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

Mr. Frederic Riccardi, President, Medicare Rights Center

The Honorable Gus Bilirakis (R-FL)

1. Currently, CMS requires that all Medicare patients be monitored for at least 16 out of 30 days as a condition of payment, except for COVID patients during the PHE.

    a. As an aspect of telehealth, do you believe that device-driven remote patient monitoring in the home, as CMS now describes and reimburses for it, is too strict in terms of the required time of monitoring and limits use cases or provider discretion and should be more flexible; and, if so, what guardrails, if any, should remain for care quality and program integrity?

Strict requirements, thresholds, and limits can curtail beneficiary access. Yet, absent or ineffective guardrails can lead to ineffective service delivery and abuses of the system. We urge CMS to collect, analyze, and publicly report data on the existing program to determine whether beneficiary needs are being met, and to inform what improvements may be needed. Determinations about what standards should be in place to best ensure quality of care must be a clinical one, made by CMS in consultation with experts in the field.

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?

In our experience, access to telehealth, especially audio-only services, has helped people with Medicare obtain mental health and substance use disorder treatment during the pandemic. We have heard from beneficiaries for whom audio-only services have been a lifeline, connecting them with care they could not have otherwise accessed, often due to lack of technology or reliable broadband. We have heard from others who prefer audio-only because they feel safer, less exposed, and more comfortable receiving treatment over the phone. While it critical to meet people where they are, technologically and psychologically, we must also do more to erase the stigma around mental health and substance use disorders so that more beneficiaries seek and receive needed care.

At the same time, as we note in our written testimony, audio-only services are not without risks. Audio-only telehealth may be of lower quality and lead to unnecessary care;[1] fraud is also a concern.[2] It could also be used as an excuse to avoid addressing underlying structural problems. Specifically, older adults and people with disabilities, in particular those in underserved communities, can disproportionately lack the technology or strong internet signals needed for useful video communications.[3] Expanding access to audio-only telehealth could improve their access to remote visits, but it could also create a tiered system.

Policymakers must fully investigate and thoughtfully balance the potential gains of changes to Medicare telehealth rules with the potential harms. Decisions about what kind of care can be delivered safely and effectively using different modalities should rely on clinical determinations and outcomes and be subject to rigorous and ongoing oversight and data collection. Any eventual expansions must put guardrails in place to protect beneficiaries and advance health equity. We also recommend pursuing complementary changes to close the digital divide, reduce the systemic causes of those disparities, and minimize their harms.

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?

Beneficiary needs must take precedence, during the pandemic and beyond. When services are clinically appropriate and found to have the same efficacy and safety when delivered through remote means as in person, we urge CMS to consider expanding allowable telehealth services to encompass that care. These decisions should be made following the

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[1] Lori Uscher-Pines, *et al*., "Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic" JAMA (February 2, 2021), https://jamanetwork.com/journals/jama/fullarticle/2776166.

[2] The U.S. Department of Health and Human Services Office of Inspector General, "2020 National Health Care Fraud Takedown" (last accessed April 14, 2021), https://oig.hhs.gov/documents/root/230/2020HealthCareTakedown_FactSheet_9dtIhW4.pdf.

[3] Yohualli Balderas-Medina Anaya, *et al*., "Telehealth & COVID-19: Policy Considerations to Improve Access to Care" (May 2020), https://latino.ucla.edu/wp-content/uploads/2020/05/Telehealth-COVID-19-Report.pdf.

data, in a way that ensures ongoing assessments of beneficiary satisfaction and health outcomes, allows for revision based on such information, and using reimbursement levels that allow access to telehealth without supplanting or deterring the availability of in-person care.

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?

Such decisions should be a matter of clinical appropriateness, health outcomes, and beneficiary satisfaction. We urge Congress to work with CMS to find ways to be both rigorous and nimble regarding what services and providers are allowable, always in a way that centers beneficiary needs and preferences.

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?

Remote tools like continuous glucose monitors and home blood pressure monitors can give providers critical, additional information about a Medicare beneficiary's condition, supplementing the data that is obtainable through in-person visits and tests. Such monitors can help pinpoint trends, causes, and dangerous changes in one's condition, information that providers can use to create treatment plans that better meet beneficiary needs. At the same time, we recognize that this level of care may not be appropriate for all patients. For example, some stable diabetics and people with well-controlled hypertension may not need such intensive monitoring.[4] Not only is there a balance when it comes to necessary versus unnecessary care, there is also a balance between safety and invasion of beneficiary privacy. As with all remote care, we urge a thoughtful exploration of beneficiary needs, outcomes, and preferences, reliance on clinical appropriateness, and a rigorous attention and deference to the data.

    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?

[4] Laura A. Young, *et al*., "Glucose Self-monitoring in Non–Insulin-Treated Patients With Type 2 Diabetes in Primary Care Settings: A Randomized Trial" JAMA (July 2017), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2630691.

In general, we support the use of remote patient monitoring when such care is clinically appropriate and serves the interests of beneficiaries. While in some situations, such tools may be both wanted and needed, in others they may be unwelcome and/or unnecessary.[5] We urge Congress and CMS to follow the data and ensure beneficiaries have access to clinically appropriate care, while not being burdened with unnecessary requirements and expense.

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?

As stated above, we support the use of tools that are clinically appropriate for the given beneficiary. Such coverage decisions must be based on outcomes and beneficiary needs.

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?

All beneficiaries—rural, suburban, and urban—may struggle to obtain affordable, high quality, in-person care. They may have compromised immune systems or chronic conditions that put them at heightened risk when exposed to public environments; caregivers who are work full-time, for whom attending in-person visits can be a challenge; or they may be unable to leave their homes for other reasons, such as physical frailty or a lack of affordable, reliable transportation.

We agree it is important that these beneficiaries are able to get the care they need, including via telehealth. Prior to the pandemic, Medicare's originating site and geographic requirements often made this impossible. We frequently heard from beneficiaries across the country who were unable to access needed telehealth services because of these rules. Meaningfully improving access to telehealth will require eliminating these limitations and addressing other long-standing problems, like the digital divide and its structural causes.

We again urge that any changes center beneficiary needs and preferences and recognize the value of in-person care. Some conditions require office visits, and some beneficiaries prefer them. In-home care can be an important tool, but we must always be alert to inequity and barriers that can be inadvertently built into such a system or appear later, due to inadequate implementation or oversight.

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[5] *Id.*