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LEGISLATIVE PROPOSALS TO SUPPORT

PATIENT ACCESS TO TELEHEALTH SERVICES

WEDNESDAY, APRIL 10, 2024

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:04 a.m. in Room 2123 of the Rayburn House Office Building, Hon. Brett Guthrie [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Bucshon, Hudson, Carter, Dunn, Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz,

Dingell, Kuster, Kelly, Barragan, Schrier, Trahan, and Pallone (ex officio).

Also present: Representatives Balderson and Pfluger.

Staff Present: Kate Roberts, Digital Director; Jolie Brochin, Junior Professional Stafff, Health; Grace Graham, Chief Counsel, Health; Sydney Greene, Director of Operations; Calvin Huggins, Staff Assistant; Tara Hupman, Chief Counsel; Alex Khlopin, Staff Assistant; Emily King, Member Services Director; Chris Krepich, Press Secretary; Carla Rafael, Senior Staff Assistant; Emma Schultheis, Clerk; Jay Gulshen, Senior Professional Staff; Caitlin Wilson, Counsel; Lydia Abma, Minority Policy Analyst; Keegan Cardman, Minority Staff Assistant; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Saha Khaterzai, Minority Professional Staff Member; Mackenzie Kuhl, Minority Digital Manager; Una Lee, Minority Chief Health Counsel; Katarina Morgan, Minority Health Fellow; and Andrew Souvall, Minority Director of Communications, Outreach, and Member Services.

*Mr. Guthrie. The Subcommittee will come to order.

The chair recognizes himself for five minutes for an opening statement.

Thanks for all of our witnesses for being here today, and today we are here to examine long-term solutions to ensure individuals maintain access to affordable and high-quality telemedicine services that so many Americans have been able to rely upon for the past four years.

It has been widely reported how popular telehealth has become for Medicare beneficiaries throughout the COVID-19 pandemic, with over 28 million seniors utilizing telehealth care in just the first year of the pandemic. Virtually overnight our health care system underwent a significant transition. Soon after the first case of COVID-19 was detected within our borders, Congress and the Centers for Medicare and Medicaid Services acted to remove barriers that had previously prevented many seniors from utilizing telehealth. Seniors were allowed to use telehealth across the country, and can now access their health care providers from the comfort of their home.

Additionally, the number of health care services

Medicare would cover it performed throughout _ through telehealth increased from 118 to 260 services. Restrictions such as requiring seniors to have an established, pre-existing relationship with a health care provider to receive mental health services through telehealth were waived, allowing patients to consult with a provider through a simple audio-only phone call if an audio visual connection wasn't available. These flexibilities proved to be particularly impactful for those living in rural communities that so many of us have the privilege to represent.

Thankfully, Congress, under the leadership of those on this committee, again took action to extend these valuable telehealth flexibilities beyond the pandemic through December 31 of this year, which is one reason we are here today. The looming deadline gives us a chance to examine long-term telehealth solutions that can drive innovation in health care through greater delivery.

I believe telehealth can expand access to both primary care and other specialty providers, improve the health and well-being of patients, and eventually drive significant cost savings across our health care system. I am hopeful that the

testimony today can answer outstanding questions and provide an update on where telehealth continues to be beneficial to patients in the post-COVID-19 era.

The legislation we are discussing today looks at many facets of telehealth, from the now-traditional issues such as originating site requirements to improving our past investments in behavioral health and new opportunities such as making it easier for those with language barriers to see a telehealth care provider, and addressing challenges around physician licensure.

A number of the bills make permanent a variety of COVID-era policies, most notably permanently waiving originating site requirements, as well as the policies to expand the list of providers eligible to treat patients via telehealth. I want to thank Representative Carter for leading one of these bills, H.R. 7623, the Telehealth Modernization Act. I also have to thank the newest member of the Energy and Commerce Committee, Representative John James, who is leading important legislation, H.R. 7858, Telehealth Enhancement for Mental Health Act. This bill will help us improve Medicare's delivery of critical tele-behavioral health care services,

which played a significant role throughout the pandemic to help seniors cope with social isolation and substance use disorder.

There are often two issues raised with telehealth. First there have been concerns about increasing waste, fraud, and abuse. On that issue it appears that telehealth can be used to deliver care without actually raising those serious concerns. According to the Office of Inspector General, of the over 700,000 providers they studied who provided telehealth care during the pandemic, less than 2,000 warranted further scrutiny resulting from their telehealth billing practices, and mostly because they charge facility fees for the actual telehealth visit.

On cost I want to remind my colleagues that the previous extension was estimated by CBO to increase cost of Medicare by over $2 billion. Making these authorities permanent is likely to cost more than a short-term extension, and we want to make sure that whatever we move out of the committee is paid for and is delivering the best value for seniors.

Starting today I think this committee can work together to move legislation making sure seniors have access to

telehealth when they want it, while also including appropriate program integrity measures addressing the cost of such access to the Medicare program.

[The prepared statement of Mr. Guthrie follows:]

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

*Mr. Guthrie. Thank you, and I will yield back, and will yield five minute _ or will recognize the ranking member of the full committee, Ms. _ ranking member of the subcommittee, Ms. Eshoo, for five minutes for her opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman, and good morning, colleagues, and good morning to the witnesses. Thank you for being here. We are all looking forward to hearing from you.

Today our subcommittee is considering 15 bills to expand access to telehealth, and the majority of them are bipartisan. So that is good news to everyone here in the hearing room.

Telehealth is, I think, one of the few bright spots that emerged from the pandemic. During the public health emergency, HHS waived many outdated rules and payment policies surrounding telehealth coverage in traditional Medicare, and these changes really ensured the continuity of care for patients who, obviously, like the rest of us, needed to stay home and out of crowded care settings like doctor's offices or hospitals.

The year before the pandemic, 2 million of the 66

million total of Medicare beneficiaries used telehealth services. I know I represent the Stanford Medical Center in Palo Alto, California. And previous to the pandemic there was a single-digit usage of telehealth with many suspicions about it which really prevented people from moving forward and using it. When they did, it zoomed up to 90-some percent approval. So that _ those numbers really speak for themselves. So from March 2020 to February 2021 the HHS Office of the Inspector General found the number of beneficiaries using telehealth skyrocketed to 40 percent of all Medicare patients. So it reflects what I said, what we experienced right in my own congressional district.

Importantly, telehealth served as a lifeline to beneficiaries, as I said, that were isolated from their families, especially those that were in need of mental health services. By the end of 2020, virtual visits with mental health providers were as common as in-person visits.

Telehealth has been, I think, a godsend to the disabled community, as well, and we need to make sure that that is protected, because they obviously use services on a more frequent basis. The whole notion of having to travel, to get

_ to park, to get in, all of that is especially burdensome to that community. So I think the changes that HHS made set _ they set a standard for the private insurance companies who increase their telehealth offerings for millions of Americans.

