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

Ms. Elizabeth Mitchell, President and CEO, Purchaser Business Group on Health

The Honorable Michael C. Burgess, M.D. (R-TX)

1. Ms. Blunt Rochester and I just reintroduced the TIKES Act. This bill requires the Centers for Medicare and Medicaid Services to issue guidance and best practices to states on the use of telehealth in Medicaid. It also includes a MACPAC report to assess gaps in access to telehealth.

    a. Has COVID-19 led any states to be particularly innovative in utilizing telehealth in their Medicaid programs that might inform these best practices?
    b. Has COVID-19 exposed any gaps in access to telehealth for Medicaid or other populations?

I appreciate the question from Dr. Burgess. As I noted in my oral and written testimony, there is too little reliable information regarding the clinical effectiveness, quality, patient experience, and cost of telehealth. PBGH supports efforts to build on the available literature, particularly for under-studied populations, including children. Unfortunately, our research in telehealth has not focused on Medicaid populations or children, so I am unable to directly answer Dr. Burgess' questions.

The Honorable Gus Bilirakis (R-FL)

1. What conclusions have private payers that have expanded telehealth drawn from their experiences over the past year regarding utilization of services, patient satisfaction, and program integrity?

Thank you for the question. For 20 years, PBGH has led the largest statewide patient experience program, collecting data from over 40,000 patients each year and producing performance ratings for roughly 180 provider organizations in California. Included in our research are questions regarding patient experience with telehealth. Among the high-level results:

- ***Patients are roughly equally satisfied with virtual and in-person care***

- ***Overall, telehealth is popular: 87 percent of respondents say they recommend telehealth, and 73 percent want to continue using telehealth in the future***
- ***Video visits are favored over audio-only by most patients***
- ***The audio-visual / audio experience does not appear to negatively impact provider communication, which is rated highly among patients***

Despite these promising findings, PBGH research has been, to date, limited to commercial populations in the State of California. Further research on patient experience and clinical outcomes should be conducted nationwide with more diverse populations, including Medicaid beneficiaries, racial and ethnic minorities, and those with limited English proficiency. PBGH will have preliminary results from a survey with a sample of patients with Medi-Cal coverage in Spring 2021 and seeks to expand this measurement nationwide.

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?

These issues have not been a focus of PBGH's research into telehealth. However, the academic literate is clear: Telehealth can be very effective when used to address mental health issues and substance use disorder. Further, audio-only services can be effective at expanding access to care, particularly for people in areas with limited broadband services, but there needs to be more research on its differential effectiveness compared to audio-visual services.

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?

I appreciate the question. Unfortunately, PBGH has not done direct research on these subjects so is unable to directly answer the Congressman's question.

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?

   I cannot speak to specific issues around telehealth use audiologists and other therapy professions, and our expertise is focused on the use of telehealth by private employers, rather than Medicare beneficiaries. But we do support efforts by policymakers to ensure continuity of care for beneficiaries who have received telehealth during the pandemic, when clinically appropriate and cost effective. While a temporary extension of flexibilities may be necessary to ensure continuity of care, we recommend policymakers invest in further research on clinical and cost-effectiveness, and patient experience before deciding to make flexibilities permanent.

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?

   I appreciate Congressman Bilirakis' questions. Unfortunately, PBGH does not have direct expertise in remote patient monitoring to provide insight as to whether it is clinically or cost effective.

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

1. Remote patient monitoring can help with the issues of "no-shows," or missed appointments, which can be problematic and ultimately costly for chronic disease patients. It also has shown to reduce "frequent flyer" ER visits. Remote monitoring can

allow for *almost* office-style care without exposure to communicable diseases. These are all savings in my book. Clearly there are decrements in physical examination and testing remotely, but technology continues to improve. Is there data to help us determine the degree to which remote patient monitoring can generate savings?

a. How should we be thinking about accounting for costs and savings in regard to remote patient monitoring?

I appreciate Dr. Dunn's question. Unfortunately, PBGH does not have direct expertise in remote patient monitoring to provide insight as to whether it is clinically or cost effective.

2. Some payers are exploring remote monitoring to incentivize health habits. How can payers build trust with patients who may be wary of continuously sharing their data with payers?

a. Please share your thoughts regarding the privacy considerations we will face to ensure patient data is safe when using remote patient monitoring technology.

While academic evidence demonstrates the potential effectiveness of remote patient monitoring to anticipate signs of patient illness, relevant laws and regulations pose challenges for employers who might choose to use remote patient monitoring to provide incentives for healthy habits.

Specifically, the Americans with Disabilities Act (ADA), the Family and Medical Leave Act (FMLA), Fair Credit Reporting Act (FCRA), the Health Insurance Portability and Accountability Act (HIPAA), and many state laws all have strict requirements limiting the ability of employers to collect, use, and disseminate health data of their employees. To date, PBGH has not advocated to changes to these statutory requirements to enable remote patient monitoring of employees or their families.