specialty about when it is most useful and when it is best deployed, versus when we need to see a patient in person. We have seen high-quality telehealth increase access and convenience for patients, saving them transportation time, avoiding missed work, and

avoiding child care issues. It has helped under-served communities in rural and inner-city areas, where a lack of sufficient medical services has really contributed to health inequities over decades.

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

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

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

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

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

For the last 11 months, being able to offer coordinated telehealth services for some portion of these patients' visits has been a game changer. But without further action from Congress, my Medicare patients and millions of other Medicare beneficiaries will lose access to covered telehealth services at the end of the public health emergency. We would

revert back to the old rules, old rules under which access to telehealth services was restricted only to those Medicare beneficiaries who live in designated rural areas, old rules that only allow those individuals to access care and specific authorized medical sites, not using their own personal devices in their own homes or wherever they may be located at the time.

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

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

Second, in conjunction with expanded access to telehealth services, we urge Congress to continue to support the expansion of high speed, broadband Internet access to under-served communities. My colleagues and I continue to be surprised by how many patients can't take advantage of telehealth services, due to a lack of affordable Internet connectivity. Telehealth is not a service unto itself, but it is a vital part of high quality, coordinated health care.

Congress needs to act now to ensure that Medicare patients can continue to rely on these essential tools after

the current emergency ends. The AMA and I welcome the opportunity to work with you to expand telehealth services for our patients, and I am really looking forward to today's conversation, and to responding to some of the more thorny topics that have already come up. Thanks so much.

[The prepared statement of Dr. Resneck follows:]

**********INSERT 4**********

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

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

STATEMENT OF FREDERIC RICCARDI

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

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

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

The idea of telehealth as only important to people in rural areas, or only for a limited set of services has long

been outdated. During the pandemic Medicare is allowing more beneficiaries to receive more telehealth services, using more types of technology for more providers and locations -- importantly, their own homes.

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

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

With so much unstudied, we view sweeping calls to make the emergency system permanent as premature. Medicare's limitations on telehealth no longer reflect the technology

landscape or the beneficiary experience. But we must move forward with caution.

We respectfully ask you to move forward deliberately, collecting and following the data, centering beneficiary needs and preferences in a way that recognizes telehealth as a valuable supplement to in-person care. And to allow time for this, we support a glide path to prevent a beneficiary's access to services from ending the moment or soon after the public health emergency does.

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

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

who are locked out of the system.

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

[The prepared statement of Dr. Riccardi follows:]

**********INSERT 5**********

*Ms. Eshoo. Thank you very much for your testimony.

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

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

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

*Dr. Mahoney. Thank you --

*Ms. Eshoo. Is all utilization the same?

Are the -- will one reimbursement covered the costs, can you give us some direction on that?

And do you think that it is possible to write that type of clinical determination into law?

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

Yes, the utilization typically refers to patient consumption of health care services, whether it is --

*Ms. Eshoo. Does that mean the time that is used?

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

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

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

*Ms. Eshoo. So does your --

*Dr. Mahoney. -- provide our care --

*Ms. Eshoo. -- show that telehealth could substitute for in-person care?

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

*Ms. Eshoo. And Dr. Mehrotra -- excuse me, Mehrotra -- when you gave your testimony, you were cautionary. Do you agree with Dr. Mahoney?

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

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

*Ms. Eshoo. I think that we need more data.

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

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

*Dr. Resneck. This is Jack.

*Ms. Eshoo. Go ahead.

*Dr. Resneck. So we have been tremendously supportive and appreciative of the efforts on this front, including last year's version of the CONNECT bill, and we are generally supportive. I think we prefer the approach this year of the

Telehealth Modernization Act, and the CONNECT for Health Act could certainly incorporate this provision. But adding sort of permanent repeal of the rural exclusions and the originating site exclusions, rather than giving CMS the authority to do ongoing waivers, really would give us the certainty in our practices to be able to --

*Ms. Eshoo. I only have 33 seconds left.

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

*Dr. Mahoney. Oh, I was actually going to say something very similar to what Dr. Resneck said --

*Ms. Eshoo. Okay.

*Dr. Mahoney. -- that we would be supportive of anything that expands access to care, removing geographic barriers and the --

*Ms. Eshoo. Frederic?

*Dr. Riccardi. Yes. And we also support the CONNECT Act, and we believe that it would provide important assistance.

*Ms. Eshoo. And Dr. Resneck, Ms. Mitchell?

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

*Dr. Resneck. Can I come back to this utilization issue?

*Ms. Eshoo. Pardon me?

*Dr. Resneck. Can I come back to one point on this

utilization issue?

*Ms. Eshoo. Well, I have 2 seconds left.

*Dr. Resneck. I will get to it later.

*Ms. Eshoo. All right, okay, so now we will move to -- recognize Mr. Guthrie, the ranking member of our subcommittee, for your 5 minutes of questions.

Thank you to all the witnesses.

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

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

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

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

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

I support the expansion of telehealth, but want to make sure we are balancing the needs of patients and doing our

best to ensure their care is provided in the setting best suited for them.

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

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

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

*Mr. Guthrie. Okay, thank you for that. And I will go to Mr. Riccardi on the next issue.

Some of the healthcare providers in my district would like to continue -- because we have some of the broadband areas and some of the issues -- using technology that has

only been able to be used for telehealth during the pandemic, due to enforcement discretion of HIPAA, such as Facetime, Google Hangout that may not be HIPAA-compliant. How do we balance the accessibility of technology with patient privacy?

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

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

*Mr. Guthrie. Okay, thank you for your answer.

Then, Dr. Resneck, you stated in your testimony that state medical boards play a pivotal role in protecting the safety of patients to physician licensure regulations and disciplinary action. And before coming to Congress I was in

the state legislature and chair of our licensing professionals committee, and understand the role states play in regulating health care. Can you tell us more about the safeguards state legislators -- legislatures and medical boards have put in place to ensure the safe practice of telemedicine?

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

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

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

those states the ability to come and see about the quality of care I have been providing to their patients.

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

*Ms. Eshoo. The gentleman yields back.

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

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

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

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

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

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

So then the question that you asked was how do we address that we have high-value uses. I will maybe just touch upon one or two that haven't been addressed so far, and the first one is really payment reform. I think it is a really key issue that we have a fee for service system, and we are paying for each visit. And there is a lot of interest and, I think, appropriate movement in -- particularly in primary care -- to moving towards a capitated or a alternative payment model. And we give the primary care provider or other provider the flexibility of which model to use, in terms of payment.

*The Chairman. Right --

*Dr. Mehrotra. -- which model of care to provide, excuse me.

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

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

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

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

*The Chairman. Thank you --

*Dr. Mehrotra. -- and cost effective.

*The Chairman. Thank you, Doctor.

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

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

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

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

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

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

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

*Dr. Mahoney. No, thank you for the question. I absolutely agree that now we have 12 months of real data, a

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

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

*The Chairman. Thank you. I have to tell you, I always worry that when CBO, MedPAC, and these other agencies look at over-utilization, they don't pay enough attention to whether or not -- yes, okay, maybe there is more utilization because it is actually better, you know?

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

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

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

have learned that.

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

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

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

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

to make sure that our kids get the care that they need?

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

I think the research is, in this particular area, pretty consistent, that when we look at patients who receive their care via telemedicine versus in-person care, the outcomes are generally the same or -- and sometimes even better for, you know, the treatment of mental illness. And that is also true among our adolescents and children. And so I think there is a lot of excitement, and this is a clear area of telemedicine where I think I would term it as "high value,'' or where we should focus on.

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

I would emphasize maybe a couple of things that have already been touched upon. I think there is consensus among many of us that licensure is an area that can be addressed, because there is a lot of private companies that have been coming into this space that offer an option for parents who are really struggling to find a therapist or a psychiatrist nearby. And those companies struggle, in terms of their

business model, because they have to get licensure in all 50 states. And so how can we -- I think that is a key area for the Congress to potentially focus on.

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

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

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

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

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

And if you want to speak to licensure again, that is great. But let's start with Dr. Mahoney, and then Mehrotra, Ms. Mitchell, and Dr. Resneck, and then Mr. Riccardi. And

let's -- a little over a minute, but just whatever you want to add would be great.

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

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

I also would say that the application of remote patient monitoring will also be probably increasingly utilized, and home diagnostics. And so it is exciting to think about how all of these, in combination with e-visits, e-consultations, we will be able to meet the needs of our patients, and then also get that value that we are expecting out of telehealth.

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

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

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

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

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

[Pause.]

*Ms. Eshoo. Where are you, Mr. Butterfield?

[No response.]

*Ms. Eshoo. All right. Going, going, gone.

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

You are recognized for 5 minutes.

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

The pandemic has brought on serious increases in

anxiety, depression, and other mental health concerns that are likely to last long after we get the virus under control.

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

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

What has been a primary driver of these changes?

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

I also wanted to highlight the important point that you

are making about behavioral health, and we would like to be able to provide access to patients when they are ready when it comes to behavioral health and addiction services. And I have heard from my colleagues who practice in addiction medicine and behavioral health that they have actually seen an increase, an uptick in the number of patients who are showing up for their visits because of the added convenience of being able to see them through telehealth.

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

*Dr. Resneck. For mental health services, in particular?

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

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

just wouldn't want to see that frozen in statute.

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

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

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

And so, as we think about the purpose and use of audio-only going forward, I think decisions can be made on the clinical appropriateness of them, although there is quite a bit of research and data that suggests that audio-only visits

are applicable and should be used for people who need behavioral health services. So that is another consideration.

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

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

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

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

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

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

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

appreciate the opportunity for this hearing.

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

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

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

*Dr. Resneck. Congressman, thank you. I share your frustration when I see those examples. And I am glad OIG and the Department of Justice are keeping an eye on it. I am actually serving as an expert on some of the national

takedown cases that have come up related to telehealth fraud. So I have some insight into this, and I feel pretty strongly that they have the tools they need, and they are doing a good job.

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

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

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

think the tools are there for OIG and for DOJ.

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

*Dr. Resneck. Well, I am not sure I commented on the level of penalties, and I need to refresh and get back to you on the level of penalties. But in terms of OIG and DOJ's ability under the law to investigate this fraud and telehealth fraud, it is no different than any other healthcare fraud that is going on, and I think they have the tools to investigate it.

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

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

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

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

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

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

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

*Ms. Eshoo. The gentleman yields back.

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

*Ms. Castor. Good morning, Chairwoman Eshoo, and thank

you so much for calling this hearing on the future of telehealth. And you are right, our witnesses have been outstanding this morning. Thank you very much.

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

So we know that, in addition to the flexibility provided by Congress, CMS added a number of new covered telehealth services for Medicare beneficiaries over the past year. And now we know that CMS has indicated that they will not continue to cover all of these services after the pandemic, due to the lack of strong evidence of clinical benefit. But what I have heard from a number of our witnesses today is that certain telehealth services simply have been studied more than others, and have clear quality outcomes and all of that important data.

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

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

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

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

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

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

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

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

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

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

I do want to emphasize that -- you have emphasized, and

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

*Ms. Castor. Thank you very much.

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

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

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

*Ms. Kuster. [Presiding] I am happy to help.

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

*Mr. Burgess. Well, I have unmuted. Did it work?

*Ms. Kuster. Yes, we can hear you.

*Mr. Burgess. Very well. So, look, we all know we are not going back to what was the status quo a year ago, before

the expansion of telehealth occurred during the pandemic.

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

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

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

And one of the reasons that I am as confident as I am that telehealth can be used to expand access meaningfully is because so many of the PTAC models envisioned alternative sites of care, like hospital at home. We need to be able to

reach patients where they are, where they live, and we can improve access, affordability, and patient experience.

I would say that more research is definitely needed. We need to evaluate and increase the use of patient-reported outcome measures. Are patients able to resume their activities of daily living? Are they pain free? Are they able to go back to work? This -- these measures have existed for decades, but they have not been adequately used. So we want to increase that.

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

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

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

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

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

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

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

But are there any services that you provided via

telehealth in the past year, where you felt limited in treating the patient because of the virtual nature of the visit?

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

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

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

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

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

*Mr. Burgess. Yes. And -- but, you know, there is so much that -- where it depends upon the type of patient you

have in your practice, how comfortable you are in accepting their assessment of things. And we can't forget that as we go forward --

*Dr. Resneck. Yes.

*Mr. Burgess. -- with policy. There are going to be significant differences between practice types, and I hope we are mindful of that.

Thank you, Madam Chair. I will yield back.

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

*Mr. Welch. Thanks very much.

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

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

I want to start with a preliminary observation. In listening to the witnesses, it appears that telehealth works. It works for patients, and it works for providers. And that has certainly been the experience that we have had in Vermont. And many of my colleagues have raised similar

instances of it really working. And it is not just in rural areas, it is in urban areas, as well.

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

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

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

In 1970 the U.S. spent 66 percent of its GDP on health care. The European countries that are our near competitors spent five percent. We are now at 18 percent, they are at 11 percent. And my view is that, unless we can address the cost of health care, we are not going to have access to health

care. The burden on employers, the burden on taxpayers, the burden on individuals is unsustainable. But that should not become an excuse not to utilize a method of delivery that works for people and makes it easy.

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

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

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

So there are ways that we can be intentional and smart

about integrating behavioral up, integrating telehealth. But we do need --

*Mr. Welch. -- time, but thank you very much for that. I just want to hear from Dr. Mehrotra about this, as well. But thank you, Ms. Mitchell.

*Dr. Mehrotra. Yes, no, I think you -- Representative Welch, you face some really critical issues. I will make two quick points.

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

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

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

And that really emphasizes Ms. Mitchell's point that we need to -- and your point, that we need to move away from

paying for everything fee-for-service to more models, alternative payment models.

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

*Ms. Kuster. Thank you, Mr. Welch.

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

And Mr. Griffith, please remember to unmute.

*Mr. Griffith. Thank you very much. I hope I can be heard.

I would -- I would start by just touching on a couple of points that have been brought up previously. And I know that we are worried about over-utilization, but I represent a relatively economically poor area of the mountains of Virginia. And a lot of folks have a hard time getting health care, as it is. Telemedicine is a wonderful concept that is helping them greatly.

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

But I will tell you also that I am worried about the -- and I know we want a glide path, and I recognize that that has merit, but for a lot of my district, even when we get -- and we are now deploying low orbit, satellite broadband in

the district, it is just starting. But even when we get access to that, it is $100 a month, and a lot of the folks in my district can't afford $100 a month. So we have to try to figure out how to do that because, for a lot of these people, when it works the audio makes a lot of sense.

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

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

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

have that be a covered service is important.

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

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

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

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

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

congruent.

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

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

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

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

I will open it up to any of the witnesses, but I only

have 26 seconds.

[No response.]

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

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

[Laughter.]

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

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

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

*Ms. Kuster. Thank you.

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

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

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

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

think that is a much better spot to be in.