So this issue of telehealth remains, I think in all of our view, this is not a partisan issue. It remains a very important tool in _ across health care, for all the obvious reasons and what the chairman of the committee expressed. There is an urgent need to extend these flexibilities because it is going to run out, and we need to be _ take action on this.

So there is more that I can say about it. We are all for it. We know that what HHS did during the pandemic _ they cleared many weeds away. It worked well, but I don't want to see inside the health care industry _ and it is not called industry for nothing _ the gaming of telehealth.

So I am going to look to you to give us advice about how best to structure it as we move forward to meet the needs of so many Americans that already have had a good experience with it, and we want to continue it. We want to make sure

that those that would game it won't be able to because there is _ costs, money associated with this.

[The prepared statement of Ms. Eshoo follows:]

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

*Ms. Eshoo. So thank you, Mr. Chairman, for holding this hearing. I want to thank those members of the committee that have offered legislation, and I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back, and the chair recognizes the chair of the full committee, Chair Rodgers, for five minutes for her opening statement.

*The Chair. Over the last several years telehealth has proven itself to be a vital way for patients to access care, especially for rural communities.

One of the lessons we have learned from the pandemic is that telehealth should continue to be a part of modernizing the health care ecosystem across the country. That is why we are here today, working across the aisle to ensure this option for care remains available across the country moving forward.

I grew up in a small town of Kettle Falls, Washington, and I have lived through some of the challenges that people face in rural communities when it comes to accessing health care. I frequently visit hospitals and health care facilities all throughout my district in eastern Washington, many rural areas. These issues matter, which is why I am

proud to say our conversations about expanding telehealth to address barriers to care, like transportation or doctor shortages, are no longer just aspirational goals. It is happening today.

In response to COVID-19, Providence Health System, which has 4 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. And they didn't stop there. Providence Health System and physicians across Washington State have continued to innovate with telehealth technologies to reach more patients, save lives, and improve care. Using telehealth, Providence physicians have been able to diagnose appendicitis in a young patient, work with a pregnant woman to help find her baby's fetal heartbeat, and provide for patients with mental health conditions. I am glad Providence is here today to talk about how their providers have continued to use technology to help patients.

At the end of last Congress we worked together to make a bipartisan investment to continue the telehealth flexibilities patients benefitted from during the pandemic.

But those flexibilities are now set to expire at the end of the year. We want to make sure patients remain in control of their doctor visit decisions, and is a _ and it is the patient deciding whether or not to utilize telehealth services.

Today we will discuss legislation to do just that, such as Representative Carter's Telehealth Modernization Act. While we recognize continuing telehealth flexibilities for patients will require significant investment, we can't afford to go backwards and use _ lose the progress we have made in expanding access to care.

Additionally, we will hear new ideas on where we should go from here, beyond telehealth policies established coming out of the pandemic. These bills, such as the Telehealth Enhancement for Mental Health Act, led by our committee's newest member, Representative James, offer us opportunities to further improve how we are using telehealth to help patients.

I will close by noting that I am optimistic about telehealth and its ability to improve the health and wellness of Americans, especially those in rural communities across

the country. It is bringing doctors right into the families' living rooms, making it easier for patients to get the health care that they need. And it is a great example of how innovation can improve and save people's lives.

We must maintain our commitment to our nation's seniors to provide a top-notch level of care in a way that does not increase their Medicare cost, and makes sure Medicare is sustainable for the future. This hearing today is a first step towards that process for telehealth, and another important part of this committee's mission to make the health care system work better for patients.

America can and should lead the way on the best use of telehealth for the benefit of every patient.

[The prepared statement of The Chair follows:]

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

*The Chair. Thank you, and I yield back.

*Mr. Guthrie. The chair yields back, and the chair will now recognize the ranking member of the full committee, Mr. Pallone, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman. I wanted to start by saying a few words about Representative Kuster. I am not happy that she is retiring, but that doesn't lessen my admiration for her.

For the last decade here in the House, Annie has fought for the people of New Hampshire. And when it comes to health care, she founded and has co-chaired the bipartisan Addiction and Mental Health Task Force, working for bipartisan solutions to address the substance use crisis that has been particularly devastating in her home state. She is always looking for bipartisan solutions, something that has also served her well as the chair of the New Democrats Coalition.

And Annie has been an outstanding member of this committee, and she is going to be missed. Now, I know she is not leaving yet, but I am still already dreading the fact that she is not going to be here, and I _ obviously, we are going to work with her for the rest of the year, and I wish

her the best in the future because I can't convince her to stay anymore.

*The Chair. If the gentleman would yield _

*Mr. Pallone. Yes.

*The Chair. _ I will be very brief. I just want to second your comments. Annie Kuster has been a great, hard-working member of this committee.

And I, as the chair, just have appreciated the opportunity to work with you on a number of issues, bipartisan, substance abuse, mental health. I would also want to add hydropower and _ but, Annie, I just appreciate your leadership on the committee, your friendship, and just the great way that you have represented the people of New Hampshire. We are going to _ this committee is going to miss you.

I yield back.

*Ms. Kuster. Thank you so much. If the gentlewoman and the gentleman would yield, thank you so much to the chair and vice chair. It has been a tremendous honor _ Frank knows, the honor of my lifetime _ to get to Energy and Commerce, and to work on all the incredible health care issues, including

telehealth. It is really important in my district. And addiction, mental health, and clean energy, including hydro. So it has been a wonderful experience.

I have got eight more months to drive it to the end and get these bills over the line and signed into law. Thank you so much. I am grateful.

*The Chair. Yes.

*Mr. Pallone. All right. Well, back to the hearing. Today's legislative hearing builds on the committee's critical bipartisan work to expand telehealth services and access to care for Medicare beneficiaries. Telehealth has many tangible benefits, and research has shown that telehealth has clinical benefits for patients.

I can also provide _ well, it can also provide critical services to hard-to-reach populations and help underserved communities access health care providers.

And we have a long history of leading the way in this committee to expand access to telehealth services in the Medicare program. The Bipartisan Budget Act of 2018 expanded access to telestroke services, and provided additional flexibility for accountable care organizations to expand use

of telehealth. The SUPPORT Act expanded access to substance use disorder services delivered through telehealth, and the Consolidated Appropriations Act of 2021 permanently expanded access to tele-mental health services.

Now, during the COVID-19 public health emergency this committee led efforts to significantly expand access to telehealth. We moved quickly to waive statutory requirements with respect to telehealth services under Medicare for the duration of the COVID-19 public emergency, and this was critical, since seniors were some of the most vulnerable to COVID-19.

We also expanded the scope and duration of the Medicare telehealth flexibilities in the Consolidated Appropriations Act of 2023, and extended many telehealth flexibilities through the end of this year.

Expanding access to telehealth services during the COVID-19 public health emergency helped save lives and preserved access to necessary care for millions of seniors. The expansion of telehealth flexibilities has allowed Medicare beneficiaries nationwide to continue to receive telehealth services, including audio-only services, without

ever leaving their homes.

