Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"
March 2, 2021

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The Honorable Lisa Blunt Rochester (D-DE)

1. How can Congress best support state Medicaid programs in their efforts to expand telehealth? Are there supports, incentives and learnings that federal policymakers could provide?

   There is remarkable variability in how telehealth is treated by state law and in Medicaid program guidelines. The actual definition of telehealth, covered modalities (e.g., video, phone, asynchronous, remote patient monitoring), eligible providers and reimbursement rates are different in every state. For example, as of Fall 2020 only 18 states had official policies to provide reimbursement for store-and-forward, 21 state Medicaid programs provided reimbursement for remote patient monitoring (RPM), and 16 states limited the type of facility that can serve as an originating site[1]. This inconsistency creates a confusing environment for patients and providers who use telehealth, especially when those health care services are delivered across multiple states.

   Congress can incentivize state Medicaid agencies to evaluate their telehealth policies and encourage consistency across states, which begins with more Medicaid programs supporting broad coverage of video telehealth services, audio-only services at least until broadband is widely accessible, and asynchronous care like eConsults and remote patient monitoring. Federal policymakers can also take action to encourage cross-state licensure reciprocity for physicians and other qualified health care providers (HCPs), which would improve access to specialty care for Medicaid and other vulnerable populations residing in states where those providers are not readily available.

   Further, Congress should continue to examine the impacts of increased access to telehealth services to determine which policies should be made permanent after the COVID-19 pandemic. We support approaches like those in the Telehealth Improvement for Kids' Essential Services (TIKES) Act, which includes issuing guidance to assist state Medicaid programs in adopting, expanding and leveraging telehealth for their populations, and hearings to share lessons learned from state representatives and Medicaid agencies.

Payment and coverage alignment across payers is a recurring challenge for patients and providers who struggle to navigate the varying policies. We encourage Congress and HHS to seek alignment between Medicare telehealth services and Medicaid telehealth services wherever and whenever possible. Model legislation, a strong example set by Medicare, and incentives for states to evaluate and expand their telehealth policies are all levers that Congress can use to encourage state Medicaid telehealth expansion.

1. Source: Center for Connected Health Policy. https://www.cchpca.org/sites/default/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf

The Honorable Gus Bilirakis (R-FL)

1. Do you support retaining HHS authority to more robustly allow services delivered through telehealth after the COVID-19 public health emergency ends? Should that authority include waiving restrictions that exist outside the PHE on the types of providers who can furnish those services?

   Yes, we support the ability for HHS to regulate services as it allows the Agency to be responsive to expanding roles and services in telehealth. When coverage rules and provider types are limited by statute, they cannot keep pace with the real-world evolution of care, and result in antiquated restrictions that inhibit appropriate access for patients. Guardrails on the types of services rendered via telehealth are already regulated through the CMS Physician Fee Schedule (PFS), and do not require further restriction in statute such as limitations to specific specialties. CMS also already regulates which provider types are eligible to bill Medicare, and so this too does not require further restriction in statute specific to telehealth. The waivers of the antiquated 1834(m) restrictions have been critical to the pandemic response and modernization of the US healthcare system, and Congress will need to act to either strike these restrictions entirely and/or preserve HHS' ability to regulate once the PHE ends. Specifically, we support the provisions similar to those included in the bipartisan, bicameral Telehealth Modernization Act and Protecting Access to Post-COVID–19 Telehealth Act. The Telehealth Modernization Act permanently removes geographic and originating site restrictions which have been temporarily removed during the COVID-19 pandemic, and have dramatically increased access to care. The legislation would also give the HHS Secretary the ability to permanently expand the types of covered telehealth services in Medicare and the types of providers eligible to deliver those services. The Protecting Access to Post-COVID-19 Telehealth Act removes most geographic and originating site restrictions, and gives the HHS Secretary the ability to expand telehealth in Medicare during future public health emergencies.