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

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

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

*Dr. Mahoney. Yes, thank you for the question, Congressman Schrader. I agree with you. I like that story about the veteran who initially thought that, you know, he would not be interested in doing a video visit. I have seen that across many of my patients who, you know, traditionally, I would have just thought that they would have been resistant. But then they are the biggest fans, because they

gave it a try and maybe had a caregiver help them get on. So I appreciate that comment.

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

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

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

I think one thing I am hearing -- I guess I would go to Dr. Mehrotra now about, you know, alternative payment models. With fee-for-service I think it is a little constraining, to

be very honest with you. I would suggest in human medicine it is a -- it is an older-school, somewhat outdated way of providing health care. Some -- it is unavoidable in some areas. I do get that.

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

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

And so we want to provide that flexibility, and that is

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

*Mr. Schrader. I totally agree, Doctor.

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

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

*Ms. Kuster. Sure, go right ahead.

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

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

And the other thing is, as hard as we are all working to advance alternative payment models, Medicare has only adopted so many of them yet, and they are not available to many

physicians. So if we all of a sudden say telehealth is only available to patients in alternative payment models, we would be stripping it away from enormous parts of the Medicare beneficiary population. Thank you.

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

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

Mr. Bilirakis, you are on.

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

[No response.]

*Mr. Bilirakis. Can you hear me?

*Ms. Kuster. Yes, we can, yes.

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

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

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

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

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

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

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

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

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

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

Or should certain guardrails be put into place if such a policy was extended to Medicare Advantage plans?

And if so, what should those guardrails be?

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

*Dr. Riccardi. Thank you for your question. I have just three quick points that I would like to share.

First, you know, we support the flexibilities for telehealth in the Medicare Advantage program, and also

through the demonstration projects and the alternative payment models.

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

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

And so, with respect to program integrity, fraud is always a concern, and utilization. But we recommend removing barriers to access, and then using data and information on the back end to kind of detect any potential fraud, you know, waste, or abuse. And audio-only clearly, you know, has a role in the helping people, in particular with behavioral health issues, access the services that they need. So it should be considered.

*Mr. Bilirakis. Very good. Thank you, Doctor.

*Dr. Mehrotra. Yes, two points. On the risk adjustment

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

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

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

*Mr. Bilirakis. All right, thank you very much.

Madam Chair, for inclusion I provide this committee with a copy of a letter of support for a bipartisan bill I plan to soon reintroduce called the Insurance Parity and Medicare Advantage for Audio Only Telehealth Act, which includes guardrails to prevent potential Medicare fraud and abuse by ensuring patients have an established provider or practice relationship where audio-only diagnosis is being utilized,

and that diagnoses were previously documented in person. I think it is so important. So I would like to admit this into the record, please.

*Ms. Kuster. Did you just read the letter to us?

So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bilirakis. Thank you so --

*Ms. Kuster. We will make it part of the record.

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

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

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

*Ms. Eshoo. [Presiding] Thank you, Mr. Bilirakis.

*Mr. Bilirakis. My pleasure.

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

So these are all advances. He never forgot that, and became a great advocate for it.

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

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

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

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

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

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

*Mr. Cardenas. Yes --

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

*Mr. Cardenas. Okay, thank you, Mr. Riccardi.

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

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

So those are some of the things that I think that we need to be respectful about in this country, and not to make assumptions that people are just in that plight, situation, and they deserve it, or they don't care, or they are not taking care of themselves. With all due respect, I am saying

that every person in America, regardless of their circumstance, deserves to have that dignity and opportunity to have that quality health care.

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

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

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

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

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

My time is limited, and I yield back.

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

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

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

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

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

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

Dr. Resneck, can you talk about how telehealth can deliver value to our healthcare system beyond just replacing the face to face visit?

How can it lead to greater efficiency for both patients and physicians?

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

So having that as a part of the toolkit, we are seeing physician offices and health systems around the country doing really innovative things in the diabetes and hypertension and mental health spaces. So there is tremendous value there.

I also think it is really important that we measure -- when we offer somebody who lives 3 hours away telehealth, one of the benefits that I mentioned earlier is they are not missing a day of work. They are not having the economic impact on their family of that, they are not paying to park at my health system, they are not spending all those hours in the car. So I think there are just so many areas of value,

and I really look forward to seeing the progress in the chronic health space.

*Mr. Long. One of the unfortunate trends in health care is a shortage of physicians and nurses, as you know. I mean, there was a terrible nursing shortage in this country before anyone had ever heard the word "coronavirus,'' particularly in rural areas, which -- I represent a lot of rural areas in southwest Missouri. Over the years I focused on closing the gap in the rural healthcare workforce.

How can telehealth help overcome clinician shortages, and especially in rural areas and for our under-served populations?

*Dr. Resneck. Well, thanks to Congress for the GME, for the downpayment on improving GME funding in the last couple of months. That was a huge thing. Thank you.

Telehealth, in particular, it is not a magic sort of panacea for workforce issues because, at the end of the day, we don't have doctors and nurses twiddling their thumbs. They are busy everywhere. So we certainly have some maldistributions, and particularly in rural areas and some inner-city areas where there is not enough healthcare infrastructure. It is a piece of the puzzle for folks who live in those areas to be able to access specialty care, primary care. It is an important piece.

*Mr. Long. You say that it will be very difficult for

providers to invest in the technology required to provide telehealth services and incorporate telehealth into the work flows of its future is uncertain. What constituents -- what constitutes certainty?

In other words, is a statutory coverage expansion the only way to provide certainty to providers?

*Dr. Resneck. I think, one way or another, we need to know that payers, including government payers, understand that this is part of the future of health care delivery, and that it is not going to suddenly disappear, or its coverage is not going to suddenly disappear.

So I think permanently removing the Medicare restrictions is a really important part of that. You know, the big investments are not always technology investments on this. Yes, you often times have to acquire software that works with your EHR, et cetera, but it is really about retooling your entire office to be able to try and figure out in advance which patients need to come in in person, and which don't, how to coordinate all that care. So there is a real expense there.

*Mr. Long. There is a concern that expanded telehealth could lead to greater fraud and abuse or duplication of services. You say that these concerns are misplaced. Why?

*Dr. Resneck. So I think that OIG and DOJ already have the tools.

I am involved in some of these cases of telehealth fraud. They really have little to do with telemedicine, and are really about, you know, using almost sham telemedicine that they are not even billing for to try to provide prescriptions, and unneeded genetic testing, and other things.

It is interesting, the statement that came out 3 or 4 days ago from the deputy IG, Mr. Grimm, on telehealth really corroborated that, and said that the tele-fraud cases that they are seeing and investigating right now are mostly related to tele-fraud, not telemedicine fraud. Again, where these unscrupulous marketing firms are convincing patients to sign up for things they don't need, but they are not actually using telehealth or any of these codes that we are contemplating, or the Medicare broadened coverage that we are talking about.

*Mr. Long. Okay, thank you.

And Madam Chairwoman, I have no time to yield back. But if I did, I sure would.

*Ms. Eshoo. I thank the gentleman. Wonderful, straightforward questions and wonderful, straightforward answers from our witnesses.

It is a pleasure to recognize the gentleman from California, Dr. Ruiz, for your 5 minutes of questions.

*Mr. Ruiz. Thank you very much for holding this hearing

today on this important subject. The expansion of telehealth has played a critical role in the access to care during the COVID-19 pandemic. And we have seen on a large scale how beneficial it can be for both the patients and their providers.

So, as we move forward past the current health crisis, it is important that we take a hard look at what the future of health care delivery looks like, and strategically adopt policies that will move us in that direction with a key eye on equity. We must reimagine and redesign health care. Home and community-based care is the future of health care delivery in this country. It is already moving there, organically.

However, in my experience as an emergency physician taking care of very complex chronic patients who visit the emergency department, there has been studies conducted by insurance companies, hospitals, and academicians who have seen that, if you provide home-based care with tailored protocols, usually accompanied with a nurse after discharge or even before, then patients actually have better satisfaction, you reduce costs because their health outcomes have improved, and they have less emergency department visits, and their health is better. So the trifecta, or the holy grail of a health care system, has meant better health outcomes, lower costs, and patients and providers are happy.

So more and more we are seeing the importance of being able to meet people where they are. The question we need to ask ourselves is what are the current barriers to home-based care, and how do we address them?

How do we make better use of promotoras, or the community health worker, to get to patients that can't get to a clinic or health center, someone who can -- from the community, who knows the community, who can visit patients and help them connect with their provider?

How we ensure equity -- how do we ensure equity and create policies that not only increase telehealth coverage when appropriate, but ensure that everyone has access to the technology that allows them to take advantage of its availability?

I don't just want to only increase convenience accessibility for high-paying concierge patients who already have access, and leave behind the same communities being left behind now. I want to increase accessibility for all people, especially those that currently go without seeing a doctor because of time, money, or distance; or the seniors in my district that can't drive anymore and can't find someone to take them to multiple follow-up appointments; for the farm workers that can't afford to take hours off of work to go to the clinic, and then another to go to another appointment to see the referred dermatologist; for the single mom working

two jobs who can't offer to cut her hours to see a doctor for something that she thinks can wait until she has more time.

Increased focus on telehealth and home health will change the face of health care for many communities like the one I grew up in and now represent in eastern Riverside County, California, California's 36th district.

My first question is to Dr. Mahoney.

Can you tell us how telehealth can be used to improve and expand the use of home health care?

*Dr. Mahoney. Dr. Ruiz, I really appreciate your comments, and I wholeheartedly agree with the sentiments that you have made about the potential promise of telehealth in meeting the needs of all of our patients across the United States, and particularly patients who historically have been under-served.

You know, just the idea of tapping into the resources that are available, promotoras, you know, other caregivers who are in a community who will help us overcome the well-described issues that we are already talking about today along the lines of digital literacy, or, you know, being disadvantaged from understanding the technology that -- it is required. If we are skillful in leveraging the existing resources that are available, that are culturally sensitive, language concordant, I have seen, as a frontline provider, that those barriers can absolutely be overcome.

I will also mention that there are a number of licensed non-physician practitioners who are incredibly useful in helping us extend the access to care, people like pharmacists or physical therapists. And currently these vital team members are not eligible to bill for telehealth services --

*Mr. Ruiz. So I think that --

*Dr. Mahoney. -- that can in person --

*Mr. Ruiz. I really do believe, since 80 percent of what we spend in health care is -- are on 20 percent of the complex patients, we can focus -- to reduce those costs, focus on home care for those patients, as well, to put them on a protocol to improve their health and prevent them from going to the emergency department.

In addition, we can reduce healthcare disparities, promote equity by doing a concurrent community-based health care promoter track with telehealth and home-based medicine, combining those two with good, old-fashioned community public health, and we can change the health of Americans, and we can extend our lifespan, and reduce costs, and satisfy patients and providers in doing so.

And I yield back.

*Ms. Eshoo. The gentleman from Indiana -- I am sorry, the gentleman from Indiana, Mr. Bucshon, is recognized for his 5 minutes of questions.

And I am going to run to the floor to vote, and turn the

gavel over to -- is she there? Oh, we are waiting for her.

All right, well, we will wait for her. And when Congressman Kuster returns, I will get a -- put the gavel in her hand.

But meanwhile, Mr. Bucshon, you are recognized.

*Mr. Bucshon. Thank you, Madam Chairwoman. And providers and patients like telehealth, so let's do our best not to mess this up.

I want to thank all of the witnesses today. It is a critically important hearing. I was a cardiovascular surgeon before I was in Congress, and it is too bad that it took a pandemic to finally get us to recognize that we need to make some advances here in telehealth. But it is what it is.

I applaud the committee for beginning the process of reviewing what is -- what has been accomplished by the unprecedented steps made by the by the Administration, the previous Administration, and continued by this Administration, and examining which policies should be made permanent as we look towards life on the other side of the pandemic. In order for telehealth to continue to be effective, Congress must advance policies that support accessibility and quality of care.

Dr. Resneck, in your testimony you referenced a recent survey of physicians which shows that over 73 percent of respondents cited low or no reimbursement as a barrier to

maintaining telehealth usage after COVID-19. As a physician, this is a real concern of mine, moving forward. I believe doctors should be reimbursed appropriately for telehealth services based on the standard of care. And if we want to find a very quick way to end telehealth, then we can not reimburse providers for the services that they are providing.

Dr. Resneck, would you agree that doctors should be reimbursed for audio-visual visits at a same or similar rate as in-person visits?

And secondly, can you elaborate on the provider concerns expressed in the survey, and share what you are hearing on the ground regarding provider reimbursement for telehealth services?

*Dr. Resneck. Dr. Bucshon, thank you. I do agree. I think, again, telemedicine is a mode of delivering a service, and not a service unto itself. And the coding should be based on the amount of time you spend, and the complexity of the patient, whether you are on the telephone, on a video visit, or in person.

I think on the ground what I am hearing is, you know, coverage at parity rates has allowed physicians to provide this care to our patients, which we have wanted to do for a long time. It has not created some giant inappropriate incentive. Telemedicine is actually hard to do. It is a lot of work. And it is work we like doing, and want to do for

our patients. But just paying equitably for it has made a lot of sense, and allowed people to do things they have wanted -- services they have wanted to provide for a while.

*Mr. Bucshon. And I will bring up another concern that, as a physician, you might imagine I would bring up. It is the liability issue, and how we address that. For example, say a primary care doctor does a virtual visit, or a dermatologist does a virtual visit, examines a mole on a patient's arm. The doctor determines that it is not suspicious, and doesn't need further evaluation. But unfortunately, later on, it turns out to be something more severe, like a melanoma.

Is the doctor going to be liable if the picture quality wasn't what it should be? And was the tech company that provided the Internet access liable? Is it the camera -- the person that developed the camera? Is it the provider? These are serious questions that maybe we will have to address. Do you have any comments on that --

*Dr. Resneck. I do. Those are serious questions. And, as you can imagine, liability reform is something that is on a lot of physicians' minds.

I think, you know, you won't be surprised that this happens. I sometimes get very blurry photos. I sometimes get a patient thinking they are photographing their skin, and I see the dog on the grass in the background. Right?

*Mr. Bucshon. Absolutely.

*Dr. Resneck. So it -- on the one hand, I can't be held accountable, nor can my colleagues, for what we weren't shown or can't see. And that would be really frustrating if we were.

On the other hand, what I would say is we hold, ethically, physicians to the same standard of care, no matter how they are providing that care. So if you see somebody -- you know, if I see a patient with a mole, and I think that is a mole that I would need to look at under a dermatoscope in person, it is my responsibility to tell that patient, "You know what? You have got to come in person.''

Or if the pediatrician feels like they really need to look in someone's ear, that standard of care should still apply when they are doing telehealth. And if it is something where what you see is adequate to make a diagnosis and treatment plan, then you should go ahead and do it via telehealth. But that standard of care should really be the same.