And these expansions have resulted in millions of seniors accessing care. The Medicare Payment Advisory Commission, or MedPAC, has found that telehealth utilization and spending in Medicare has increased substantially, and the use of telehealth services among Medicare beneficiaries has also continued to remain high and far above pre-pandemic levels.

But I believe that any further expansion of telehealth flexibilities in Medicare must meaningfully increase patient access to care and ensure high-quality care for seniors. So as Congress considers further expansions of the telehealth flexibilities in Medicare, we must continue to assess and monitor the quality of these services, including audio-only services, to ensure that Medicare beneficiaries are accessing high-value, high-quality care.

It is also vital that CMS has the tools and data necessary to monitor the quality of telehealth services that beneficiaries are receiving. So I am interested in hearing from the witnesses today on how telehealth policies can encourage the use of high-value care, while at the same time

discouraging potential low-value care in the Medicare program.

And while there are significant benefits to telehealth, Congress must ensure that additional expansions of telehealth policies do not limit access to in-person care. It is important that we preserve patient choice, and that Medicare beneficiaries continue to have access to high-quality, in-person care and robust consumer protections, including network adequacy standards. For example, telehealth should not be used to undermine network adequacy standards in the Medicare Advantage program.

In providing increased access to telehealth, we also need to ensure that we are not further fragmenting care, and that telehealth is being used in a way that facilitates coordination. And Congress also needs to continue to monitor any program integrity risks associated with telehealth billing, such as those identified by the HHS Office of Inspector General.

So finally, I understand that some of these legislative proposals are likely to have major scoring implications, and we still need the Congressional Budget Office's feedback on

their costs. I would like to better understand the offsets for these proposals, and want to ensure it would not result in significant funding cuts to the Medicare program, or raise health care costs for seniors.

Today's hearing is an important step in our continued efforts to make health care more accessible for seniors, and so I look forward to what the witnesses have to say.

[The prepared statement of Mr. Pallone follows:]

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

*Mr. Pallone. Thank you, Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. I didn't see Ms. Kuster sitting there when I started. She is not here now, so I will save some remarks for later. She has been great to work with, and I appreciate her very much.

So that concludes our opening statements. We are going to witness opening statements. Some of you testified before. As you know, there will be a green light that will be in front of you on for four minutes. Then you will get a yellow light for the last minute. So that means your time is coming to an end, when you see a red light, to wrap up your testimony so _ as you summarize the written testimony that you have given us.

We appreciate you all being here. I am going to introduce you all. Then we will go back and call on you one by one. But I want to introduce you all now.

So Ms. Jeanette Ashlock, she is the patient advocate for the National Multiple Sclerosis Society.

Mr. Fred Riccardi, president of Medicare Rights Center.

Dr. Lee Schwamm, a volunteer, American Heart Association.

Dr. Eve Cunningham, group vice president and chief of virtual care and digital health for Providence.

And Dr. Ateev Mehrotra, who is a professor of health care policy and medicine at the Harvard Medical School.

So thank you all for being here.

And we will begin with you, Ms. Ashlock, and you are recognized for five minutes for your opening statement.

STATEMENT OF JEANETTE ASHLOCK, PATIENT ADVOCATE, NATIONAL MULTIPLE SCLEROSIS SOCIETY; FRED RICCARDI, PRESIDENT, MEDICARE RIGHTS CENTER; LEE SCHWAMM, MD, VOLUNTEER, AMERICAN HEART ASSOCIATION, ASSOCIATE DEAN FOR DIGITAL STRATEGY AND TRANSFORMATION, YALE SCHOOL OF MEDICINE, SENIOR VICE PRESIDENT AND CHIEF DIGITAL HEALTH OFFICER, YALE NEW HAVEN HEALTH SYSTEM; EVE CUNNINGHAM, MD, MBA, GROUP VICE PRESIDENT AND CHIEF OF VIRTUAL CARE AND DIGITAL HEALTH, PROVIDENCE; AND ATEEV MEHROTRA, MD, MPH, PROFESSOR OF HEALTH CARE POLICY AND MEDICINE, HARVARD MEDICAL SCHOOL; HOSPITALIST, BETH ISRAEL DEACONESS MEDICAL CENTER

STATEMENT OF JEANETTE ASHLOCK

*Ms. Ashlock. Good morning, Chairs Guthrie and McMorris Rodgers, Ranking Members Eshoo and Pallone, and members of the committee. My name is Jeanette Ashlock, and telehealth has become an essential part of how I stay as healthy as possible. Thank you for having this important conversation.

I was diagnosed with multiple sclerosis, or MS, in 2001 at the age of 30. I experienced my first MS symptoms right

after my honeymoon, when I returned to my job at a folding carton manufacturing company. My muscles and body started locking up. I was losing my ability to control my movement and losing the function. Work started to feel dangerous to me, since my office was located in the warehouse where the forklifts traveled daily, so I went to urgent care. After that I saw a neurosurgeon and then a neurologist who delivered my MS diagnosis.

My first eight years living with MS was extremely difficult. I dealt with significant pain, tremors, lost vision, and was hospitalized every few months. Within just three years of my diagnosis, my symptoms were severe enough to require me to use a cane and then a wheelchair. My neurologist worked with me to make sure I kept moving my body to maintain my function. He kept saying, "If you don't use it, you are going to lose it.’’

After that first eight years in trying and switching medications several times, my MS stabilized and symptoms improved. I have not had a relapse since then, and am now able to walk on my own. I do continue to have symptoms like severe fatigue. I had to stop working because of my

symptoms, and I have been on Medicare since two years after my diagnosis.

I am among the many people living with MS who can manage their disease and maintain their quality of life because of the care I received from a network of health care providers. Since Medicare removed many of the restrictions around telehealth, my ability to use telehealth for some of my care needs has become absolutely essential to me. I have used it for appointments with my primary care provider and some of my specialists, including my OB-GYN. I have been able to walk _ excuse me, talk _ to my providers for follow-up visits. For example, after having lab work done and to talk through new health issues as they come up. Many times I have called and been told that I can't get an in-person appointment in months, it would take months, but I could get a quick telehealth visit right away.

I have been able to stay on schedule with my visits and bring up issues right away, so I can prevent them from becoming more serious down the road. Like many people with MS I deal with some cognitive issues, including some memory problems, and it gets worse when I experience stress. When I

am doing a telehealth visit from my home, I am able to sit at my own kitchen table in front of my computer and have my pen and paper with my questions written nearby. And I am so much more prepared. I am able to describe every symptom and remember every single question I meant to ask, and take really good notes instead of having to memorize what my providers are sharing with me.

I am also better able to manage my fatigue when I can go to visits from home, rather than driving to and from in-person appointments. Telehealth has also helped ease the stress of going to the doctor, and my telehealth visits do not feel rushed. So often, as soon as you touch that doorknob in the doctor's office, everything you had in your mind to talk about just melts away because it can be stressful. And then, on the way out of the door from the visit, everything you discussed melts away. With my telehealth visits from my house, I am much more relaxed and able to have much better appointments. It has been so much better for my health all around.

