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"
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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?*

Response: I believe the Congress can most effectively support state Medicaid programs by defining Medicare payment policy and regulations. Given Medicare's size and importance in the health care system, changes implemented in Medicare often are quickly echoed by both commercial insurers and Medicaid programs. One area that is particularly important is licensure. How can the Congress make it easier for providers in one state to provide care to patients in another state? I have argued that the Congress should require automatic licensure reciprocity across states for patients in the Medicare program.

The Honorable Gus Bilirakis (R-FL)

1. *During the COVID-19 pandemic, CMS has made very clear its support for remote patient monitoring and has urged commercial payers to do the same.*

    a. *Beyond the question of 'should coverage and reimbursement be made permanent' what additional questions should this committee consider?*

Response: Remote patient monitoring (RPM) has great potential to improve the care that Americans, in particular those with chronic illness, receive. The hope is that more frequent short interactions facilitated by RPM will help patients improve the control of their disease. For example, physicians monitoring patients with diabetes might make more frequent adjustments in insulin doses to obtain better blood sugar control. Also, RPM may identify patients whose illness may be worsening and provide an opportunity for clinicians to intervene early and prevent a hospitalization or catastrophic injury. For example, RPM might help identify patients with heart failure who are gaining excessive weight and are at risk of being hospitalized. By identifying these patients early, physicians can adjust their medications and deter that hospitalization.

Unfortunately, I believe the evidence to date to support that RPM meets these goals is not always robust. This is possibly best illustrated with heart failure. A recent review of published studies on the effectiveness of RPM by the Heart Failure Society of America[1] noted that while many small early RPM studies of external monitoring (e.g. checking weights daily, reporting of symptoms) showed benefit, five large rigorous randomized control trials did not. Similarly, there has been mixed evidence on heart failure RPM where a device is implanted in the patient. Therefore, it remains unclear which patients would benefit from RPM, how RPM should be implemented, and what data is best to collect.

These results reinforce several points from my testimony:

1. We should not treat RPM as a monolithic idea. Any benefit will depend on the patient and the type of RPM program implemented. For example, a monitoring program that uses an implanted right ventricular pressure monitor may be more successful than a monitoring program that uses data from a cardiac implantable defibrillator.
2. Reimbursement should be limited to those RPM programs that have proven clinical benefit and therefore improve value.

Therefore, I do not believe the current approach taken by Medicare and other payers to pay for RPM is the right one. Medicare does not distinguish between different RPM programs, what data is collected, or which patients are treated. The current reimbursement structure instead focuses on issues such as on how many days a month the data is collected or the number of minutes of clinician interpretation. This creates a substantial amount of administrative burden for clinicians in both submitting bills and documentation. Also, it is unclear the RPM programs being reimbursed are effective.

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?*

[1] Dickinson, Michael G., et al. "Remote monitoring of patients with heart failure: a white paper from the Heart Failure Society of America Scientific Statements Committee." *Journal of cardiac failure* 24.10 (2018): 682-694.

Response: The need for mental health care was increasing in the United States prior to the pandemic and this trend appears to have accelerated during the pandemic. In response, behavioral health providers have embraced telehealth to a much greater degree than other specialties. In data from December of 2020, we find that the *majority* of visits were provided via telehealth. In other words, telehealth for the treatment of mental illness in patient's home is now the norm. Similarly, we see that providers who treat opioid use disorder have also embraced telehealth. Many have started initiating patients on medications such as buprenorphine via telehealth.

There are three issues that the Congress may consider if they would like to further encourage telehealth use in these two areas. The 2008 Ryan Haight Online Pharmacy Consumer Protection Act requires clinicians conduct an in-person visit before prescribing medications such as buprenorphine. The requirement of an in-person visit can lead to delays in initiating care and may be particularly problematic for rural residents for whom travel distances to care may be long or individuals with unreliable transportation, childcare issues, or other barriers. The SUPPORT for Patients and Communities Act called for the creation of a pathway by October 2019 for clinicians to register with the Drug Enforcement Agency (DEA) to provide telehealth services and allow registered providers to bypass the in-person requirement when prescribing medications like buprenorphine. However, this pathway still has not been implemented. It remains unclear why the DEA has not fully implemented this pathway. Given how frequently telehealth is being used for initiation of treatment already, is a special DEA pathway even necessary?

Second, the Congress might address licensure barriers. Many clinicians work on the border of states and naturally care for patients from several states. Current licensure laws make it difficult for them to care for all their patients. As I noted in my testimony, this has created situations that buck common sense. I have heard stories of patients driving several miles to cross a state border to attend a telehealth visit from their car. These patients couldn't virtually attend the same appointment from home because their physician wasn't licensed in their state of residence. Reforms that encourage state reciprocity would go a long way to address this barrier.

Third, Congress recently expanded access to telemental health for all Medicare beneficiaries in their homes. However, clinicians were required to have an in-person visit every 6 months with the patient. It may be helpful to give Medicare flexibility to waive this in-person requirement if it hampers access to care. For example, it may be reasonable for this requirement to be waived for long-term residents of nursing homes.

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?*

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?

Response: It is common for patients to not complete their recommended course of treatment with audiology and therapy providers. Many factors play a role in not completing therapy, but a major one is the cost and time required to get to the appointment. Making care easier to access through telehealth will certainly increase their uses. For those who prematurely dropped out of care this will improve their health. However, it will also likely increase utilization of care that is of lower-value. In other words, patients will receive care that does not improve health. One potential way to encourage high-value applications is to increase the use of bundled payments for audiology and therapy care.

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?*
    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?*
    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?*
    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?*

Response: I fully support the idea of remote patient monitoring that identifies physiologic changes in time to prevent catastrophic injury or death. Such systems have enormous potential to improve the health of Americans. As I noted above, unfortunately there is not robust evidence that current systems effectively do so.

As I noted in my testimony, there are several strategies to target telehealth expansion to high-value uses. One strategy is to target populations where access to care is often difficult including vulnerable patients and those in rural areas. Another option is to target specific conditions. Congress has already expanded telehealth for acute strokes, substance use disorders, and mental health conditions. Following the lead of Maryland and Massachusetts, the Congress could also expand telehealth for a trial period for select chronic conditions.

The Honorable Richard Hudson (R-NC)

1. *Dr. Mehrotra**,** it is my understanding that research has shown that telehealth has benefits for patients. For example, telehealth may increase access to mental health providers, improve outcomes in integrated care settings, and be at least as effective as an in-person visit for some psychiatric services. Given what we have seen about the increase in the need for mental health services during the pandemic, what do you recommend to build on what we've learned about from this experience?*

Response: As detailed above, I believe the Congress could support greater use of telehealth for treatment of mental illness by addressing the requirement for an in-person visit every six months and licensure laws.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. *Should Congress be evaluating all-payer claims data when considering reimbursement for in-home remote patient monitoring to identify gaps in coverage? Right now, some states cover it through Medicaid and commercial payment policies vary widely.*

    a. *What is the biggest obstacle to adopting remote patient monitoring right now?*

Response: I believe the major obstacle for providers is the complexity of the Medicare billing requirements for remote patient monitoring. As I described above, I worry that the current strategy taken by Medicare has created unnecessary administrative burden and not targeted high-value applications.