*Mr. Bucshon. Yes, I would agree. The standard of care should be the same. I think there are technical -- there can be technical challenges.

And I would also agree that it is not the patient's responsibility to do the right thing. I mean, if you can't get an adequate evaluation of the patient by telehealth, then

you have to see them person.

*Dr. Resneck. Yes.

*Mr. Bucshon. I do think, though, that this will become an issue. I think it will become an issue for the technology space, for the Internet providers, and others, because we all know how that goes in health care, when this comes down. So we will have to think about all those things.

*Dr. Resneck. Dr. Bucshon, that reminds me, this is another reason why we support physicians being licensed in the state where the patient receives the service, because if the standard isn't met by the technology company, by the doctor, the physician or the technology company can be -- the patient can pursue that in their own state.

*Mr. Bucshon. I am in agreement with you. I think a national licensing is not the way to go.

I have -- well, I am out of time. So with that, I yield back. Thank you.

*Ms. Eshoo. The gentleman yields back. I think what I am learning is that there are many common-sense practices right now that just really need to be retained. The answer is already there, when I listen to the answers of the witnesses. But it is good to have an exchange between two doctors.

It is my pleasure to recognize the gentlewoman from Michigan, Mrs. Dingell, for her 5 minutes of questions.

*Mrs. Dingell. Thank you, Chairwoman Eshoo and Ranking Member Guthrie, for this important and very timely hearing to discuss telehealth. This subject really matters, and I think that telemedicine is here to stay.

We have seen a dramatic increase in its use during the pandemic, but we need to thoughtfully explore reforms that build on what works, while coming together in a bipartisan way to address challenges in the implementation moving forward, some that were just discussed in the last questions.

Dr. Mehrotra, in 2018 Congress allowed clinicians working with the U.S. veterans -- with the VA Health System to practice both in-person and telehealth across state lines, as long as they were licensed in good standing in their home states. At the time, veterans were experiencing long wait times for care, which required action, and Congress responded. Congress did the same thing for DHS providers last spring in the CARES Act.

Given the extraordinary public health crisis we are now facing, what is your view on a temporary time-limited licensing -- I can't even talk today -- proposal to address the current public health emergency like that in the TREAT Act, which my colleague, Representative Latta, and I have introduced?

*Dr. Mehrotra. First, I really appreciate the question. I think there is broad consensus. I think most everyone here

that -- we need to address licensure reform. And how do we facilitate interstate practice of medicine?

It is -- we -- I was -- in a recent piece we were just describing how we created this very silly situation where you have a patient crossing the state line, driving a mile down the street, so they can have a telemedicine visit with their primary care doctor, because the primary care doctor is not licensed in the state they live in. So they are now having a telemedicine visit via the -- in their car. That is silly.

I think, in terms of how we make that reform, I think you have -- I think the TREAT Act is a great -- and I am very supportive of the -- where -- of creating a licensure reform, so that there is reciprocity across states. And I have argued, actually, that we should do something that is more -- also go further, and make something that is permanent, because I do think we need to address that artificial barrier of licensure.

*Mrs. Dingell. I mean it is very real. The University of Michigan treats many patients in Ohio, Indiana. It is -- and it is facing real problems in treating its patients during COVID on this. So -- and there are other hospitals, many hospitals are experiencing that. So thank you.

I look forward to continuing to work on this issue, and I would like to hear your ideas for making it more permanent. However, I also want to make sure that we are taking steps to

protect the Medicare program integrity, given the dramatic changes we are seeing in telehealth adoption and uptick. And while we all recognize the many legitimate benefits of telehealth, and how impactful the expansion has been during the pandemic, we shouldn't ignore the potential for new, sophisticated schemes that could leave our nation's seniors at risk of fraud.

I have already met with seniors that are experiencing this. For example, cold-calling beneficiaries who get personal information from a senior, and then bill Medicare for services or equipment the beneficiary did not request and, in one case, didn't even receive.

Mr. Riccardi, do you have any suggestions for how we can strengthen Medicare program integrity to, for example, prevent cold calling or billing for unnecessary services?

*Dr. Riccardi. Thank you for your question. And I think that, you know, as we consider moving forward with telehealth, that we can draw upon, you know, previous experiences with fraud, waste, or abuse, and also the privacy concerns that many older adults have, you know, with, you know, the advent of and expansion of telehealth during this pandemic.

And just stepping back, it is just important to remember that, as we consider any measures for combating, you know, fraud and scams, that we don't arbitrarily impose barriers

onto people who need access to that care. I think that there are sophisticated technologies that can be used to analyze the data that is available as it is connected to telehealth.

But also, as we move forward, we have to consider other protections that are related to Medicare law, like HIPAA, you know, considering whether we should include additional entities that should be covered by HIPAA, and investing in the infrastructure of the technology, ensuring that the protections are there in place to prevent seniors from these types of scams and, lastly, to draw upon not only the health care system, but also on supporting the community-based organizations that serve Medicare beneficiaries to help them combat fraud and scams.

*Mrs. Dingell. Thank you.

I am out of time. I yield back, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back. The chair wants -- will recognize Mr. Mullin from Oklahoma for his 5 minutes, but I am going to hand the gavel over to Congresswoman Kuster because I am going to go to the floor to vote. So I shall return.

*Mr. Mullin. Thank you, Chairwoman Eshoo, and I appreciate you. And I know you asked earlier about my son, except the irony of that is I was actually doing a telehealth with my -- with the neurologist. And so, while you asked me, I was actually on the phone with the -- or on the telehealth

with the neurologist, speaking. Because, you know, my son has had a traumatic brain injury.

And I will say this real quick. My son is doing great. But his specialist, we meet through telehealth. There are several -- his -- several specialists that we haven't even had an in-person meeting with, because he is case study number one for accidents, for pediatric neurology care, and what he is going through. He is actually experimental. And so UNLV -- or UCLA, I am sorry, has taken on his case. Then there is a specialist out of Beverly Hills that is overseeing it. And then we have another specialist in Illinois, while we are in Oklahoma, rural Oklahoma.

Telemedicine and telehealth is something that has opened up an opportunity for all of us, no matter where we live, to have those specialties come into our home, come into our communities, and allow us to have the same adequate care as we would if we were living in California, or we were living in Houston, or we were living in Chicago, or Washington, D.C.

And while the pandemic has been horrific, it has also advanced the technology that we knew was here, but we wasn't -- as Congress, we wasn't ready to look at it. We wasn't ready to embrace it, because we didn't know how to reimburse doctors. We didn't understand how to regulate it. We didn't understand how the doctor visits would work. But because of technology, we are here.

And I have a good friend of mine that is an orthopedic surgeon that -- he does surgeries robotic. And while he has to be in the same room, he actually never has to lay his hands on the patient, other than to comfort the patient. But he stands three foot away, and replaces hips, or does surgery on the shoulder, or does surgeries on the knee. And by the way, he came to us through our Army, because he was in the service, and performed surgeries even at the -- at Walter Reed.

And our government is the one that taught him this technology. And it is capable now for us to bring home to our rural hospitals, where it was hard for us to get specialist to be there. And so the technology exists, but a lot of people, they don't even know how to embrace it yet.

And so that is -- and by the way, my family has been the recipient of this. I mean, it is -- this whole year, because of the traumatic brain injury that my son had, we have embraced this.

And I will tell you personally, at first I didn't know if I liked it or not. I am a very in-person -- I like to be in person. But once I started it, I realized that I became the physician assistant. I became the P.A., which was positive, because, as a caregiver for my son, I also -- I am interacting with the doctor. I am putting my hands on my son.

Or the -- or we are having the conversation, we are having a conversation about costs, really. Because when they send over the prescription, they send it to me. Instead of me just being on my phone, checking my emails, waiting for the doctor to schedule the next surgery, or schedule the imaging or lab work, I am having to interact. And so it made me more cognitive of the care that my son was given. But it also made me more cognitive of the cost, which is a good thing. There is nothing wrong with that.

I have actually embraced it fully, where I enjoy them now. And I know I went long on explaining that, but I want to understand that I am living this life, and it is beneficial. It is beneficial for us in rural parts of America, because we had the same access to the care of those in major metropolitan areas.

Now, with that, real quick, Dr. Resneck, I have a couple of questions, because rural providers in my area are having a hard time actually understanding even how to gain access to telehealth grants. Do you feel like there is more that can be done to provide this information to the providers?

*Dr. Resneck. I know the AMA and specialty societies have, just in the last several months, rolled out a lot of additional information about some of the grants to help with implementation. You know, CMS has actually been very cooperative and supportive in terms -- over the last year, in

terms of helping us when we have needed to reach out to improve that process.

So -- but definitely put your colleagues in touch with me, and I am happy to see what we can do to help.

*Mr. Mullin. Do you think it would be helpful to maybe have a one-stop shop for funding opportunities for telehealth?

*Dr. Resneck. I don't see any harm in that, and it could be helpful.

*Mr. Mullin. Okay. Maybe we can work with you on doing something like that, too.

And my office has been working on a bill with Chairman Eshoo's office to ensure federal government creates a national telehealth strategy that streamlines and coordinates these things. Would it be beneficial for maybe there to be an elevated presence within HHS to coordinate these telehealth investments and policies across our government?

*Dr. Resneck. We would love to talk more with you about that. I mean, I think our observation, again, has been that CMS has actually made this a big priority, and been incredibly responsive to physicians and patients during the pandemic around this. And we are optimistic that that responsiveness will continue.

But this is a really important issue, and we do need to continue to have a national strategy. So let's follow up,

and talk more about what we can do.

*Mr. Mullin. Absolutely, because we -- I -- this is a great opportunity for rural America to have adequate and quality health care like all others. And I think this is a great starting point.

*Dr. Resneck. I am so glad to hear your son is doing better. And I know this --

*Mr. Mullin. Thank you.

*Dr. Resneck. -- has been a really hard year for you and your family.

*Mr. Mullin. It has, but we have been very blessed. The Lord has been good to us.

Thank you, I yield back.

*Ms. Kuster. [Presiding] Thank you so much, Mr. Mullin, and thank you for your remarks. I think, as a rural member, I can certainly say this is a really important hearing.

So as chair, I will now recognize myself for 5 minutes, and I want to thank Chairwoman Eshoo for holding this hearing today. It is so important.

In New Hampshire and rural states like Oklahoma, attending in-person treatment for substance use disorder can be a big challenge in and of itself, due to our weather, and geography, and lack of access to transportation, work obligations, child care, and all the rest. And that was before COVID-19.

So when the coronavirus added yet another barrier to addiction to mental health treatment, our behavioral health providers transformed their delivery of care to ensure that they could continue to provide critical treatments while this country battles two epidemics, the opioid crisis and COVID-19. This was made possible by flexibilities during the pandemic, and I am so grateful for this discussion to highlight these measures and provide a framework as we look ahead to expanding access to care through telehealth post-COVID-19.

I have heard from treatment providers, addiction treatment providers, who emphasize how telehealth has in many ways resulted in greater appointment attendance, fewer cancellations, and more patients arriving on time.

Dr. Mehrotra, you and your colleagues at RAND recently released a study examining transitioning to telemedicine for opioid use disorder treatment, outlining how buprenorphine prescribers quickly transitioned to provide telemedicine benefits -- visits. Could you please describe how the current flexibilities around prescribing medication assisted treatment has actually improved access to care?

*Dr. Mehrotra. Congresswoman Kuster, thank you for the question. And the study that we did was looking within the pandemic for treatment of opioid use disorder, and I think that is a real success story, and a feel-good story that, in

the context of the pandemic, patients who were in treatment were able to use telemedicine to access care, stay on their medications, and get the appropriate care and not go back to, unfortunately, using opioids again. So that is a real success story from the work we have done.

And through the SUPPORT Act, post the pandemic, that is going to be accessible to folks.

I think there has been some frustration with the changes that have been asked for -- the Ryan Haight Act -- to allow all providers to prescribe Suboxone and other medications for opioid use disorder, and have that flexibility so it can be done via telemedicine. And I think that is a key area for us to provide that flexibility so we can provide that treatment in New Hampshire and the rest of the nation.

*Ms. Kuster. Well, I think it is so important.

Now, you have mentioned that several of the participants were hesitant to see new patients, and that is concerning. What can be done to encourage greater uptake among providers who might be hesitant for using some of these new flexibilities, and especially for new patients?

*Dr. Mehrotra. So I think we have been surveying and talking to a lot of opioid use disorder providers, and there is wide variation in how comfortable they feel.

One thing that we have called for is -- this is more not on the congressional side, but on the clinical side -- to

create guidelines among the treatment community so that people feel more comfortable that this is a reasonable way to treat opioid use disorder. And I think that is going to be the key to convincing providers to move in that direction.

*Ms. Kuster. Okay, great. Thank you. Thank you so much.

I wanted to question you about flexibilities allowed for opioid use disorder treatment providers in providing telehealth across state lines. So New Hampshire is a small state with a lot of state lines: Vermont, Massachusetts, Maine. And I would love to get your thoughts on delivering telehealth across state lines to some of our most vulnerable, including addiction and mental health patients.

*Dr. Mehrotra. Right. So in New Hampshire -- we are very close by, obviously, where I am. And it is difficult in many of those communities to find an opioid use -- to get treatment, and providing that flexibility across the nation. And we do see a number of private companies that are providing very innovative new models to expand the use of telemedicine, and they can work across all 50 states, so people can have that access.

And as I articulated before, the keys to providing that in New Hampshire and the rest of the nation are licensure reforms, so that we can make that easier for those providers to do so, as well as -- as I think all of you know, and it is

a really key aspect of this committee -- which is broadband expansion. It is very frustrating in 2021 that so many Americans don't have access to that necessary technology.

*Ms. Kuster. Well, absolutely. And you have read my closing remarks, which are about exactly that. In places like northern New Hampshire, my district, Coos County, broadband is very limited in the western part of our state, and the successes of telehealth are only as great as the access to the digital infrastructure.

And so lastly, I just want to submit for the record a recent report from Dartmouth-Hitchcock on telehealth as a tool for rural health equity.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Kuster. And with that, I will yield back. And, as chair, I will now recognize Representative Dunn for 5 minutes of questioning.

Representative Dunn?

*Mr. Dunn. Thank you very much, Chairwoman. I appreciate that. Let me say I am enjoying this discussion about the future of telehealth, and I appreciate hearing all of the thoughtful views of our panel of witnesses.

You know, among the myriad ways which COVID-19 pushed the limits of our health system, telehealth expansion was a bright spot in that mess. Obviously, it means treating our patients and meeting our patients where they are. And I too have a large rural district, Florida 2, and telehealth expansion during the public health emergency enormously facilitated access to care for some of my most vulnerable constituents. Telehealth is helping Americans stay in touch with their health care, while so many other aspects of life have been put on hold.