Finally, one of the biggest reasons I am so grateful for telehealth is because during the pandemic I was able to

access a mental health provider via telehealth for the first time. Like a lot of people with MS, I sometimes face mental health symptoms. I was able to find a therapist who was a little further away from my house, but able to see me right away via telehealth without the long wait that you usually face when seeking a therapy appointment. I have been able to meet with her regularly through our telehealth appointments, and it has made such a difference in my life.

I am not the only person in the MS community who benefits from telehealth, and I want to represent some of their needs today, as well. Unfortunately, many people living with MS, especially those in rural areas, residing in areas with limited or no neurologists, these are often referred to as neurology deserts. For people with MS who live in those neurology deserts, or for those with mobility issues or those with no accessible transportation, telemedicine can offer meaningful access to care for those who may struggle to get it otherwise.

It is so important that patients continue to have a choice of whether to use telehealth when it is appropriate. I urge the committee to advance legislative solutions to make

sure that our telehealth access does not disappear. Thank you.

[The prepared statement of Ms. Ashlock follows:]

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

*Mr. Guthrie. Thank you, Ms. Ashlock. I appreciate you being here. The chair now recognizes Mr. Riccardi for five minutes for his opening statement.

STATEMENT OF FRED RICCARDI

*Mr. Riccardi. Good morning. Thank you, Chairman Guthrie, Ranking Member Eshoo, and Ranking Member Pallone, and distinguished members of the committee. Thank you for the opportunity to speak with you today about Medicare telehealth. I am Fred Riccardi, president of the Medicare Rights Center.

We are a national consumer service organization that works to ensure affordable and equitable access to older adults and people with disabilities through direct counseling, educational programs, and public policy initiatives. We serve nearly three million people per year, including through our national helpline and our educational resources called Medicare Interactive. Based on this experience, we know telehealth holds great promise and that beneficiary-centered policymaking can ensure it reaches its full potential.

Early in the pandemic it was clear people with Medicare were at high risk. Congress responded quickly, relaxing restrictions so more beneficiaries could obtain telehealth

through more types of technology, more providers, and at more locations than ever before. Your intervention was desperately needed, and prior to the pandemic Medicare telehealth was very limited to beneficiaries in rural areas who had to go to health care facilities to be remotely connected to a provider.

This idea of telehealth, a small set of services only available to people in some parts of the country that still required travel, was woefully outdated. The pandemic exposed this policy lag as beneficiaries quickly embraced the expanded telehealth options. Uptake has since slowed, but remains well above the pre-2020 levels.

Despite increased utilization, the beneficiary experience has been mixed. Some helpline callers have enjoyed easier access to remote care, but others report being left behind. They may lack adequate technology or infrastructure, prefer in-person care, or want a modality that their provider just can't offer. This range in perspectives is not surprising. Like other Americans, Medicare beneficiaries are indeed a diverse group with diverse needs and preferences. It is imperative that any

changes to telehealth meet them where they are, and recognize the importance of patient choice and autonomy in care delivery.

Policy must also be driven by evidence and outcomes. Given the flexibility, scale, and circumstances, there is still much we don't fully understand, including how various services are working for beneficiaries, whether they are high-quality, or their impact on health care disparities. And much of what we do know suggests room for improvement. As a result, we believe that continuing the pandemic-era system without adjustments to incorporate lessons learned, such as the need for additional data oversight and beneficiary protections, would be a missed opportunity.

Just to be clear, we agree modernization is needed. The pre-pandemic Medicare telehealth limitations no longer reflect the reality, technology, medical, or health care landscape anymore. We have a generational opportunity to expand and to shape care for millions of current and future beneficiaries. We hope you will begin by acknowledging the experiences of the past four years and their limitations.

In our written testimony we outline a set of principles

that may aid your efforts. We recommend prioritizing telehealth policies that meaningfully increase access, promote health equity, include robust consumer protections, and drive high-quality care. Adhering to these goals will help ensure that the system works for everyone with Medicare, regardless of where they live, the coverage pathway they choose, or how they receive their care.

Thank you again for this opportunity to be here today. I look forward to working together to make sure that all people with Medicare will have affordable and high-quality health care. Thank you.

[The prepared statement of Mr. Riccardi follows:]

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

*Mr. Guthrie. Thank you, Mr. Riccardi.

Dr. Schwamm, you are now recognized for five minutes for your opening statement.

STATEMENT OF LEE SCHWAMM

*Dr. Schwamm. Chairman Guthrie, Ranking Member Eshoo, and members of the subcommittee, thank you for the opportunity to testify today on behalf of the American Heart Association. My name is Dr. Lee Schwamm, and I have been an advocate and senior volunteer for the AHA for nearly 25 years.

My CV attests to my internationally-recognized expertise in stroke diagnosis, treatment, and prevention. I am a professor of neurology and an accomplished clinician scientist with more than 600 research and policy publications. Currently I lead a digital health strategy for the Yale School of Medicine and Yale New Haven Health System that promotes the equitable adoption of telehealth.

Before joining Yale I spent three decades at the Mass General Brigham Health System, where I oversaw all systemwide telehealth activities. In March of 2019 we deployed a telehealth platform that enabled 10,000 of our clinicians to provide over 1.7 million virtual visits during the first 6 months of COVID.

Speaking to you today as a practicing stroke neurologist, a telemedicine pioneer, physician leader, and consumer of telehealth, the bottom line is this: telehealth reliably improves access to quality health care, and failing to make the COVID-era telehealth waivers permanent will result in a tragic loss of access to care for Medicare beneficiaries.

As a doctor, telehealth has given me the ability to evaluate my patients' safety and recovery in their home environment, to determine the need for additional services, and truly, as was said before, meet patients and families where they are. So often we give lip service to providing patient-centered care, but rarely do we deliver on that promise. Telehealth allows us to do that, especially when a medical condition or social circumstance makes travel to the doctor's office a physical, emotional, or financial ordeal.

Prior to the pandemic, telehealth was mostly a cash-only service, out of reach for most vulnerable populations, used to deliver isolated and episodic care for low-complexity conditions, or what we sometimes humorously refer to as the tele-sniffles. While some telehealth services to patients in

rural areas were reimbursed, patients had to be physically located in a Medicare-certified facility, which dramatically limits access and adoption. The pandemic drove patient and provider adoption of telehealth at a pace and scope that is unprecedented in medicine.

Here is what we know. Telehealth and in-person care are now deeply integrated and intertwined in routine health care delivery. Telehealth has a low risk of fraud and abuse. Telehealth has enormous untapped potential to increase health care value. And due to congressional inaction, telehealth's uncertain future continues to have a chilling effect on the health care ecosystem.