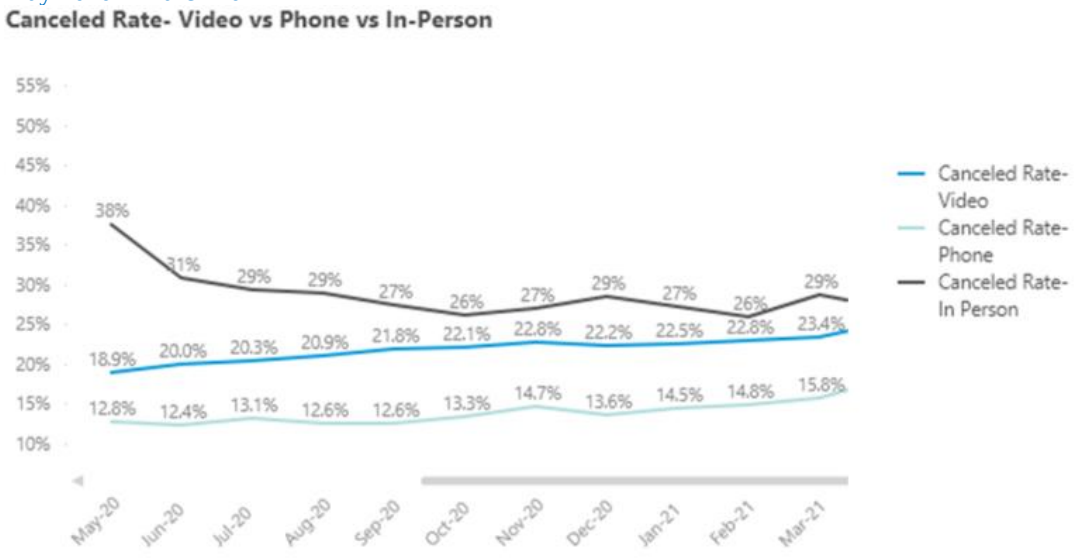
2. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated

suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020 – signifying an almost 20% increase year over year, with no indication that this trend is reversing.

a. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

Access to mental health services is a nationwide, systemic challenge that has been dramatically exacerbated by the pandemic. Telehealth shows incredible promise in improving the ability for patients to access mental health services when and where they need them. Consider the patient with severe depression, for whom even leaving the home and traveling to a clinic can be a tremendous barrier. While these patients often struggle to keep appointments due to their symptoms or stigma associated with the in-person clinic visit, providers across the nation are seeing meaningfully lower no-show and cancellation rates via telehealth[2].

Fig 1. Stanford Health Care Cancellation rates for in-person, video and telephone appointments May 2020 – March 2021



We support Congress' efforts to expand behavioral health access, but the Consolidated Appropriations Act requirement of an in-person visit 6 months before the first video visit is a major barrier to delivering these services. In fact, this was the first time an in-person requirement has been put in statute for any telehealth service. Patients can very successfully establish care with a provider via telehealth, and particularly for behavioral health and substance use, the requirement of an in-person appointment adds no clinical value and functionally limits access for those who are homebound, transient, lack access to services in their region, or face other challenges to accessing care. An effort should be made

to modify the language passed in the FY2021 appropriations bill to strike the in-person relationship requirement.

We also support the continued ability to initiate and manage Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) via telehealth. Our own clinical experience at Stanford, and recent evidence including a new report from AHRQ, show patients receiving MAT fare just as well via telehealth/hybrid models, as those who receive treatment entirely in-person[3].

Because not all patients have access to sufficient broadband for video services, we encourage CMS to cover audio-only telehealth services when and where necessary to bridge gaps in access to care. This would include, at a minimum, flexibility for areas with limited broadband service, for populations without telehealth-capable devices, or in necessary situations such as a future public health emergency. We recognize that this modality is an important tool to promote equitable access to care for vulnerable populations.

2. Source: National Committee for Quality Assurance (NCQA). https://www.ncqa.org/wp-content/uploads/2020/09/20200914_Taskforce_on_Telehealth_Policy_Final_Report.pdf
3. Source: Agency for Healthcare Research and Quality (AHRQ). https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/mat-retention-strategies-rapid-review-1.pdf

3. Should HHS consider expanding the types of audiology, speech-language pathology, physical therapy, and occupational therapy services that can be provided during the PHE if they are clinically appropriate and can be delivered with the same efficacy as in-person visits?

   Yes, we strongly support the permanent expansion of eligible providers for telehealth to include speech language pathologists (SLPs), physical therapists (PTs), occupational therapists (OTs), audiologists, and any other provider type that is approved to independently bill Medicare. However, HHS does not currently have the authority to extend these very appropriate services because the eligible provider types for telehealth are restricted in the antiquated statute of Section 1834(m) of the Social Security Act. The delivery of clinically appropriate services requires action on two gatekeeping factors: (1) the services must be covered under the PFS; and (2) Congress must either add, or grant HHS the authority to add, audiologists, SLPs, PTs and OTs to the list of approved telehealth providers.

   Clinicians should have the ability to provide the most clinically appropriate services to each patient, with the same standards and guardrails whether those services are rendered in-person or via telehealth. If a practitioner has the training and experience to provide a clinical service, they also have the training and clinical judgement to appropriately identify and provide that service via telehealth.

4. Do you believe Congress should consider allowing audiologists and members of the therapy professions to provide telehealth services under Medicare permanently when

clinically appropriate, especially since they are currently doing so during the public health emergency and patients appear satisfied to receive services in this manner?
Our experience at Stanford Health Care is that audiologists, speech language pathologists, physical therapists, occupational therapists, and other allied health professionals have successfully provided needed clinical care via telehealth during the pandemic. In fact, almost 30% of our speech language pathology practice continues to be virtual, even as our clinics have reopened to in-person care.