I do think audio-only telehealth has to remain a backup option. Many of the most rural of my constituents lack reliable Internet access or, in some cases, the ability to employ video technology. And again, I would say who among us has never struggled with video conferencing?

I continue to be extremely concerned about the medical care that was foregone during the pandemic and quarantine,

and what that is going to mean for everyone and for everything, from cancer screening to management of chronic disease. I am encouraged that telehealth offers the opportunity to bridge some of those gaps that are occurring.

We had a great case right here at Children's National Hospital, a place where I trained many years ago, who was able to -- they were actually able to virtually see the family a day after a very concerning newborn screening. And the family didn't have a car, no care for their other children. And instead of having to wait for answers, they saw a physician the very next day, and started to build a care plan -- virtually saw a physician, and the physician even had a Spanish translator on the call. So that is a model for timely care and coordination that we absolutely want to continue in the post-COVID world.

I want to focus my questions and also offer my support for exploring ways to expand the use of remote patient monitoring technologies. We have made some mention of that during this discussion. Remote patient monitoring can offer physicians improved abilities in post-operative management, chronic disease management, a lot of tertiary benefits there, and even if it just triggers a phone call, you know, because something in monitoring technology indicates that, or it is not sending anything in.

So in that vein, Ms. Mitchell, I would like to start

with you. Remote patient monitoring, I think, can help these issues of no-shows, missed appointments. I think it can ultimately decrease the cost of chronic disease for -- managing that for patients. It reduces frequent flyer ER visits, and it is an almost office-style care without exposure to communicable diseases.

I know there are detriments in the physical examination and testing remotely. Technology continues to get better. But is there data now to determine the degree to which remote patient monitoring can generate savings?

And how should we be thinking about accounting for the cost and the savings in regard to remote patient monitoring?

*Ms. Mitchell. Well, thank you for the question. I completely agree, this -- telehealth will enable much more innovative and patient-friendly models of care in the home, in the community. But we do need to remove the payment barriers to that.

I wanted to add, in our research we survey over 40,000 patients a year on their patient experience in California. And I -- to your point about audio versus audio-visual, the satisfaction across both methods was the same. People do appreciate both, and we can share those results with you if you are interested.

We don't have any data that I am aware of that quantifies the savings from telehealth at this point. Again,

we do believe if it is deployed correctly and, again, used to avoid unnecessary hospital visits or ED visits, we believe there are significant savings.

We ran a federal -- federally-funded program in California with small practices for several years. And we found that, by working with those practices, utilizing telehealth, utilizing, you know, new methods of monitoring patients, we saw significant total cost reductions and better outcomes. So we think we can extrapolate that, but we do believe there is more research needed on the outcomes and cost.

*Mr. Dunn. So we are running out of time, but I do think this is a terrific aid to practice. I think it can -- it is a leverage for more -- access to more patients.

I am going to be submitting some questions in writing, since we are out of time here. And with that, Madam Chair, I yield back.

*Ms. Eshoo. [Presiding] The gentleman yields back. It is a pleasure to recognize the gentlewoman from Illinois, Ms. Kelly, for her 5 minutes of questions.

*Ms. Kelly. Thank you, Madam Chair. I thank the committee for bringing us together to discuss the future of telehealth. And I thank the witnesses for being here today.

States play an essential role in licensing providers, and ensuring that providers practicing in the state are in

good standing. During the pandemic many areas experienced increased demand for providers and, in response, states moved early on to loosen or waive licensure requirements so that out-of-state providers could support areas overwhelmed by COVID-19.

However, even prior to the pandemic, many states partnered on licensure issues. Dr. Resneck, can you discuss what states have done before and during the pandemic to increase care across state lines?

And also, should states improve Medicare plans -- should states improve Medicare plans -- can contribute to creating an unequal system in health care delivery?

*Dr. Resneck. Congresswoman, thanks for the question, and thanks for your leadership in maternal health and health equity on that front. We look forward to continuing to work together on that.

*Ms. Kelly. Definitely.

*Dr. Resneck. You know, there are a couple of things that help us with some of these licensure issues. So one is a thing called the interstate compact, which actually makes it easier for physicians who are in good standing with their own state medical board to get licensed in multiple states. It is a new thing. And already we have, in the last few years since it has gone live, 30 states, the District, and Guam have all signed on. We have got six or seven states

that are considering legislation.

So it essentially -- once you are licensed in one place, you can very easily check boxes on a form to get licensed in multiple other places. We would like to see the fees go down for that. I think that would be an improvement.

I think I also recognize that state medical boards do need some ability to create unique local reciprocity solutions around state border areas. And we have supported local reciprocity of licensure as long as, again, fundamental safeguards are met around the site of service being where the patient is located.

There is one more thing which people may not be aware of, which is there are a set of codes that CMS has approved called interprofessional codes that also -- sometimes when I get consulted about a patient in a state where I don't have a license, where it wouldn't be responsible for me to take care of the patient, and assume care, and do all the prescriptions and everything else, because maybe I wouldn't be available if urgent things came up, or side effects came up, I do what is called an interprofessional consult.

So there are codes that actually recognize my doing the consult with them and their primary care doctor, or them and their specialist, where I give advice and thought and consult on the case, but the responsibility for the daily care remains local. And so that is another opportunity we have to

work on the interstate issue.

*Ms. Kelly. And let me just ask my question again. Can you expound on how our already unequal system is made worse by the way these virtual services are provided?

And how can we address and remedy these inequities in virtual services provided through Medicare?

*Dr. Resneck. Oh, so sorry I missed that, the broader issue of disparities.

I mean, I think the last year has actually ameliorated some of that. So we have talked about broadband issues today. That definitely affects patients of color, low-income patients more than others, and that still needs a substantial amount of work.

But in the old -- before we had this irony where it was largely wealthier patients who were able to use the convenience of telehealth, where many of our minority and other disadvantaged patients weren't. And so, by fixing this Medicare issue, I think we will go a long way towards helping us work on health equity. Is that what you were asking about? Okay.

*Ms. Kelly. And I look forward to continuing to work with you. Thanks for all of your partnership. We really appreciate it.

And with that I yield back with an extra minute.

*Dr. Resneck. I hope we can get the MOMS Act passed.

*Ms. Kelly. Yes.

*Dr. Resneck. Mortality issue.

*Ms. Eshoo. Absolutely. The gentlewoman yields back.

It is a pleasure to recognize the gentleman from Utah, Mr. Curtis, for your 5 minutes of questions.

*Mr. Curtis. Thank you, Madam Chairman. And what a very interesting hearing. As I have listened, it is clear to me that there is broad consensus that we have something very important here. I like that it is bipartisan.

I have been impressed with the depth of knowledge from the members who have participated in this community, everything from personal experience, Representative Mullin, to our constituents. It seems to impact every single one of us. And many of us have talked about the impact on rural parts of our district.

We have been fortunate, in the sense that we have had this opportunity as we have gone through the pandemic, to try things we might not have otherwise tried. And it occurs to me that most of us can see intuitively a lot of good things. But there is also a strong sense, as I have listened to the members, for more data, for more information, for worry about abuse, worry about fraud.

And I have introduced a piece of legislation that, Dr. Mehrotra, I would like to ask you about. It is called the COVID-19 Emergency Telehealth Impact Reporting Act. I am

really pleased that it has some really good, strong bipartisan support from members of this committee. In essence, it would require the federal government to collect and analyze telehealth data from the pandemic.

And Doctor, it seems like almost so obvious that it would be a rhetorical question, but I want to ask it, particularly in light of other options, which is how important is it for the U.S. Department of Health and Human Services to work with Congress to obtain better telehealth data?

And maybe contrast that to academia or, you know, to industry that would be also looking for data. But what is the role here for us, here in Congress?

*Dr. Mehrotra. Representative Curtis, as a researcher who studies telemedicine and does exactly what you are describing, this is obviously of great interest, and I think, really, critically important.

And in terms of -- I would definitely agree that we need more data, both on what is happening during the pandemic -- myself and many others are studying that right now -- but also in that post-pandemic period, hopefully very soon, where we can start to see how things get into more of a steady state.

One thing that I might emphasize where I see a real weakness and that Health and Human Services could act is in

Medicaid. It is a real area where it is such a critical aspect of the U.S. health care system, yet we don't have as much data right now that people are looking at, in terms of what has been the impact of telemedicine in that patient population.

*Mr. Curtis. So that is great. I would also like to kind of get your thoughts on the metrics. What metrics should we be using to determine if we make a lot of these things permanent?

What -- you know, in your community, what metrics would you like to have available to you that would help us make better decisions?

*Dr. Mehrotra. I think the key here is obviously -- and the thing that we are all hopeful of -- is that telemedicine will improve health. And so I think that would be the metric that I would love to look at.

In a paper we just looked at yesterday -- or published yesterday, we found that roughly a third of U.S. hospitals have now introduced telestroke, and that is leading to decreased mortality. And that is the kind of work that we really want to demonstrate across many areas of telemedicine.

The only other -- you know, the similar measures of patient satisfaction, and whether physicians and other clinicians are following those guidelines is also a really key aspect, as we assess the impact of telemedicine across

these different areas.

*Mr. Curtis. Could you weigh in on just the little bit of time that we have left on not only this, but behavioral telehealth and total medication-assisted treatment?

And how do we, you know, capture this opportunity for cost savings?

*Dr. Mehrotra. Yes, no, I think in the area of, say, opioid use disorder or other substance use, how long patients are in treatment is going to be the key aspect of that.

And then, in terms of looking at -- the hope would be -- is that if we can control -- address the people's substance use disorder better, they won't end up in the emergency department, or will have further complications. And those are the types of metrics that we can look at.

*Mr. Curtis. Excellent. Thank you. I have got just a moment left, and didn't want to ignore some of the other witnesses. I don't know if you have any comments. If not, I will yield my time back. But do any of the other witnesses want to comment on those questions?

*Ms. Mitchell. Hi, I just wanted to let you know that we will have early data on patient experience using telehealth for the Medicaid population this spring. We are happy to share that with you.

*Mr. Curtis. Thank you, that is awesome.

Madam Chair, I yield the balance of my time.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentlewoman from California, Ms. Barragan.

*Ms. Barragan. Thank you, Madam Chairwoman, for this very important hearing. It has been really great to hear all the conversation about telehealth.

This is something I am quite new to, and I represent a district that is majority minority, very working-class, and, frankly, hadn't heard a lot about telehealth. And when COVID hit, my own mother had to have a telehealth visit.

Now, the problem was, number one, my mom doesn't have any technology that has video. She has a flip phone and can hardly answer that phone. And so it became a challenge to make sure that somebody either took the day off, or was able to go over there to make sure that she had video access. And she still has an old-fashioned landline. And so, for me, this was happening in my backyard with my own mom. I thought to myself how often is this happening to constituents of mine who don't have that similar access, or older Americans who are having the same kind of access?

And so I know that community health centers have also moved to telehealth to make sure that they are providing safe access to care for constituents. And something -- in my district community health centers are still very key.

Many of the providers are still offering over 50 percent

of their care via telehealth. Now, my concern is the equity issues, and making sure under-served communities are not left behind, and having access adequate to technology, and think that it is only going to help provide access to care.

So Dr. Mahoney, you have discussed this, but I just want to, you know, get more of your thoughts on this issue, on what we can do to make sure, you know, under-served communities are not left behind. There is certainly a benefit here for those who don't have access to transportation to be able to get that telehealth. But, you know, on the broadband issues and access to technology, what you think Congress should be keeping in mind when we are doing all we can to keep telehealth, but also making sure that there are going to be instances where maybe a telephone for some time is going to be the only available means?

*Dr. Mahoney. Thank you, Congresswoman Barragan, and thank you for the question. And also thank you for sharing the story about your mother. I think that that scenario does reflect a large number of the patients I see. And throughout my career, I have been a telehealth provider, and I have seen firsthand the ways in which we can make tremendous progress using the phone alone.

And so, when we think about the medical decision-making that is required, the clinical effort on the part of the practitioner that is required, that should be reimbursed and

compensated in the same way as we reimburse and compensate for other modalities of care. So I think that that would be something that we should keep in mind.

The other is, as we have already mentioned, is the expansion of broadband access to all communities, so that all communities can enjoy the benefits that come along with that technology. So, in the circumstances where a video is feasible, maybe going to that first, but having the phone as a vital backup so that we can ensure access to care. I think we have -- already have heard from many of our panelists, and I share the sentiment as well, that tremendous, high-quality care can be provided by audio-only means, and should be reimbursed accordingly.

*Ms. Barragan. Great. Thank you, Doctor.

Dr. Resneck, my next question is directed at you. At the beginning of this Congress, I reintroduced the Improving Social Determinants of Health Act. This is legislation that would empower public health departments and community organizations to address social, economic, and societal barriers to health access in under-served communities. The COVID-19 pandemic has underscored that Internet connectivity is a social determinant of health. Dr. Resneck, can you discuss ways community organizations and community health care providers are leveraging telehealth to address social determinants of health?

And how can Congress better support these efforts?

*Dr. Resneck. We really need everybody on the team helping with particular disadvantage in minoritized patients that we can get involved in their care. And broadband has been an issue. Getting the previous grants that were out there for broadband expansion renewed would be great.

You know, I think about the individual patients that I see who are coming from those areas with no broadband, and it is -- still, it is unbelievable sometimes to me that -- the lack of broadband that they face. Last night, after clinic, I was talking to some of my colleagues in the hallway, and just asking them about cases, telling them I was going to be doing this hearing.

And one mentioned a farm worker from rural northern California who has a condition called scleromyxedema, where their hands and face thickened. This guy could no longer make a fist and do his work, and could not put the apples that he was picking and his own mouth. It is a really terrible condition. We admitted him to the hospital, got him treated. He got back home. We were able to coordinate month's worth of his care. And using that whole team and his community of local physicians, local nurses, and PAs, and community workers and others to help coordinate his care, he is now doing great.

But we do find ourselves sometimes doing this audio

visit with a patient who is literally on break in the fields, or who is literally a frontline grocery worker between shifts, or who lives on an indigenous reservation with no Internet, or who has to get on a bus in the midst of COVID to come and see us, all of which are difficult.

So the broadband issues are tremendously important for us to continue to be able to provide telemedicine to those patients.

*Ms. Barragan. Well, thank you, Doctor, for sharing.

And with that, Madam Chairwoman, I see our time has expired; I yield back.

*Ms. Eshoo. The gentlewoman yields back. I really think that our -- the public health care systems, Medicare, Medicaid should be sending something to the beneficiaries in both of those systems, and just ask the simple question, "Do you have access to broadband?''

We don't even know what we are talking about. We -- well, we do when we give the stories, as Ms. Barragan did, her own mother. That story is replicated in inner cities, in rural areas in the country. And -- but we have no yardstick by which to measure this by. So I -- the committee, obviously, is going to have to do something about that. But I can't help but think these agencies should be informing us so that we can build on good data. And it seems to me that Dr. Mahoney and others are doing that.