First, the pandemic-era payment and eligibility flexibilities have created a highly effective hybrid model of care that blends telehealth and in-person delivery into an integrated care model to support coordinated care for complex conditions delivered by established health care providers. Reimbursement has increased access to care for patients with chronic and complex conditions who often require frequent visits, as outlined by Ms. Ashlock, or who live in rural or underserved areas. It has enabled additional support and

services for patients with disabilities, with limited English proficiency, or low digital health literacy, further narrowing the gaps in health equity. Medicare beneficiaries with social drivers of health consume telehealth at higher rates, and often rely on audio-only visits for a vital connection to care.

Second, research shows that fraud and abuse are rare, and there is no evidence that such abuse is more prevalent in telehealth than in person. Published data also suggests telehealth visits are largely substituted rather than additive for creating low-value churn. This makes sense because these visits consume clinician time in the same manner as in-person visits from a limited pool of providers who already face a huge amount of unmet demand.

Third, we are already seeing evidence that the looming telehealth cliff is driving a reduction in telehealth claims and a reversion to a pre-pandemic, fragmented approach to care. The Medicare beneficiary utilization of telehealth has dropped steadily, from a peak of 48 percent in 2020, as was described, to a steady state of about 15 percent now in 2023.

Since where Medicare leads others will follow, this will

have a ripple effect _

[Audio malfunction.]

*Dr. Schwamm. _ vulnerable populations. When COVID exposed enormous vulnerabilities in the U.S. health care delivery network, telehealth was the back-up generator that kept the lights on and averted a potential secondary health care disaster.

All major industries now provide virtual first options for their consumers, and have built business continuity and disaster recovery capabilities. Given the evolving U.S. health care crisis with a shrinking workforce amidst burgeoning demand, modernizing our health care system and making it more resilient should be a major national priority.

In conclusion, it is in the best interest of all Medicare beneficiaries that a permanent extension of the pandemic-era flexibilities be enacted. I urge Congress to take swift action to protect this vital piece of our health care system, and let us not lose the hard-earned momentum gained during the pandemic.

Thank you for the opportunity to testify, and for your continued leadership to improve the health and well-being for

all people in America, regardless of wealth, geography, race, ability, literacy, or age. Thank you.

[The prepared statement of Dr. Schwamm follows:]

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

*Mr. Guthrie. Thank you, Dr. Schwamm.

And Dr. Cunningham, you are recognized for five minutes for your opening statement.

STATEMENT OF EVE CUNNINGHAM

*Dr. Cunningham. Thank you. Good morning, Chairman Guthrie, Ranking Member Eshoo, Chair Rodgers, and Ranking Member Pallone, and members of the subcommittee. My name is Dr. Eve Cunningham, and I serve as chief of virtual care and digital health at Providence, a not-for-profit health system comprising a diverse family of organizations across seven states. I am pleased to be here today to discuss the critical and growing role telehealth services play in providing high-quality care to millions of Americans. I oversee one of the largest telehealth programs in the country, serving an extremely diverse patient population.

I would like to start by thanking this subcommittee and your colleagues for your leadership in granting Medicare telehealth flexibilities and extensions over the last four years. It was a silver lining from COVID-19, and I am grateful to be here to share the benefits it has brought the 1.2 million unique patients we serve annually via telehealth at Providence.

During the early days of the pandemic, our experience

with telehealth gave us the strong foundation we needed to rapidly expand virtual care access at scale to meet mounting demand in the communities we serve and beyond. Today telehealth has become an integral part of our care delivery system. Telehealth is no longer a nice-to-have, but a core function of health care delivery, constituting approximately 20 percent of our ambulatory care encounters.

As a physician, there is no better way to promote the health and healing of a patient, especially for our seniors and those with disabilities, than to care for them in their homes and communities. Among its many benefits, telehealth has improved the health delivery experience for patients and providers. Most importantly, telehealth expands access to high-quality, coordinated care to more people in more places.

Telehealth enables us to offer specialty services in remote and rural areas like Kodiak, Alaska, while also allowing us to care for underserved communities in urban areas like Los Angeles.

Telehealth improves health outcomes and patient satisfaction. We know that some patients delay or forgo care if it is not easily accessible, which can result in poorer

health outcomes. Telehealth has become a new standard of care. Our patients value and expect it.

In addition, as this committee knows well, we are facing a severe workforce shortage and clinician burnout. At Providence we have found telehealth is part of the solution. For example, telehealth allows clinical experience to extend beyond the four walls of a clinical setting. In turn, patients are able to access specialists that they may not otherwise have access to. For example, our tele-neurology program _ in our tele-neurology program patients are able to access telestroke services at 93 hospitals across 7 states, many of which would not have access to those services otherwise.

Telehealth has also reduced overall health care costs and provided greater reimbursement predictability for providers. Prior to the Medicare telehealth waivers, there was limited reimbursement for certain sites of service provided by certain providers for telehealth, making the model more challenging to deploy, despite its proven benefits for patients. One example out of many is that our hospital-at-home program has a lower 30-day readmission rate compared

to in-hospital care, despite a comparable patient acuity.

In conclusion, telehealth has become a core component of how we deliver care every day to our patients at Providence and for health care providers across the nation. Removing telehealth options for seniors and disabled Americans would create complete chaos across our health system.

My written testimony contains a number of specific policy recommendations, including support for the Connect for Health Act, Telehealth Modernization Act, and other initiatives. The most important thing that Congress can do this year is make the Medicare telehealth flexibilities that you have enacted and extended on a bipartisan basis permanent.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Cunningham follows:]

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

*Mr. Guthrie. Thank you, Dr. Cunningham.

And Dr. Mehrotra, you are recognized for five minutes for your opening statement.

STATEMENT OF ATEEV MEHROTRA

*Dr. Mehrotra. Thank you, Chairman Guthrie, Ranking Member Eshoo, and distinguished members of the subcommittee. I am honored to testify before you on a topic of such great importance to Americans and their health.

I conduct research on telehealth because I am excited about the _ how these technologies can improve access to care and address the complaint that I often _ so often hear from my patients, and what I am sure you hear from your constituents, that so many people across this nation struggle to access timely care. And these barriers are often larger among those who live in rural communities and underserved communities. In my testimony today I will discuss how recent research can inform potential legislation.

First, telemedicine has resulted in a more modest change in health care delivery than initially envisioned. At the start of the pandemic some had contemplated whether the unprecedented growth in video and telephone visits was the beginning of a new normal. The reality has been more of a modest change in most clinical areas. And though use remains

higher than it was prior to the pandemic, the number of telemedicine visits per month in the Medicare program continues to fall.

In surveys and interviews, patients and physicians greatly value the availability of video visits, and want them to remain an option. However, it is important to acknowledge that they also remain uncomfortable and, when given a choice, many patients still prefer an in-person visit.

Second, our research has found that telemedicine increases health care spending, but by a small amount. A key impediment to permanent expansion of telemedicine has been the possibility that telemedicine will increase spending. In my own research we find that greater telemedicine use does lead to more visits, as well as improvements in chronic disease, medication adherence, and fewer emergency department visits.