Provider shortages in the allied health professions are a barrier to patients nationwide – for example, over half of US counties do not have an audiologist in residence[4]. This dynamic exists across many allied health disciplines, which underscores the importance of telehealth as tool to reach patients who may otherwise be unable to access services. We would support any action by Congress that permanently expands the list of eligible telehealth provider types to provide clinically appropriate care to patients, and practice at the top of their training.

[4.] Source: Planey A. (2019). Audiologist availability and supply in the United States: A multi-scale spatial and political economic analysis. Social Science & Medicine, Vol (222), 216-224.

5. I think you would agree that the earlier the identification of deteriorating patient condition, the better the chance of a positive outcome, and that we need to find a way to harness the spread of disease, especially in vulnerable patient populations such as the elderly and those with chronic medical conditions.

    a. Chronic diseases place immense strain on the operation of our health system. Could you discuss how remote monitoring is used today, in addition to telehealth, to help in the care of those living with chronic conditions like diabetes, hypertension, asthma or kidney disease?
    Virtual chronic disease interventions are designed to improve clinical outcomes, increase care plan adherence, and prevent downstream costs to the Medicare program. For example, virtual diabetes prevention programs (DPP) can be remarkably effective for managing weight loss, reducing the prevalence of obesity and preventing the progression to prediabetes and type 2 diabetes. DPP services were temporarily approved during the pandemic, but a long-term pathway is needed for these programs to continue past the public health emergency.

    Other remote patient monitoring (RPM) programs are ideal for chronic conditions like hypertension, congestive heart failure, asthma, and chronic obstructive pulmonary disease that have been historically managed via singular interactions every few weeks-months, with little opportunity to check-in or adjust care plans between visits. RPM programs facilitate much more frequent touchpoints, which means flare-ups in a patient's condition, medication titration, and other needs can be addressed timelier, leading to better outcomes and improved care plan adherence.

b. Do you support the use of remote patient monitoring that enables the early identification of physiologic changes in patient conditions in time to prevent catastrophic injury or death?
Devices such as implantable heart monitors have been used for years to remotely monitor changes in patient status and alert care teams when a patient is at risk. Through the pandemic, home monitoring was expanded to support more acute issues such as COVID-19 symptom monitoring and oxygen levels which allowed more patients to recover at home. When deployed appropriately, these can be effective tools to aid teams in early identification of rising risk and acute patient care needs.

c. Would you agree that the recent use of remote patient monitoring tools that have helped clinicians, nursing homes and hospitals respond to COVID-19 should be continued with appropriate Medicare coverage and reimbursement even when this current crisis is over?
Yes, remote patient monitoring services have been effective during the pandemic and show great promise as a high-touch approach to managing chronic diseases. For example, gathering patient data outside of the traditional clinical setting can provide a more complete picture of a patient's care needs – and enable the patient to address changes in their health status before progressing to the point of requiring an emergency department visit or hospitalization.

We support CMS' coverage of RPM codes, and their recent clarification that the intraservice time of these codes includes both face-to-face and non-face-to-face time spent in communication with, and care management of, the patient. Importantly, remote patient monitoring programs are almost always deployed by an interdisciplinary care team, so it is critical that multiple provider types such as RNs, care managers, clinical social workers, and other allied health professionals be eligible to contribute to the service time required to qualify for the RPM billing codes. This ensures providers and staff are engaged at the appropriate level, and able to develop scalable care models that meet the needs of entire populations.

d. Do you agree that by bringing the healthcare to the patient at home will increase access to affordable and quality healthcare for vulnerable patients and those in rural areas?
The US healthcare system has been experiencing a shift from centralized, hospital-based care to decentralized ambulatory networks with surgery centers, multi-specialty practices and other services. The natural evolution of decentralized care will be distributed care that meets patients where they are, and brings more care into the home. Successful care models can range from fully digitally enabled services between a patient and a distant provider, to hybrid models where an in-home provider is supported by a distant, facility-based specialist. It is important to note, however, that virtual care requires reliable internet access, a smartphone or computer, digital literacy, and insurance

coverage of services, which need to be considered to prevent exacerbating existing health disparities.

We believe that the expansion of telehealth and other at-home services will improve affordability for patients not just through health system cost savings, but by reducing unnecessary travel, time away from work, childcare, and other expenses associated with a bricks-and-mortar clinic visit[5]. These savings will be particularly impactful in rural and underserved areas, where the barriers and distances to travel for care are more pronounced.

[5.] Source: https://www.valueinhealthjournal.com/article/S1098-3015(17)30083-9/fulltext