Wonderful to recognize the only pharmacist -- are you still the only pharmacist in the House?

*Mr. Carter. No, we have another one now. We have two now.

*Ms. Eshoo. But we don't know who that --

*Mr. Carter. She is much better looking.

*Ms. Eshoo. Let's put it this way. The only pharmacist on the Health Subcommittee --

*Mr. Carter. There you go.

*Ms. Eshoo. Yes, the gentleman from Georgia, Mr. Carter.

*Mr. Carter. Thank you, Madam Chair. I appreciate this. And I appreciate all the panelists being here today.

You know, at some point, when this pandemic ends -- and it will end -- at some point, people are going to list the silver lining. They are going to list the things that were good that came out of all this. And there are good things coming out of this. And one of those, at the top of that list, is going to be telehealth.

You know, we have heard that there has been 10 years of progress in 1 week in telehealth. In fact, prior to the pandemic, there were roughly 13,000 telehealth appointments per week. Yet we have seen an increase during the pandemic. And even a few months after the pandemic started, we saw it go up to over 3,000 percent of that. Unbelievable, the --

what has happened with telehealth. We knew it was there, and I had been looking at it for years. But this was the opportunity for us to really see it flourish. And I just -- I think it has been great, and I think it is going to be even better, and an important part of our health care delivery system.

The benefits are endless, there is no questions about it. Patients with co-morbidities were able to continue to get care without having to be physically present with the physicians. And we have seen it, and I have seen it work. I saw it work even before that, but we have all seen it work now, during this pandemic. And it truly has been part of the silver lining, again, that we have noticed.

Dr. Resneck, I wanted to ask you. In your testimony you discussed that Congress should make the telehealth flexibilities from the pandemic permanent. But I hear others say, well, we need more data, we need more research. Yet we have got a year's worth of data collection and tens of millions of telehealth visits that provide us the data to review the success of expanded telehealth services. In your opinion, is that enough, what we have experienced thus far?

*Dr. Resneck. Yes, these are not new services we are providing, and the data have accumulated exponentially in the last year, thanks to Ateev and other colleagues on this panel. So I think we have data to move ahead with making the

expansion for visits permanent.

I am all for continuing to study all of the subareas of telehealth, because we, as physicians, are going to learn from that, and continue to learn what things are best done by telehealth and what things we need to see a patient in person for. But that is really at the standard of care level, and not the coverage level. So I think we have got a lot of data, and we are ready to move forward.

*Mr. Carter. Would you agree that it has increased access to care, as well, particularly in minority communities, even?

I represent south Georgia, which -- you know, we struggle a lot with rural broadband. And that is certainly something that we are addressing in this committee, as well, and certainly something that needs to be addressed. And there is no better example, obviously, than our educational system, but also with our health care system, with telehealth.

But it does -- and it also decreases costs. So would you agree that it increases access, as well as decreases cost?

*Dr. Resneck. Clearly, it does increase access. There will be instances where it is cost effective and reduces costs. There are instances.

You know, when I see a patient who comes to see me from

a rural area, and they have something that I know I am going to need -- it is going to be chronic, and I am going to be taking care of with them in partnership for quite a while, I feel really bad when I tell them they are going to need to sit in traffic and miss work and all those things to come back and see me.

So whether it is your constituents in south Georgia and their physicians, or my folks in rural California, just having the option to know that it is covered for me to be able to pick which visits are most appropriate to see them via telehealth is a huge improvement to their access.

*Mr. Carter. And not only that, but, just as you are pointing out, it decreases health inequities because it increases access, it helps people who are disadvantaged -- at a disadvantage because of various reasons, but some that you just stated right there.

*Dr. Resneck. It was this -- we were in this very ironic situation, pre-pandemic, where there was a big -- like a growth in telehealth. But again, it was mostly -- the fastest growth were in these direct consumer providers, which were for people who had spare money and could go online and just pay for it out of pocket. They got access. But people who paid into Medicare and had Medicare coverage, or many who had commercial insurance couldn't follow up with their own physicians who knew them well.

So this has been a great improvement, in terms of disparities, and in terms of patients --

*Mr. Carter. So basically --

*Dr. Resneck. -- telehealth.

*Mr. Carter. Right. So basically, we have got the research and the data. We know that it increases access. We know that it decreases costs. We know that it decreases health inequities. To go back now, I think, would be a disservice to our citizens, and a disservice to health care, in general.

That is why I have -- cosponsored a bill, along with one of my Democratic colleagues, the Telehealth Modernization Act, that essentially would make the flexibilities from the pandemic permanent. Common sense. We got the data, we know that it decreases costs. We know that it decreases health inequities. We know that it increases compliance and access.

*Dr. Resneck. Yes, we --

*Mr. Carter. A common-sense bill.

*Dr. Resneck. We strongly support it, and I know my Medicare beneficiaries that I take care of would be unhappy to have this access yanked away from them. So thank you.

*Mr. Carter. And once again, bipartisan that I am cosponsoring with another member of the -- Lisa Blunt Rochester with -- on the Energy and Commerce Committee, a bipartisan bill that we should all support. And I hope my

colleagues will do that.

And thank you, Madam Chair, for your indulgence.

*Ms. Eshoo. I thank the gentleman.

You know, there is something else that the members, if you don't realize this, when the waivers are no longer in place, and we don't do something on this issue, it is only Medicare Advantage patients that will be able to receive telehealth services. Those that are enrolled in just straight-away Medicare will not be eligible. So we have got some work to do to make sure that no one falls through the cracks.

Now it is always a pleasure, and we are all, I think -- I know we are a better committee because she is a part of it, the gentlewoman from Delaware.

Ms. Blunt Rochester, you have 5 minutes for your questions. And thank you for being here for the -- from the very beginning of the hearing.

*Ms. Blunt Rochester. Thank you, thank you, thank you, Madam Chairwoman, for the recognition, and especially for your leadership on a topic that I think is transformational in our health care system. And because of the telehealth flexibilities granted under the COVID-19 public health emergency, physicians and health systems across the country have been able to rapidly scale up and deploy telehealth services.

Dr. Resneck, a lot of questions have been asked of you, and there has been a lot of conversation with my colleague, Mr. Buddy Carter, Robin Kelly, and Nanette Barragan about just the waiver itself, and the impact that it has had. And I was curious, number one, if there is anything else that you want to add about making it permanent.

But also, you hinted at the impact that it would have for your patients, those Medicare beneficiaries, if they were abruptly to lose access to telehealth services. Can you talk a little bit about that?

*Dr. Resneck. Well, they have gotten comfortable with the technology. And I think, you know, they have a better understanding of when it is appropriate to use it, I have a better understanding of when it is appropriate to use it. And that partnership and trust has grown between us. So I would have a very hard time looking them in the face at the end of the public health emergency and saying, "Sorry, we are done with all that. That is going away.'' So I feel really strongly.

There are -- you know, there are just so many side benefits, and many of them have come up today. We have talked about a lot of them. We haven't talked a lot about social determinants, even though we have talked about differences in access. And I never cease to be surprised about how much more I learn about my patients' lives that

they are willing to share when I am on a video visit that just might not come up in my office.

*Ms. Blunt Rochester. Yes.

*Dr. Resneck. You know, I have colleagues who -- endocrinologists who take care of diabetes patients, where the patient might walk over and open up their fridge and put it on the video to say, "Do you think I am doing the right thing with this, Doc, with the way I changed my diet?''

You know, this is not a social determinants issue, but I had a patient with just constant dermatitis that wasn't going away, and wasn't going away. And they didn't have any pets, and we couldn't figure out what their allergy was. And they showed me the lovely foliage all down the side of their house, which was poison oak, and we solved their problem.

So there are just so many things you don't expect for a new technology like this to be helpful with that you discover as you go. You also discover the situations where it is, like, okay, it is not so helpful for this. You really need to come to my office. This is different. It has just been a wonderful learning year, and I have been so proud of colleagues all over the country who have implemented this so quickly, and all of whom have, I think, learned a great deal.

*Ms. Blunt Rochester. Yes, I appreciate you sharing that. I actually have legislation on the social determinants of health, as well, and it is a big topic for our committee,

and bipartisan, as well.

Buddy Carter, as has mentioned, he and I both reintroduced the Telehealth Modernization Act that would permanently waive Medicare's geographic and originating site -- for telehealth coverage for Medicare beneficiaries.

And what you just talked about, in terms of the social determinants of health, goes right into the H.R. 1332, our bill, as well as others that we are working on for equity. Could you talk about just how this opportunity intersects with broadband, transportation challenges, and other things that both, whether you are rural or urban, might experience or face?

*Dr. Resneck. Yes, I mean, you have heard from several of my colleagues on the panel, this same idea that we just are constantly surprised by how many patients struggle with the broadband access. And I just was not aware, I think, until this year, of how widespread an issue that is.

And I thank you for bringing up the urban issue, because I think there is a sense that this is unique to people who live very far from an urban area, and really is an issue of the rural parts of our country, where it is real, and it is a real issue for our rural citizens. But I have plenty of urban patients who simply can't afford broadband access, or the devices that they need. And so, again, it is another reason for having backup audio only for them, and working to

improve affordability for broadband access for those patients.

*Ms. Blunt Rochester. I was happy to hear a mention about Medicaid, even though it is a -- slightly switching gears. But we know that close to 40 million children are enrolled in Medicare. And in my state of Delaware alone, 39 percent of children are in Medicaid or the CHIP program.

And so Congressman Burgess and I reintroduced the Telehealth Improvement for Kids Act -- Essential Services Act, which is TIKES, H.R. 1397. And I would love to follow up in writing and ask the entire panel about how Congress can best support state Medicaid programs in their efforts to expand telehealth. And are there supports, incentives, and learnings -- and I think it was Ms. Mitchell who talked about a report that is coming out. So we would look forward to hearing about that report, as well, and we will follow up in writing.

And I yield back 1 minute of my time. Thank you, Madam Chairwoman.

*Ms. Eshoo. Well done. My goodness. The gentlewoman yields back. I now would like to recognize the gentleman from Texas for his 5 minutes of questioning, Mr. Crenshaw.

*Mr. Crenshaw. Thank you, Madam Chairwoman, and thank you to all of our witnesses for being here. If I am going, it means you are near the end, so great.

This is a great conversation. There is a lot of consensus about the benefits of telehealth. And so the question is how do we properly regulate it. I think this body tends to try to answer every question with regulation, whether that is through mandates, incentives, or punishments, or restrictions. And maybe there is a tendency sometimes to have 1,000 of them, right, to make sure that we have thought of everything. I tend to think that the opposite is true. I tend to think that simple rules for complex problems are the best approach. And so I will direct this to Dr. Mehrotra.

What would -- if you had to pick maybe a top five, or just two or three essential regulatory incentives, restrictions, mandates, whatever it is, what do you think we should be focusing on, as this body moves forward, to properly regulate this?

*Dr. Mehrotra. Yes, so the first part that I want to emphasize is that -- that you sort of touched upon with your question, but I think it is really important -- is that one of the barriers to providers using telemedicine has been just pure confusion. It is a very complicated landscape to try to navigate both Medicare, Medicaid, private insurers, state medical boards in five different states that you are providing care for, and that becomes a real impediment to providing telemedicine care. And it becomes, at least in our conversations with providers, a real deterrent: "I just

can't bother, it is just so confusing. How the heck am I going to do this and pay for it?''

We have seen a lot of change in the last year, but I still think that that is a major issue, and something that I hope Medicare will kind of simplify a bit to make sure that it is easier for providers to bill.

But you asked the question about -- in terms of regulations and so forth. I mean, I think here -- I think it is a real balancing act that we don't want too many different regulations. And so I have argued that we should try to limit -- when we are making limitations on telemedicine, to try to only focus on one dimension. I focused on the aspects of different diagnoses and conditions where there is cost effectiveness data to support it, but I think that would be the place that I would focus.

*Mr. Crenshaw. Okay, and I appreciate that answer. It is helpful, as we all go forward, right? There is always a balance of how much risk do you accept in the regulatory world. You know, some of us are more risk tolerant than others. I would love to dive down that rabbit hole for about an hour.

But Ms. Mitchell, I want to ask you a question, because you mentioned a large employer is projecting eight percent cost savings using telehealth. And if that is just one employer, any idea across all of your large members how much

we would save in telehealth?

And then the second part of the question would be what are some of the best practices that you might suggest small and medium-sized businesses could use to incorporate telehealth and, more importantly, pass these savings on to patients?

*Ms. Mitchell. Well, thank you for the question. We haven't measured across our other employers, but again, we don't think eight to ten percent is unreasonable. And when they are collectively spending $100 billion a year, that is not an insignificant amount.

I will remind you that our members are mostly self-insured. So those savings go back to them fairly immediately. And they are looking for ways to reduce the cost of health care for employees, waiving cost sharing, or lowering premiums, ideally.

But again, the barriers that we are currently facing are in the payment model, and we have not seen commercial health insurance companies actually change payment that would enable more flexible use of resources, particularly for physicians. So we think that there is enormous potential here. We -- and we have heard it supported by physicians, patients, and employers.

So we would like to move this forward as quickly as possible, and we need both CMS and commercial health plans to

enable that.

*Mr. Crenshaw. Well, can you expand on that, and on the payment models?

Do you mean moving away from fee for service? Is that what you are referring to?

*Ms. Mitchell. Yes. And again, more flexible, prospective payments, particularly for primary care. We work directly with small, primary-care practices. They need to figure out how to enable teams to do this work, or to connect with some of the community health workers. Current payment systems create barriers to doing that. They create barriers to giving optimal care.

But right now, most health plans will only pay fee-for-service. So we really need to move past that.

*Mr. Crenshaw. I am a big fan of direct primary care. I have introduced legislation to promote direct primary care, and I think direct primary care is deeply intertwined with telehealth --

*Ms. Mitchell. Agreed.

*Mr. Crenshaw. -- as well. And it is -- I think it is a perfect model for this. And I can go down a rabbit hole for an hour, but I only have 5 seconds left.

So I yield back my 3 seconds. Thank you, Madam Chairwoman.

*Ms. Eshoo. Great job, Mr. Crenshaw.

I am not so sure what the average reimbursement is for an appointment online, but I don't -- this is not, I don't believe, an expensive part of health care. I mean, you know, surgeons are not operating on people while they are talking to them. So I don't think that is something to be really concerned about. There has to be a reimbursement, of course, but I don't think we need to make a bigger deal out of it than need be. At least that is my view.

A new member to the committee, a wonderful addition, the gentlewoman from Minnesota, Ms. Craig, you are recognized for 5 minutes.

[Pause.]

*Ms. Eshoo. Are you there, after I said all those wonderful things about you? I guess you are not there.

All right, another new member to our committee. Everyone is -- each member is value added. It is Dr. Kim Schrier, recognized for 5 minutes for her questions.