However, these improvements do come at a cost. We estimate that greater telemedicine use is associated with a one to two percent increase in overall health care spending in the Medicare program, and our results are generally consistent with other recent work, including those from

MedPAC. Based on these findings, I urge that the Congress permanently eliminate site location requirements and allow video visits for all conditions at any site.

While telemedicine does increase spending, the increase is modest, and is associated with improvements in access and quality. And perhaps most importantly, patients and clinicians want telemedicine to remain an option. And given this emerging evidence, it is hard to justify stopping coverage.

Invariably, areas will emerge where we see overuse as well as outright fraud. But I believe those areas can be addressed selectively by Medicare. For example, Medicare could address concerns of fraud by requiring in-person visits when _ if a physician wants to order specific, high-cost tests.

Third, I believe telemedicine visits should be paid less than in-person visits. Payments for care in Medicare are based on the time a clinician takes to provide that care and the associated space, staff, and equipment. If something costs less, it should be paid less. Roughly half the payment for office visits in the United States are for practice

expenses. And while it does require some overhead, telehealth visits do not require the same practice expenses as in-person visits.

I do not think Medicare should cross-subsidize in-person visits with telehealth visits, because it will create distortions in the market. It will give virtual-only companies, many of those funded by private equity, an unnecessary competitive advantage. It would also incentivize clinicians to give up their practice, their physical practice. Already, 13 percent of mental health specialists have given up their physical office and gone virtual-only.

Lastly, if we are going to curb spending growth in Medicare, it is important to provide more care more efficiently, and reward that care with _ more efficient care with lower prices.

Lastly, I want to urge the committee to consider licensure changes. The norm currently is that physicians must be licensed in the state in which their patient is located. This geographic limitation of telehealth has created tremendous frustration among patients. Patients rightfully wonder why, instead of the comfort of their own

homes, they are asked to do video calls in their car in a parking lot just across a state border. Not surprisingly, many patients have stopped following up with their in-person _ following up with their out-of-state physicians.

To help these patients, I recommend that Congress create exceptions for licensure. This would build on prior legislation. For example, in the Sports Medicine Licensure Clarity Act of 2018 Congress allowed out-of-state sports physicians to provide care to athletes without a license who were in another state. Congress could create similar exceptions for follow-up of mental health treatment via telemedicine.

Again, I thank the committee for allowing me to appear before you, and I look forward to your questions.

[The prepared statement of Dr. Mehrotra follows:]

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

*Mr. Guthrie. Thank you. That concludes opening statements. Thank you, Dr. Mehrotra, for your opening statement. And that concludes. We will now move to members' questions, and I will begin by recognizing myself for five minutes for that.

So Dr. Mehrotra, you just mentioned the sports licensure. I worked in _ that was my bill, actually. I worked in the state legislature. I was licensing and occupation chair. That was my toughest two years, probably, in politics, between all the different professions. And so that is important because what would happen, if you were a team doctor for Auburn and you are playing in the Rose Bowl and you have Cam Newton, who is worth hundreds of millions of dollars, and you are treating him in California if he gets hurt, then your medical licensure _ your liability insurance was in question. That was one of the things we wanted to make sure was clarified. And that was difficult, it took a while to get that done, as simple as it sounds.

So the question is, how do we preserve the integrity of state licensure while geography doesn't become _ you know, telemedicine doesn't require geography, you show up in a

state to have that care. How do we preserve the integrity of state licensure while allowing telehealth to move forward?

*Dr. Mehrotra. To address that, I mean, I think that, first, a _ anyone who uses such an exception must be licensed in the state in which they are located. So if the physician is licensed in South Carolina, they must maintain a full license in good standing in the State of South Carolina, for example. And therefore, if there is an issue in another state, they can go to that medical board and address that complaint appropriately.

I would also say that the _ just to emphasize the importance of that, people are moving all over the country right now _

*Mr. Guthrie. Yes, and different states have different scopes of practices, so _

*Dr. Mehrotra. That is true.

*Mr. Guthrie. Yes, I mean, how do you _

*Dr. Mehrotra. And you have to ensure that the scope of practice would be consistent, just as if we go _ on a driver's license I have to follow the rules of the law within whatever state I am driving in.

But I do think it would allow me to _ for example, if one of my patients is traveling and they have a mental health issue or another issue, I can at least follow up with them and not risk my license, because right now it is creating a lot of a chilling effect where physicians are worried that _ I don't want to abandon my patient, but I am risking my license by caring for them and providing, you know, advice over the phone or on a video visit. So that is why I just think it is super important.

*Mr. Guthrie. Okay, thanks. I want to get to a couple of other questions.

So Dr. Cunningham and Dr. Mehrotra, as well, what services are _ you know, telehealth can't solve everything. So what are at least candidates for a good telehealth? What kind of service do you think are at least appropriate?

And how does Congress ensure people are getting what they are paying for with telehealth?

Let me start with Dr. Cunningham and then Dr. Mehrotra.

*Dr. Cunningham. Sure, thank you. Thank you for the question. It is a great question.

I would say that within pretty much every specialty

there are opportunities for virtual care to be delivered. Within each specialty there might be more volume opportunities and more of a percentage of that care that could be delivered virtually versus others. That, I would say, is a very clinical decision, and really should be left to the clinical decision-making of the clinicians that are delivering the care, and also the patient preference, whether or not the patient prefers to have an in-person versus video visit.

That being said, I would say that across every specialty there is opportunities for _

*Mr. Guthrie. Yes, thanks. And I think I will just _ instead of going to Dr. Mehrotra, Ms. Ashlock, on that, so can you talk about how telehealth has impacted your MS patients through the pandemic?

I know you talked about that, but did _ were there times that you said, "I really need to come into the office,'' and was your opinion listened to, or did you ever have that situation or do MS patients or any patient _ you know your bodies better than everybody else, and say, "You know what, I know I am doing this through telehealth, but I really think I

need to see you,'' was that receptive if you had to do that?

*Ms. Ashlock. Yes, there was a time when I said I would like to come in. But once again, it took me a while to get that in-person appointment. When I _ it was _ when I was having some women issues, the OB-GYN _ I was like, "I think I want to come in and get checked out, or have that one-on-one with you in person.''

*Mr. Guthrie. Okay. And so Dr. Cunningham, what are the services that saw the highest utilization during the pandemic?

[Pause.]

*Mr. Guthrie. What are the services that saw the highest utilization for telehealth in the pandemic?

*Dr. Cunningham. So thank you for the question. So I would say, within my portfolio of services that is in my division at Providence, we have one of the largest tele-neurology programs in the country. I referenced the 93 hospitals that we have deployed across 7 states. So huge opportunities within neurology.

I think more cognitive-focused specialties is where you can see a lot of opportunity for virtual care deployment. We

also have a very large tele-mental health and tele-psychiatry program at Providence. We have a 43-hospital tele-psychiatry program across 5 states, and some ambulatory virtual behavioral health services, as well. So great opportunities there.

We are launching tele-infectious disease, tele-cardiology this year as enterprise service programs, tele-ICU or critical care, as well. So lots of different specialties where there is opportunities to provide telemedicine.

*Mr. Guthrie. Thanks, thanks. My time has expired and I will yield back and recognize the ranking member for five minutes for her questions.

*Ms. Eshoo. Thank you, Mr. Chairman, and thank you to the witnesses. Both your written testimony and your spoken testimony today are really quite instructive.

We have 15 bills before us, and my sensibilities are that you are all really smart, that you have taken a look at those bills. Do you have a specific recommendation relative to any one of the 15 because it covers best what needs to be addressed?

Anyone want to speak up?

*Mr. Riccardi. Thank you for your question. I think to keep it very simple _ and I think we all agree that, given the opportunity that was afforded by the pandemic, that we do have to continue to make telehealth permanent. But we must also be cautious with a number of the flexibilities.

*Ms. Eshoo. But do you have a bill that you think speaks the best to _ or a number of bills?

*Mr. Riccardi. I think there is _

*Ms. Eshoo. I mean, if you don't, it is not a trick question. It is okay. I just wanted to know if there is, you know, legislation that jumps out to you and fills the bill as far as you are concerned.

Yes, Doctor.

*Dr. Schwamm. I think we feel that, again, there are many elements that are _ have _ the bills have in common, but the Telehealth Modernization Act appears to be one that seems to incorporate the most appropriate and comprehensive approach to this.

*Ms. Eshoo. Okay.

*Dr. Cunningham. I would like to advocate for the CONNECT Act for permanency and reimbursement for telehealth

for Medicare beneficiaries.

*Dr. Mehrotra. I think both of those bills, and particularly the CONNECT for Health Act, really balance that issue of expanding access, but also putting safeguards in to ensure that we don't lead to overuse and increased spending.

*Ms. Eshoo. Telehealth, I mean, we all agree that it needs to be extended.

You know, I guess the $64,000 questions are _ and how best to do this. Wherever there is money, there is someone or some outfit _ or plural, outfits _ in the country that look to game it because it can become a cash cow. And that is the last thing that we want or we need. We need to be really diligent about costs.

So in my view, telehealth is a convenience. It is a wonderful convenience for people. But what should not be included in services? I want to turn the, you know, the pancake over. We always talk about what is needed, how are we going to pay for it. What shouldn't be included in this so that the system isn't gamed as a cash cow for organizations to just move appointments under telehealth and cha ching, cha ching, cha ching? Who would like to address

my question?

Yes, Doctor?

*Dr. Mehrotra. You know, I think that you raise a critical issue, which is that we need to put safeguards into the system. We also need to recognize that the system in telehealth is evolving so rapidly, so it is hard to, like, legislate specific examples.

So I think, in _ my view is that Medicare needs the flexibilities to address some of that overuse. So just to give some concrete examples that I feel _

*Ms. Eshoo. But should it be that only a doctor can meet with the patient? Is it RNs that _ I mean, because, you know, an organization can take someone that is down in the middle of the health care food chain and put them online, and, you know _

*Dr. Mehrotra. Yes, I think that is a great point. And some of the legislation that is proposed addresses the issue of incident-to billing. And I think that would be an important safeguard to ensure that incident-to billing via telehealth is you _ there is a modifier code that is used to indicate that so the Medicare program can track this and make

sure that the patients are getting the care they need.

There will also be examples of where we need to allow Medicare to target services. One of the areas that we have seen a lot of growth in, which is _ I am very excited about, is remote patient monitoring. But I think that there is a very appropriate idea that _ Medicare to, say, limit remote patient monitoring to the patients who are going to benefit the most, and also put limitations on who cannot get it. So those are just two concrete examples _

*Ms. Eshoo. Well, that is helpful.

*Dr. Mehrotra. _ of how we need to provide and address those safeguards.

*Ms. Eshoo. Well, my time has run out, but I can follow up with the other witnesses with, you know, submitting written questions.

[The information follows:]

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

*Ms. Eshoo. Thank you very much.

*Dr. Mehrotra. Thank you.

*Ms. Eshoo. Helpful.

*Mr. Guthrie. The ranking member yields back, and the chair recognizes Chair Rodgers for five minutes for questions.

*The Chair. Thank you, Mr. Chairman.

Ms. Ashlock, I was going to start with you, and I appreciate you being here and sharing your story and hearing your testimony and Dr. Schwamm's testimony. It strikes me that there is many different factors that could make telehealth versus in-person care the right choice for each unique patient in their unique situation.

As a patient or as a provider, what are some factors that you consider when deciding whether you want to do a virtual or in-person visit, and how might those factors be unique to each individual?

*Ms. Ashlock. To me, because of my multiple sclerosis, if I am having an exacerbation, we know that it takes three months to get a neurologist appointment. When I am having an exacerbation, I have a 24-hour window before it becomes

severe. So that is a telehealth to me and _ because he can order a nurse to come in to do my infusion for steroids. An in-person to me is when I need to do follow-ups with my neurologist, he has to check on my vision, my _ you know, my walking gait, and things like that. I need to go in person because he needs to physically do some tests.

*The Chair. Okay, thank you.

Dr. Cunningham, in your testimony you highlighted the many ways Providence has used the current telehealth flexibilities to enhance health care services like in my district in eastern Washington. If we were to allow these telehealth flexibilities to expire, how would that impact your ability to care for people in eastern Washington?

And how would that impact your system's decisions on whether or not to invest in trying to encourage innovative care delivery?

*Dr. Cunningham. Thank you for the question. It would, as I said in my oral testimony, create complete chaos in our health system.

We are very dependent on the ability to be able to deliver care. And just to give some context, we provide a

significant amount of our services into rural communities. Our telemedicine programs reach 30 critical access hospitals and 42 non-Providence hospitals, all of which are in smaller communities where they really depend on our ability to extend specialty expertise into those communities, and keep patients where they are in their communities, and empower the clinical workforce in those communities to care for those patients.

So it benefits not only our patients, but our providers and our caregivers that are in those sites. It is a driver of burnout if we are not able to provide these services into those smaller communities.

And in addition, we already have overtaxed facilities in the larger tertiary hospitals where we have patients boarding, we don't have enough hospital beds. And if we did not have the ability to extend these services into these smaller communities, we would further transport patients unnecessarily into these bigger hospitals where they don't need to go. So it really is almost a critical need within our system for patient flow, not even our system within our entire geographic footprint, where we are also providing these services to non-Providence facilities, as well.

*The Chair. Thank you.

Dr. Schwamm, this leads me back to the point you made in your testimony that the certainty of payment for telehealth allowed providers to invest in ways to overcome potential patient access barriers such as providing telehealth to patients with limited English skills.

There are some that would argue we shouldn't move forward with telehealth because there still may be disparities in telehealth access. But from your experience, are we likely to overcome health care disparities by extending the current telehealth flexibilities, or shrinking or even not extending those flexibilities?