[Pause.]

*Ms. Eshoo. Are you there? You need to unmute.

*Ms. Schrier. You would think that, after this long in a pandemic, I would know to unmute. Thank you, Madam Chair. Thank you for that very warm introduction, and thank you to our witnesses.

Telehealth is definitely here to stay. Docs love it, patients love it. And this pandemic has been devastating in

so many ways. But the silver lining is that we have this real-world data that shows that telehealth can strengthen provider and patient relationships, and maybe even improve care.

Certainly in my family, my parents are 78 and 82 years old, and telehealth, over the last couple of months, has allowed me to join their medical visits, remember the things that they don't, ask the questions that they might not think of, clarify things, and then I even send them an email, summarizing the visit, and then giving the plans afterwards. And this has been an absolute godsend.

Then myself, as a patient with type one diabetes, access to health -- telehealth has been great. My doctor also has type one diabetes, so it reduces risk for both of us, and keeps my health in good shape.

And as a pediatrician, I hear from my colleagues that telemedicine has actually strengthened their relationships with their patients and enhanced care in many ways, because you can see kids kind of in their own -- know what the environment is like at home, and get a better snapshot of developmental issues.

But there is a lot that you can't do remotely, so I have a couple of questions. One -- and my first one is for Dr. Mahoney.

Just as a doc, I would send my patients to specialists.

They would come back to see me. I would also get a note from the specialist. And often times the two stories did not match up. And now that I am going through these health issues with my parents, I am just curious about whether you could take telehealth even a step further, and have, say, the primary doc and the neurologist and the neurosurgeon and the interventional radiologist sort of all in the room together making a decision, and coming up with a plan, so everybody hears the same information. And so I was wondering if you could briefly comment on how that might improve medicine.

*Dr. Mahoney. Yes, thank you, Dr. Schrier, for the question. And as a fellow primary care provider, I really do resonate with your stories of the benefits of talking to caregivers who are doing heroic work for our senior population, taking into account work schedule, child care responsibilities. And then, also as a family physician, I do have the benefit of seeing children and watching their developmental milestones, and observing those within their home environment, which is a lot more helpful.

So I -- can you repeat the question, again? I am sorry, I lost --

*Ms. Schrier. I guess just, you know, do you see that as a possibility, where you could have multiple layers of specialists --

*Dr. Mahoney. Oh, right.

*Ms. Schrier. -- in the room, all hearing the same story?

Like, would that improve a care -- care coordination, if you had everybody --

*Dr. Mahoney. Right.

*Ms. Schrier. -- there at the same time?

*Dr. Mahoney. Absolutely. So there are models out there, and we have experimented with that in the inpatient setting and also in the outpatient setting, where we have video conference, multiple consultants, family members, also the patient. We do this in the inpatient setting, when we want to have a family conference, if it is and end-of-life discussion, in particular. So that has been successful.

The barrier is the coordination of scheduling of all these very busy individuals. And what is also helpful is asynchronous communication through the electronic health record. So that is -- that has also been incredibly helpful, in also --

*Ms. Schrier. Oh, that is great.

*Dr. Mahoney. -- being able to --

*Ms. Schrier. Can I ask one more question? I wanted to -- this one is for Dr. Mehrotra about pediatric care.

You note in your work for the Commonwealth Fund there has been a 24 percent decrease in visits. There has been about a 30 percent decrease in vaccinations. You can do some

things really great in pediatric care with telemedicine, but other things are going to fall through the cracks. And so I was just wondering if you could talk about the good, bad, and the ugly with pediatric care, specifically. What are the wins? And where are the liabilities -- we have some improvements?

*Dr. Mehrotra. Yes, one of the things that we -- while there has been a big resurgence in visits in the United States and back to baseline, one big area that we haven't seen that is in pediatrics, and I think that is a combination of both good things and bad things.

The good part, and the silver lining, is kids are less exposed to illnesses, and so we are seeing a dramatic drop in acute respiratory illnesses, colds, gastroenteritis, eye infections, and so that is the positive part. But as you highlighted, Dr. Schrier, there is a real concern that there has been a real deficit in immunizations and preventive health visits. And so that is a key place that, as we come out of the pandemic, how do we make sure we catch up with those kids? And telemedicine could play a role there.

*Ms. Schrier. Thank you. I am going to add one more thing from experience. When Microsoft patients had to pay a copay to come see the doctor, they stopped coming in the first time their child sneezed. And so, as we talk about over-utilization, sometimes just a little copay makes a big

difference.

Thank you, I yield back.

*Ms. Eshoo. I think money is always involved in just about everything in life.

The gentleman from Pennsylvania, Mr. Joyce, is recognized for his 5 minutes of questioning.

*Mr. Joyce. Thank you, Madam Chair Eshoo and Ranking Member Guthrie. This is an important hearing, a topic of telemedicine. As a physician myself, I understand the increased telehealth services during COVID-19 has spurred substantial changes, positive changes in the delivery of health care.

Last year, when in Congress we acted to provide the Secretary of HHS with additional flexibility surrounding telehealth, I don't think any of us envisioned the full impact that this would have. The pivot to telehealth has raised many new questions surrounding patient care access, rural availability specifically in broadband, and even privacy and security issues.

I want to thank the witnesses for appearing today, and for answering our questions.

Dr. Resneck, as another board certified dermatologist in this conversation, you and I realize that derm is a very visual field of medicine, and visual access to patients is sometimes all that is necessary for an evaluation, diagnosis,

and treatment. But this isn't always the case with all sub-specialties, specifically surgical sub-specialties, which our Chair Eshoo talked about, that surgeons aren't going to be doing these procedures via telemedicine, but also in obstetrics. Do you see any long-term consequences for these fields, given the shift that we all know is occurring to telemedicine?

*Dr. Resneck. Thank you, Doctor, Congressman Joyce. So I think every specialty has found its places where telemedicine can be useful.

So you mentioned surgeons. I have surgical colleagues who -- their patient gets discharged from the hospital, lives a couple hours away, and maybe they do a post-op visit via telehealth. So, you know, every specialty is figuring out this -- okay, this is where telehealth does not work for me, and this is where it does.

You know, you and I are both dermatologists. Sometimes a still image can be way more useful than a blurry video for us. So we are -- you know, I am grateful that we have a variety of codes to use, including the e-visit codes, where a patient can upload really high-quality photos into my EHR portal for me to look at. So I think having a variety of tools at our fingertips, the continuation of every specialty figuring out where this is useful and isn't, is going to bring us to a place of ongoing progress here.

*Mr. Joyce. I certainly enjoyed hearing about your treatment of the patient with scleromyxedema, knowing how complex with the cardiac and pulmonary, that you required ultimately that that patient be brought in hospital for ultimate care. But your ability to keep that patient working is significant.

I also wanted to address another issue that I think is important, and that is the training of residents and medical students in telehealth. And I will ask the physicians on the table at this conference.

Dr. Mahoney, do you think that that should be integrated as part of training, both to medical students and to residents?

*Dr. Mahoney. Thank you, Congressman Joyce. This is an excellent question. I wholeheartedly endorse and am enthusiastic about integrating telehealth and more modern modalities of care into the training of medical students and our residents. We really do need to prepare for the next generation of providers, and we need to ensure that they are empowered with all of the knowledge to do so effectively.

We have been training our residents. We have been bringing them in, either in the visit that we have with the patient directly, so they can observe -- they are able to see patients directly, we can conference in as attendings and observe, and then they can also have one-on-one appointments

with their patient, and then present to us later, depending on their level of training. But absolutely, I endorse that recommendation.

*Mr. Joyce. Dr. Mahoney, do you recommend this as a requirement to complete residency training?

*Dr. Mahoney. You know, I am not an expert in that field, but I am very enthusiastic about that, that idea, absolutely.

*Mr. Joyce. Dr. Mehrotra, would you weigh in on this, as far as medical students and residency requirements in telemedicine?

*Dr. Mehrotra. You know, I think it is a key point, and it is already happening -- let's be clear -- just because all -- as you know, residency is often an apprenticeship. You follow attendings around, and you see their care that is being provided. And as all of health care has moved to telemedicine, I am seeing so rapidly how education is moving in that direction. So I am very enthusiastic and excited about how the future will incorporate telemedicine in training.

*Mr. Joyce. Thank you all for being present.

And Madam Chair Eshoo, I will remain -- return my remaining 12 seconds.

*Ms. Eshoo. Well, I thank you, Doctor. You raised a very important, wonderful point, just as we were kind of

winding down in the hearing and we think that we have covered all the corners and then some. And you raised the point about training. So good for you. See what each person brings to the committee? It is really wonderful.

I think Ms. Craig -- has she returned? Yes.

It is a pleasure to yield to you 5 minutes for your questions, the gentlewoman from Minnesota, Angie Craig.

*Ms. Craig. Thank you so much, Madam Chair and Ranking Member, and thank you to all of the panelists who have been here for so long today.

I know that each one of us shares the goal of ensuring that our constituents can safely and affordably access health care and, of course, virtual care, telehealth has been just a critical, critical piece of this during the COVID-19 pandemic.

I am particularly encouraged by the potential for telehealth and virtual health care to expand access to mental health services in rural parts of my congressional district, and to help alleviate a provider shortage for so many communities, including my own. In 2017 rural areas in Minnesota had only one licensed mental health provider for every 1,960 residents, while my metro areas had one mental health provider for every 340 residents.

As others have noted, one of the silver linings of the past year has been the adoption of telehealth, virtual health

care for mental and behavioral health care. One telehealth vendor in our state saw an over 300 percent increase in visits to their behavioral health platform last year. Telehealth for mental health care has also shown great promise for, especially, our Medicare beneficiary population, who might otherwise feel stigmatized or have other limitations preventing them from seeking out care in person.

I want to start with Dr. Mehrotra.

You have highlighted that telehealth could lead to the potential for overuse of care. HRSA has designated the majority of the U.S. as health professional shortage areas for both primary and -- primary care and mental health. And the same, of course, is true in my district. In your view, how do we best expand the reach of our existing health care workforce, especially for services like mental health, behavioral health care, and, at the same time, balance the appropriate use of care and guard against overuse?

*Dr. Mehrotra. I think that first, Representative, I just want to highlight I think what many of you know, that if we were to look at rural areas of the United States versus urban areas, and we look at how much care patients are getting, it is much lower often in rural areas, in particular for specialty care. And that is why there has been so much of a focus on telemedicine to increase access there.

One other point that we haven't really addressed here

that I thought might be important is that states are also under a quandary of how do we address this balance of increasing access, but addressing this overuse. And so a number of states have said, you know what, we don't have enough data from the pandemic, it is such an unusual time in our lives, and that they will extend temporarily telemedicine expansion for 1 to 2 years afterwards, and use that as a period of time to try to understand what the impact is, and whether this overuse concern is valid. So I wanted to highlight that point.

*Ms. Craig. It is an incredibly important point, and I think you are exactly right. As we look at this, we are going to need an additional level of research on what is appropriate and for how long for each particular health care action.

My next question is for Mr. Riccardi.

You discussed the digital divide in your testimony, and many of our districts, including mine, lack full access to broadband. A recent study published in Health Affairs found that telemedicine and overall outpatient access during COVID-19, of course, were lower in rural than urban areas. The authors theorized the difference could potentially be attributed to limited broadband availability in rural areas. I could tell them that is probably true.

In expanding access to telehealth, what additional

policy tools do you think Congress should consider to address this digital divide and ensure that health services reach these under-served communities?

*Dr. Riccardi. Yes, thanks for your question. I am concerned about the regional variation. We still only have early 2020 Medicare claims data, and that information has not been publicly released, and physicians still have additional months to submit that data. But early we know that about 30 percent of beneficiaries who receive telehealth services were located in urban areas, and 22 percent of beneficiaries were in rural areas. So there is that discrepancy there.

Earlier, you know, you had mentioned, you know, concerns around affordability. As we think about expanding Medicare telehealth going forward, it is also important to consider the types of facilities that people can receive care from, including community-based clinics is particularly important. And as the CMS releases this data, and it is analyzed by researchers, we should be looking at what impact has the cost-sharing waivers that have been in place have had on the utilization of services. And we recommend that there is standard cost-sharing applied both to telehealth services and in-person services to create parity, to avoid incentivizing one form of care over another.

And then, as we consider finances, we should look towards CMS's current telehealth payment schedule for the

starting point to determine what is the appropriate payment for telehealth versus in-person care, not only looking at the emergency waivers.

*Ms. Craig. Thank you so much. And there is about a million question that -- questions for follow-up that calls for. But sadly, I am way over my time.

So, Madam Chair, I will yield back.

*Ms. Eshoo. The gentlewoman yields back. Now I would like to move to members that are waiving onto the subcommittee.

To the witnesses, these are members of the full Energy and Commerce Committee, and we always extend the legislative courtesy to any of our members that would like to join our subcommittee for questioning. The only thing is that they have to be -- they have to wait, wait, wait, and be taken toward the end of the hearing. Nonetheless, they all count.

And the chair is pleased to recognize the gentleman from Ohio, Mr. Latta, for 5 minutes of questions.

*Mr. Latta. Well, I thank the chair, my friend, for holding this very important hearing today, and for allowing me to waive onto the subcommittee.

You know, we are approaching one year since the way Americans lived, worked, and learned all changed due to the outbreak of the COVID-19 global pandemic. We have seen how quickly the virus has spread through our communities. The

response to the pandemic -- action was taken by the Trump Administration. Thanks to the leadership of the President, telehealth services have really expanded to provide care and assistance to the most vulnerable at a distance.

Even with these efforts, I have had numerous constituents contact me with concerns regarding the lack of access to telehealth services, whether it is related to issues with broadband connectivity, electronic appliances, or a lack of available care, it is clear that more needs to be done.

Early in the pandemic, students in my district who were receiving higher education were abruptly notified that they be required to return home, even if it meant traveling long distance in and out of state. This severed relationship with campus-based mental health providers during a stressful time.

In addition, people fighting cancer and other rare conditions, weren't able to travel safely for care due to lockdown protocols.

Because of the concerns, I introduced the TREAT Act, along with my good friend and colleague, the gentlelady from Michigan, Mrs. Dingell. This bill would establish temporary reciprocity at the state level for a provider in good standing to virtually see patients during the COVID pandemic. With only -- groups representing patients, physicians, universities, health systems, employers, and many others,

this bill would alleviate the overall health care professional shortage we are facing, and provide immediate relief to providers and patients.

I address my first question to you, Dr. Mahoney. In light of the immense stress and pressure that has been placed on our hospitals and mental health providers and addictions counselors, do you believe that temporarily waiving state licensure requirements would help ensure that patients can receive the quality care they need?

*Dr. Mahoney. Thank you, Congressman Latta. I -- we believe the TREAT Act is a step in the right direction that will ensure continuity and access to care for patients, nationwide, during this pandemic. The issue of specialty care access and behavioral health access across state lines will last beyond the pandemic. And so we encourage, as well, the re-evaluation of the system with that in mind.

And so we are excited about potentially enabling providers who are licensed in good standing to treat patients at any state, and they can require, you know, oral and written acknowledgment of services, require notifying state and local licensing boards within 30 days of first practicing in another state. And many of the other parts of the TREAT Act make a lot of sense. We definitely believe this is a step in the right direction.

*Mr. Latta. Well, let me follow up. In your

experience, could you share any examples of licensure challenges faced by Stanford's providers, and why the current patchwork of state laws is making providing care for those patients more difficult, especially during the pandemic?

*Dr. Mahoney. Right, right. So after lockdown, our providers received requests for care from all 50 states. And we were able to provide that care during this time in states where there wasn't a pediatric rheumatologist available in the entire state, or a pediatric endocrinologist. Academic medical centers are unique, in that they are able to provide subspecialty services that are not available throughout certain states. And so we were very honored and enthusiastic about having that ability to do so.

*Mr. Latta. Well, thank you very much.

Dr. Mehrotra -- I hope I pronounced that correctly -- in 2018 Congress allowed clinicians working within the U.S. VA Affairs health system to provide care to patients both in person and across state lines through telehealth services, due to veterans experiencing long wait times. And that emerged into federal action.

Would you agree that the severity of this crisis also demands that Congress address the licensure issue, and expand deployment of care during the duration of this public health emergency?

*Dr. Mehrotra. I definitely agree, Representative

Latta, and I would say that -- two other points there is that I would go beyond the TREAT Act and make this -- using -- under the Medicare system, allowing any Medicare beneficiary to receive care from a physician who is licensed in the state that he or she is located in.

One nuance that I might bring up is that there was this issue of the interstate medical licensure compact as another way of improving the ability of providers to get licensure in other states. And I think, in theory, it is a great idea. Our data highlights that very few providers have used it to do so, to provide telemedicine across state lines, simply because it has a lot of administrative paperwork, and the cost of it. So I would say that that is one thing I wanted to flag.

*Mr. Latta. Well, thank you very much for our witnesses.

And Madam Chair, again, thank you very much for your indulgence and me waiving on to the subcommittee. Thank you very much.

*Ms. Eshoo. We are always happy to have you with us, Mr. Latta. You are -- when we say "gentleman,'' you are truly a gentleman. You are always welcome at the Health Subcommittee.

*Mr. Latta. Thank you, ma'am.

*Ms. Eshoo. Yes. The chair is pleased to recognize

another one of our new members to the full committee from Massachusetts, the gentlewoman by the name of Ms. Trahan.

You are recognized for 5 minutes. Thank you for waiving on. Oh, no, you are a member of our committee. You don't need to waive on.

*Ms. Trahan. I am, but I would have waived on if I wasn't.

*Ms. Eshoo. Right.

*Ms. Trahan. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, as well as all the witnesses here today. I really appreciate all of your -- all of the insight.

Missed appointments, or no-shows, are a measure of health disparity, with low-income, Medicaid, and minority patients traditionally having the highest no-show rates. Lack of private transportation, access to health care, inflexible work schedules contribute to higher no-show rates in an already under-served community. Given the ability of telehealth to improve patient convenience and eliminate barriers to care, I want to just discuss how one year of accessing telehealth has resulted in a decrease in no-show rates for hard-to-reach patients in the pandemic.

Greater Lawrence Family Health Center is a community health center in my district that serves a diverse population. Approximately 70 percent of patients are non-English-speaking, approximately 75 percent have Medicaid.

Excluding testing and vaccination appointments, this health center has had more overall visits at this point this year than they did last year. And they have also seen a ten percent decrease in no-shows, which providers at the center attribute to the expansion of telehealth services.

Also, a study was conducted by a member of the Massachusetts Medical Society on all patients that completed or no-show appointments with the dermatologist at the campus during the months of May and June 2019, compared to 2020. And the study found that, compared with the clinic visits, televisits had significantly lower no-show rates, with the greatest reduction seen for Black, Latinx, and primary non-English-speaking patients.

So I know that there is limitations to the study, you know, with a small sample size, and single institution experience. However, the study provides early evidence that tele-dermatology may play an important role in mitigating no-show rates and improving access to care for our most vulnerable populations.

So, Dr. Resneck, are the findings from the study I mentioned consistent with your clinical experience?

And do you believe these findings represent a trend across practices and institutions?

*Dr. Resneck. Congresswoman, those findings do not surprise me. This is what I am hearing from my colleagues

around the country and experiencing myself.

As you sort of highlighted, traditionally -- at least in my practice and colleagues who work around me -- some of the highest no-show rates are in patients who already suffer from health disparities. Their lives are more complicated, it is harder to get out of work, transportation issues, child care issues. And the decrease in no-show rates, I think, has had a particular impact on improving care for those minoritized and disadvantaged populations.

So I am seeing it in my own practice. I am hearing about it from colleagues. And I think, as we see more national data, they will confirm what you read from U Mass.

*Ms. Trahan. You know, another opportunity that our Chairwoman Eshoo actually brought up in her opening remarks is that telehealth creates the opportunity to get Black and Brown patients in front of physicians who look like them. Data suggests that individuals are more inclined to visit a medical professional if they share their same race or ethnicity.

So given the historical context that, you know, people of color, particularly Black people in our country being mistreated and exploited by our health care system, it may take more time and effort for a provider to build trust with a patient of different demographics in a virtual setting.

So Dr. Mahoney, I was wondering if you can shed some

light on the impact telehealth is having on making the case for investing more -- in a more diverse medical workforce, including physicians, pharmacists, nurses, and medical professionals, and how that will help to build trust with patients across cultural, ethnic, and racial dimensions.

*Dr. Mahoney. Thank you, Congresswoman Trahan, for that excellent question. And I appreciate the acknowledgement of the data that is out there, supporting the association between race concordance, between patient and provider and clinical outcomes along the lines of patient satisfaction, trust. But also, perhaps even quality of care might be better when there is race concordance.

And some of the studies that I participated in, we found that if there is a single team member -- it doesn't have to be the physician, because we know that we don't have high numbers of people of color who become physicians now -- hopefully, that is something we can work on and improve in the future. But if there is a single team member -- so I am glad you have highlighted the idea of a team member being someone who is culturally or racially concordant with the patient, and the importance of that.

Absolutely, access to telehealth, any modality that is going to improve access to care, is going to, as a result, improve the trust and the connection that a patient will have with her providers. It will improve the availability of

multiple team members to engage with that patient.

*Ms. Trahan. Terrific. Well, thank you. I am out of time. I appreciate those answers.

I yield back.

*Ms. Eshoo. The gentlewoman yields back. Thank you for your patience. Thank you for your patience in waiting to be recognized.

The chair recognizes another wonderful member of the full committee that is waiving on, Mr. Johnson of Ohio.

Thank you for joining us and for, I think, just being with us since we started at 10:30 this morning.

*Mr. Johnson. Yes, I have. I have been paying very close attention. And Madam Chairwoman, I thank you and Ranking Member Guthrie and the subcommittee for allowing me to waive on, and to try and contribute today.

As co-chair of the House Telehealth Caucus, along with my colleague, Ms. Matsui, I am delighted that we are taking a close look at this. I represent a very rural district, as you know, and telehealth plays such an important part of health care delivery in rural parts of our country. In fact, you know, it was about this time last year, as COVID began to spread and the shutdowns took hold, that telehealth began playing such a key role in protecting vulnerable patients and helping to slow a run on our overburdened medical system.

I was proud to fight for the emergency telehealth

waivers that gave providers additional tools to make sure millions of Americans still receive and are receiving today the health care they needed. But this emergency will end, thank God. But many of these temporary waivers will end with it. And in my view, we should make this progress permanent to prevent a "telehealth cliff,'' which would reverse the gains that we have made, and deny patients the telehealth services that they have grown to appreciate and rely upon. I have legislation that will do just that, and I look forward to working with my colleagues this Congress to make responsible, permanent changes.

So first, to Dr. Mehrotra, as we have heard today, obviously, telehealth isn't appropriate for every type of ailment or doctor visit, but it is uniquely positioned to make a huge difference in many others. One of those is in accessing mental health treatment. In a rural Appalachian district like mine, specialists such as counselors and psychiatrists could be perhaps hours away, and treatment can be out of reach. Telehealth could be a lifeline to someone headed down the path to a mental health crisis, and with prompt intervention a possible emergency room visit or worse could possibly be avoided.

So, Dr. Mehrotra, in your testimony you mentioned that telehealth can be used to prevent more costly care down the road. Can you outline why, in your view, it is so important

to address issues early?

And can you provide some more examples on how telehealth could be used to achieve this?

*Dr. Mehrotra. Representative Johnson, thank you so much, and I just do want to emphasize what a key role telemedicine has played in rural communities. In some of our work prior to the pandemic we found that, in some rural communities, 30 to 40 percent of the visits for patients with serious mental illness were provided via telemedicine. This is, again, in the Medicare population before the pandemic. And certainly within the pandemic that rate has increased dramatically.

Though I will emphasize what Representative Craig -- she cited one of our papers that, unfortunately, during the pandemic, rural patients, unfortunately, are using telemedicine at a lower rate than people in urban areas. So it has really flipped.

But your question, Representative Johnson, was more about how we can address, where we can address -- if we can intervene early, how can we prevent downstream issues from coming on. And one area that I think is very promising, and I think Representative Eshoo had mentioned this previously, was in skilled nursing facilities, where we see that, if we can provide telemedicine coverage for after-hours coverage as well, it allows patients to be treated within the skilled

nursing facility and not be transferred out to the local emergency department and be hospitalized.

And so it is helpful for people to stay within the facility, and it also saves money. So that is a really great example of where it can be quite cost effective.

*Mr. Johnson. Well, good. Well, good. Well, your point about rural Americans being some of the lowest volume of telehealth users, I think there is a really good reason for that, and that is why I want to go to Mr. Riccardi next.

If Americans don't have reliable broadband Internet, our debate over payment models, state licensure, and permitted services won't be of any help to people that live in rural areas, low-income individuals who would benefit the most from telehealth services. So I agree with your testimony that closing the digital divide is essential.

So as policymakers, why is it so important, as we consider permanent telehealth policy changes, that we also keep working to build adequate broadband infrastructure, especially in the midst of a global pandemic like this, when school work and health care have moved online?

*Dr. Riccardi. Thank you, Congressman Johnson. I think currently, as we consider expanding the Medicare telehealth benefit, that we also have to invest in the infrastructure to ensure that all communities have access to broadband and the technologies that they can use to receive care from home.

So as we consider all of this, we -- to revisit a point I shared earlier, I think it is important that we have a glide path in place to ensure that there is no disruption in care once this public health emergency ends. And as we consider expanding the benefit, that we consider people living in the rural environment who have benefited from telehealth for many years, but still lack the essential connectivity that is needed to maximize the capability of receiving care, and then also consider, you know, urban areas and, in particular, the necessity for beneficiaries in rural environments and in cities to receive care from home, as a supplement in-person care.

So I think there is quite a bit of investment that needs to be made, both in the -- in technology, and then also in the expansion of the benefit.

*Mr. Johnson. Well, thank you. Madam Chairwoman, thank you for the indulgence in letting that answer run a little over. Thanks for having me.

*Ms. Eshoo. Oh, absolutely. Well, if we can go all day, what is a few more minutes here or there, right?

I would just add to this that, in the American Rescue Act, there is literally billions of dollars directed to build out broadband in our country. So everyone should know that. I mean, whether you support the whole bill or not, there are -- there is significant funding in it. And of course, it is

COVID-related. So I just wanted to add that.

So thank you, Mr. Johnson.

A wonderful new member to our -- of our committee, the gentlewoman from Texas, Mrs. Fletcher, you are recognized for 5 minutes for your questions.

*Mrs. Fletcher. Thank you, Chairwoman Eshoo, and thanks to you and Ranking Member Guthrie for holding this hearing on telehealth today. Thank you to all of the witnesses for sharing your insights, answering our questions.

As we have discussed throughout the day, the COVID-19 pandemic has drastically changed the way that we receive care. And I agree with my colleagues that telehealth is a silver lining of this experience. Even before the pandemic, providers in my community were telling me how they were using and hoped to expand telehealth. And we have seen that in my district over the last year. I want to touch on two issues in the time that I have.

First, another somewhat new area, and I believe it is following up on the pediatric issues that Dr. Schrier raised, and the issues that Ms. Craig raised. I heard in -- from my constituents that the need for pediatric behavioral health is both enormous and growing. COVID has increased suicide rates, has created isolation from peers, and access to adults like teachers and coaches and pediatricians who often help spot issues or provide help, and that telemedicine has really

kept the lights on for mental health programs. So my constituents working in this area tell me that they have converted their evidence-based treatments to things that work for telemedicine.

Dr. Mahoney, I appreciated that in your written testimony you noted the importance of applying virtual care in all areas, including physical therapy and speech language pathology, and occupational therapy, which are very important in my district, as well, and something that I worked on at the beginning of the pandemic. These have been critical for my constituents. Can you speak a little bit to these behavioral health issues from your perspective, especially pediatric behavioral health issues?

And while I understand it is a very complicated issue, the need or the possibility for reimbursement beyond Medicaid for behavioral health, telemedicine.

*Dr. Mahoney. Great. Well, thank you, Congresswoman Fletcher, for the excellent question and the attention to this important issue, particularly during this pandemic, when children are experiencing more isolation and often are overlooked and aren't able to get the most evidence-based treatments for their conditions.

And so what I would say related to reimbursement, this is primarily a question about Medicaid law, and sort of outside of, you know, my expertise. And I am happy to follow

up in writing with a response.

But in general, what I will say is that having the interstate restrictions waived has been beneficial in providing access to subspecialty services across state lines in order to address this demand for behavioral health services among our pediatric patients.

*Mrs. Fletcher. Thank you so much for that. And on a slightly different topic, although it certainly applies to pediatric patients, as well, but, you know, even without the challenges of COVID-19, for people with disabilities or medical complexities just getting to the doctor can be extremely burdensome on both the patient and the caregiver. And we have certainly heard about some of those challenges earlier today. I have heard a lot of stories from my constituents about how telehealth has really helped ease some of those burdens. Just the other day I was on the phone with a constituent who has epilepsy and can't drive herself to the doctor, has limited access to transportation, and basically just lost her reliable transportation.

So, Mr. Riccardi, are there particular issues that we should be thinking about to ensure that more people with disabilities or complex medical conditions are able to access these services?

*Dr. Riccardi. Yes. And, you know, fortunately, the pandemic has allowed more people to access these services.

And from, you know, the -- our helpline and our clients, we do see lack of transportation or access to facilities that meet ADA compliance as an issue.

So as we consider moving forward with telehealth, we want to make sure that in-person facilities still are meeting these requirements, and telehealth does not become the barrier for people with disabilities that may need follow-up care, in-person care.

And as we know, people with chronic conditions have been able to receive services through the pandemic, e-visits, and others that we would like to see moving forward. But we must ensure that access to in-person care is both accessible and available.

*Mrs. Fletcher. Thank you so much, Mr. Riccardi. Thanks to all of you for your really insightful testimony today.

And Madam Chairwoman, thank you again for holding this hearing. I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure now to recognize another one of our wonderful members that is waiving on today, the gentleman from Indiana, Mr. Pence.

You are recognized for 5 minutes for your questions.

*Mr. Pence. Well, thank you, Chair Eshoo. I haven't been called wonderful for quite some time. And thank you,

Ranking Member Guthrie, for holding this hearing. And thank you to the witnesses for appearing before us today to discuss the advantages of telehealth technologies during the COVID-19 pandemic and beyond.

In rural districts like my Indiana 6th district, telehealth expansion during the pandemic has been a game changer. Countless Hoosiers have benefited from the convenience of services that remotely connect patients to doctors, specialists, and other health care professionals, all from the comfort of their own home. Throughout the pandemic telehealth provided that it can provide high-quality, patient-centered care that, in many instances, mirrors the type of care received in person.

Under President Trump's leadership, flexibility in telehealth services allowed physicians to stretch their resources to meet the diverse needs of disparate communities, quite often 2 hours away from health care, as mentioned earlier in the hearing today.

In Indiana's 6th district two hospital systems received funding under the FCC's COVID-19 telehealth program to service patients' needs with innovative methods of care. Bangkok Regional Hospital and Greenfield used these grants to develop a portable camera system for COVID-19-infected patients to connect with infectious disease experts located at neighboring hospital systems.

Beyond the pandemic, the telehealth services will play a key role in addressing barriers to care for rural patients, especially those that suffer from mobility issues or patients with chronic conditions. It is important to recognize, however, that these services are rendered useless for Hoosiers and all Americans that sit on the wrong side of the digital divide, which covers a large portion of my district. Innovative models of care will not overcome inadequate Internet connections.

Further, as this committee develops solutions to the future development of telehealth technologies, we must remain cognizant of the challenges of wasteful spending and fraudulent claims that will strain an already bloated health care system.

Dr. Mehrotra -- I am sorry, Mehrotra -- I understand that there are certain conditions such as movement disorders which require in-person interactions to properly diagnose and treat. In your testimony you also mentioned the limitation of telemedicine visits for things like ear infections for infants. This is especially difficult for patients in rural America with limited access to resources. Doctor, can you expand more on how we could blend telehealth services into traditional care to better impact rural America and patients with chronic health care conditions?

*Dr. Mehrotra. Well, thank you very much for the

question, Representative Pence. And I might highlight something before I turn to your question directly. I do want to emphasize something that you brought up earlier in your testimony, when you discussed the health systems in your area using telemedicine.

We are also seeing a lot of, in rural communities, telemedicine used in emergency departments to try to facilitate specialty care being provided within those communities. And the one thing I wanted to emphasize there that I am concerned about is, while we have evidence that that telemedicine used in emergency departments is effective, the smallest and rural -- most rural hospitals are the least likely to have that technology. And so it is a real barrier there. So how do we make sure that those hospitals have that technology?

In regards to your question more directly related to the -- how do we incorporate telemedicine care into rural communities, I think the -- one of the points that we made earlier in the conversation is how do we allow patients in rural communities to access the care from anywhere else in the country.

And I think we heard a story of how, in many cases, patients in rural communities don't -- it is not someone within the State of Indiana, for example, but is in many states away. And so we talk a lot about licensure, and being

such a critical reform to try to allow patients in rural communities to access the care that they need.

*Mr. Pence. Okay, thank you.

And thank you for letting me come on, Madam Chair. I yield back.

*Ms. Eshoo. The gentleman yields back.

You are always welcome at the subcommittee.

And now, last but not least, the gentleman from Arizona, Mr. O'Halleran, who is also waiving on today.

I do believe you are the last one.

And thank you to the witnesses for this long hearing. But Mr. O'Halleran is worth hearing from, and then we will have a few closing business things to do.

Mr. O'Halleran, you have 5 minutes to question.

*Mr. O'Halleran. Well, thank you, Madam Chair, for letting me waive on. I always appreciate being last, if I can speak, so I appreciate that very much.

You know, this committee is made up of individuals across the whole spectrum of political thought, but they are -- all care about one thing. That is the health of the citizens of our nation.

The COVID-19 pandemic has finally forced Congress -- and I mean forced us -- to look at HHS and CMS to rapidly address some of the issues regarding telehealth.

One of the most significant issues in administering

telehealth in rural America is the lack of specialists and, for that matter, just plain lack of doctors, lack of nurses, lack of professional -- health professionals that we need.

Nothing I am going to say is going to be -- and talk about -- is new to any of you. It is just why is it still an issue in our country, this great country, decade after decade after decade?

It shouldn't be this way. Our citizens are not expendable. We are all -- should be treated equally in health care also. And we have to make these temporary changes, those that are adaptable, permanent.

My district -- why I am so passionate about this is that my district is larger than the State of Illinois. It is 58,000 square miles. And so we have got a little bit of room there. And I have the same amount, plus or minus, of any other congressperson here.

I have been working on telehealth issues since I was in the legislature 20 years ago. And changes have gone in the right direction, but not fast.

I have 12 tribes in the district, and they include some of the largest tribal lands in the nation: the Navajo, the Hopi, the White Mountain Apache, some in the San Carlos. These are tribes with larger land masses than many of the states in this country.

I go to different areas with Meals on Wheels to make

sure I get out there and talk -- and actually talk to people, not just deliver the food, but see the conditions they live in, talk to them about what their issues are. It always gets back to health care, and it always gets back to not only affordability, but the ability to even get care in a way that they can get to the doctor that is even nearby. That is wrong. We have to do something differently about that, and telemedicine is only a piece of that puzzle.

The disparities even in urban communities is a problem in this country, and we have to address those issues.

The CMS issues that are critical to being able to get reimbursements at the appropriate level are critical in this process.

Rural doctors, I mean, I just watched a caravan going out of rural America, not coming into rural America, and we have to do that. That is critical, to be able to address the issues that we just got done talking about. How do we tell somebody on a telemedicine thing to come on down, come on down, we will see you down at the VA, or we will see you down at the center, down in -- or whatever, and it is a 5-hour trip, one way, and they can't afford to stay at a hospital. They need health care, they need it now, they need to talk to that specialist. If it is not a physical examination, then to be able to go over their medications and stuff. And that is not always available. I can't tell you how many homes I

am in where there is no such thing as a computer in those homes.

And the need for additional technology, we shouldn't be -- broadband is something we all want to work on, but we can't work out to -- and thinking about it today. We have to think about it tomorrow, where the technology is going, and have the capacity and speed in which to do that.

And so I just -- I want to end there with my comments, but I do have a question for -- let's see where it is at -- Dr. Resneck, and I will get to the short end of it.

Without access to high-speed broadband, are there certain specialists who may be difficult to see, treatments that may be more difficult to obtain because of these -- Americans lack high speed broadband?

And what is the future with broadband, as far as bringing care to people and us being able to adapt to it in the appropriate way?

*Dr. Resneck. Thank you for all of your comments. You brought up a lot of outstanding issues, Congressman.

And yes, but there is not just a specialty. I mean, there are certain things that require more bandwidth than others. But I would say all of us and all of our patients need the option to be able to communicate with us electronically, and that requires broadband access.

But I am optimistic. I am optimistic that you all are

going to help solve the Medicare rules problem that we will be facing after the pandemic. And I am optimistic that, as a result, for rural populations like yours, telehealth will be a big part of the answer so that people's life expectancies and their health are not so heavily determined by the zip code that they live in, by their race, ethnicity. I think we are going to make big progress, and I think telehealth is going to be a part of it. And I agree, we need broadband to be part of it, too.

*Mr. O'Halleran. So thank you very much.

And, Madam Chair, I thank you for the time over which you allowed me to go. Thank you.

*Ms. Eshoo. You waited a long time to speak. So, as I said earlier to another member, a couple of minutes here, a couple of minutes there -- a lot of chairmen have cut me off in the middle of a sentence over 28 years, so I find myself being generous as a result of that.

And we have one more member to recognize. We are glad to see him. And he is the gentleman from Maryland, Mr. Sarbanes. I -- he has been probably on the floor the better part of today.

So we are glad you made it to our subcommittee hearing, and you are recognized for your 5 minutes of questions.

*Mr. Sarbanes. Thanks very much, Madam Chair. I appreciate it. And I appreciate you holding this very

important hearing.

We have been hearing from many constituents and provider groups in my district -- and I know this is the case for my colleagues -- about how much of a benefit telehealth can offer, particularly during this terrible pandemic that we are facing. It allows continued access to medical care for patients, while protecting the health of both the patients and the medical staff that are serving them. So it makes eminent sense.

We know that we took steps to greatly expand telehealth under the CARES Act, which now allows federally-qualified health centers and rural health clinics to utilize those services under Medicare. And that is the case across the country.

But in Maryland, there is places like school-based health centers that still can't use telehealth to access their student populations. And we know that school-based health centers provide high-quality, comprehensive primary health care, mental health services, preventive care, social services, and youth development to primarily low-income children and adolescents across the nation. And they play a critical role in helping to reach under-served populations and to achieve health equity.

I will note that the Maryland State Senate actually recently passed a bill that would allow school-based health

centers to provide their services via telehealth. In Congress I think we should be looking at similar kinds of things to make sure that that opportunity is available.

Dr. Resneck, how has the experience in telehealth services helped doctors and medical staff reach younger patients, particularly under-served populations?

And what opportunities do you see to broaden access that can benefit those populations?

*Dr. Resneck. Yes, I have seen this improvement at both ends of the spectrum. It is younger patients, as well. We have a lot of pediatric dermatologists on our team here, and you know, the issue is getting them into the office. Again, it doubles up. You have got them out of school, you have got a parent who has to potentially miss work. You have got transportation issues to get into the clinic. All those things are still true for kids, and sometimes -- and in some instances are actually multiplied for kids.

So the other thing is just in terms of social distancing with COVID. Sometimes in pediatric visits we have got a kid, family member, medical student, multiple people in the room. It makes social distancing even more difficult. So very important that those in-person visits still be available to kids, when they are appropriate, and very important to have that telehealth tool as an option, as well.

*Mr. Sarbanes. Thanks very much.

Dr. Mehrotra --

*Dr. Mahoney. I am sorry, Congressman Sarbanes, can I just add a comment about school-based --

*Mr. Sarbanes. Yes, sure.

*Dr. Mahoney. Okay, thank you. So, yes, I just wanted to, you know, just amplify that point, that school-based health centers have the potential to significantly improve telehealth access to children because it helps us overcome this broadband device issue, whereas some children would not be able to have access to telehealth, and in the school-based systems they would have access.

And so we have been working at Stanford with schools for one-off family needs. But it would be tremendously helpful to be able to expand that, of course, as a Medicaid issue. But I just wanted to add that comment. Thank you.

*Mr. Sarbanes. No, that is an extremely valuable perspective to offer.

I have got about a minute left. Dr. Mehrotra, maybe you could just -- and this may have been covered already, or talked about, but give us your thoughts on what telehealth is going to look like on the other side of the pandemic. Because, obviously, the radical change here and expansion of it in the midst of the pandemic, I think, is probably creating a new foundational level of the access to it post-pandemic. So can you just give us some quick thoughts on

that?

*Dr. Mehrotra. Yes. Well, I couldn't resist, but I will just make a very quick comment on the school-based health centers, that we also see that it allows teachers to get involved with things like attention deficit disorder. So it is really another value, a key person in a child's life.

But in terms of post-pandemic, one of the ideas that has come up, and I think maybe bears emphasizing in terms of where telehealth is going, is that we are seeing new models of care which really push our boundaries on what is a visit. And what I mean by that is such as these tele-endocrinology providers, where they have continuous glucose monitoring 24 hours a day, 7 days a week, and they are sending messages to patients several times a day, "Adjust your insulin. How are you doing on your diet?'' And I think these new models of care, which kind of come under remote patient monitoring, are where we are headed post the pandemic, but also really complicate how does the Medicare program or any other payer pay for a visit?

*Mr. Sarbanes. Thank you.

We have got our work cut out for us, Madam Chair. I yield back.

*Ms. Eshoo. The gentleman yields back.

Well, we don't have any other members at this point that are coming in to speak.

I just wanted to give the exact amount for broadband in the American Rescue Act. It is $7 billion, with a B. That is going to go a long way, because, regardless of what side of the aisle or what part of the country, members have spoken over and over and over again the need for broadband, because that is the platform that telehealth really rests on. If we don't have that, there isn't any telehealth.

I want to thank each one of the witnesses. You have been extraordinary. I think this is one of the best hearings we have ever had. And I think one of the reasons for that is that each one of you is superb. But you also spoke very directly to the American people. Whatever question members asked, you actually answered the questions. And that is so welcome. So for 4-and-a-half hours, you have met with and answered the questions of 36 Members of Congress. You saw firsthand that each and every member really cares very deeply about this issue, and that it is thoroughly bipartisan.

So that gives me great hope, together with each one of you being such a great source of, you know, of not only professional advice, but being such a great source of intellect for us. And we will continue drawing from you. I would like to see one bill, one bill that is comprehensive, and we will keep working with you so that the bill that we come up with really speaks to not only this moment in time, but that it is so durable that it will really speak to the

future beyond, God willing, this pandemic.

So I can't thank the witnesses enough. Dr. Mahoney, Dr. Mehrotra, Elizabeth Mitchell, Dr. Resneck, and Frederic Riccardi, you have just been outstanding.

Now I would like to make a unanimous consent request to enter into the record documents. And I want to ask my friend, the ranking member, Mr. Guthrie, if you would consent to my request that we place these in the record. There are 50. And if you would consent, then you don't have to listen to me reading 50 --

*Mr. Guthrie. You have my -- I consent. I consent --

*Ms. Eshoo. They are all important, but --

*Mr. Guthrie. You have my consent.

*Ms. Eshoo. -- thank you very much. Thank you.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. And so these will all be made part of the record. Any of the organizations or individuals who are listening in, thank you for submitting something for the record.

So with that, I thank the ranking member too. Four-and-a-half hours, it is a long time. But you know what? I think every minute was worth it. And I hope that you all feel that way, as well. If we can get this done and done well, we will have made a major contribution with your extraordinary help, and in our day and our time for the American people.

So with that, we will adjourn the subcommittee hearing for today, and everyone stay well. We need you. Thank you.

[Whereupon, at 2:56 p.m., the subcommittee was adjourned.]