*Dr. Schwamm. Thank you for the question. You know, I want to also remind the committee that with enrollment in Medicare Advantage reaching new heights and crossing the 50 percent threshold, as enrollment in that program increases it becomes the decision and the opportunity for health systems and health care providers to figure out the best way to deliver those services and leverage the lower cost of delivering a telehealth visit to support better integrated care.

I think it is really important that we try to understand ways we can mitigate disparities in this country. COVID showed us just how devastating your zip code can be in terms of your predicted mortality. I sit on the board of a non-profit called Tech Goes Home that is devoted to increasing digital literacy, and through COVID digital literacy became health literacy.

So I do think there are ways that we can improve the digital access for underserved communities, but that will only happen if health systems know that there will be permanent payments so they can afford to shift investments from things like real estate and building new buildings and building new clinics to building underlying capability.

*The Chair. Great, great. Thank you. Thank you all for being here.

I yield back.

*Mr. Guthrie. Thank you. The chair yields back, and the chair will now recognize the ranking member of the full committee for five minutes for questions.

*Mr. Pallone. Thank you, Mr. Chairman.

Thanks to the important work of this committee, millions

of seniors have been able to utilize telehealth services and access care. And as Congress considers another extension of the Medicare telehealth flexibilities, it is important that we consider the latest evidence and target those flexibilities to meaningfully increase patient access and ensure high quality of care for beneficiaries.

So in that line I wanted to start with Dr. Mehrotra. Can you briefly discuss the importance of continuing to examine the quality of care for telehealth services, and what steps should be taken to ensure quality improvement, if you will?

*Dr. Mehrotra. I think _ thank you so much for that question, because I think it really addresses a critical issue, which is this is a rapidly changing environment. Telehealth, new modalities, new forms of care are emerging all the time. And so ensuring that both the Medicare program, as well as other groups such as the National Academy of Medicine and others are monitoring the quality of care as it emerges, as new forms of telehealth come on, as well as we see health systems and others adapt to the changing environment. So I think it is a really important issue that

we focus on quality moving forward. We don't know the final answer.

*Mr. Pallone. And Doctor, are there any additional data elements that would be helpful for CMS to collect in this regard?

*Dr. Mehrotra. Yes. In my written testimony I highlighted one area that I am particularly concerned about, which is virtual-only or telemedicine-only companies, which have a great amount of _ there is a lot of excitement, they have a lot of appeal. But I am also concerned about some of these companies and the quality of care that they might provide.

I think we need to give CMS or Medicare the data so that they can monitor these virtual-only companies closely and monitor the care that they are providing. And right now that is in _ when they enroll in Medicare, using those forms and others so that they can actually track that data, I think, is really important.

*Mr. Pallone. I think I mentioned in my opening about MedPAC's, you know, statements about over-utilization. So let me ask you. Can you discuss policies that could

incentivize high-value care and avoid over-utilization?

*Dr. Mehrotra. Yes, I think that we have touched upon a couple of those in terms of some of the concerns I have in terms of over-use. Incident-to billing would be one area, targeting some of the services. In my written testimony I argued that audio-only telemedicine visits, that we should continue those, but only for a short term because _ and ensuring that we focus on video because of some of the concerns I have with over-use.

Also, payment differentials are also going to be another mechanism so that we can keep a check on over-use of care. So those are a couple of the ideas in which _ how we can make sure that we ensure that the telemedicine that is being provided is of the highest value for our Medicare beneficiaries.

*Mr. Pallone. Thank you, Doctor. Let me go to Mr. Riccardi.

You know, obviously, telehealth is particularly important, you know, for hard-to-reach populations, rural populations, others. But personally, I think I would prefer to receive _ and I think most people prefer to receive _

their care face-to-face at the doctor's office. So I was just going to ask you, can you briefly discuss the importance of preserving seniors' choice and ensuring continued access to high-quality, in-person care?

*Mr. Riccardi. That is correct. And preserving choice and the option of in-person care is essential, especially, say, for example, on the topic of Medicare Advantage. We know that nearly half of people enrolled in Medicare are enrolled in Medicare Advantage, and there are network adequacy rules. We must not have telehealth providers meet network adequacy rules. A substantial portion of people enrolled in Medicare Advantage already have trouble navigating the system. Provider directories are hard to access, they are unclear. So I think it is really important, this is one area where we could protect beneficiaries' choice for in-person care to ensure that we are not changing the rules around network adequacy.

*Mr. Pallone. Well, let me ask you a last question. Are there some services, in your opinion, that beneficiaries should receive in person, or are just more appropriate to receive in person?

*Mr. Riccardi. I think there is two key services to consider. We have some experience with Medicaid long-term care, and also hospice. These are two high-risk, high-touch services, where it is extremely important that in-person assessments continue to take place. It is important to see a person in their environment to observe their activities of daily living, and I think this is an area where we should really be cautious in waiving in-person assessments.

*Mr. Pallone. Well, thank you. I just think it is important that we examine the data, preserve patient choice, and, you know, consider the impact of telehealth flexibilities, make sure that the data being collected today informs our decisions going forward. So thank you again to both of you and to the panel.

I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The ranking member yields back. The chair recognizes Mr. Griffith for five minutes for questions.

*Mr. Griffith. Thank you, Mr. Chairman. Before we get started, you can keep the time going, but there is a gentleman here today who is a little bit younger than most of

our people sitting in the witness row, and I was just wondering if somebody might want to introduce that person.

Dr. Cunningham?

*Dr. Cunningham. Yes. I would like to claim _

[Laughter.]

*Dr. Cunningham. This is my son, Benjamin. He is 14 years old, and he is here with his mom today, very excited to be able to witness this testimony.

*Mr. Griffith. Well, I think that is great. Some of my fondest memories were going _ my mother was a schoolteacher going to school. The two weeks before school started, and she was setting up, and it is amazing what you can learn when even _ if you are bored, I would say even if you are bored, it is amazing what you can learn just being in the process.

*Dr. Cunningham. He insisted on coming. He really wanted to be here.

*Mr. Griffith. That is great.

*Dr. Cunningham. He is very excited.

*Mr. Griffith. That is fabulous. That being said, let me get to my real questions, but I am glad you are here today. Thank you for being here with us.

Ms. Ashlock, I am a Virginian, as well. Can you please explain where your providers are located when you use telehealth services, and why it is important that we continue to have these services in the Commonwealth of Virginia?

*Ms. Ashlock. My mental therapist, she was, like, maybe 45 minutes away from me. And this is right during COVID, and it was very hard to get an in-person appointment. So I chose telehealth, and I liked it. It is important that we do keep it. What about those people that are homebound? You know, that can't get out?

And another thing that I like about telehealth is that you can have someone join you. So my son that is in Texas, if I need him to join me, he can join me and listen in on my telehealth, and which _ that is important to me with multiple sclerosis, so that he understands where his mother is and with her MS.

*Mr. Griffith. Yes, ma'am. And for those watching it at home, she is from Newport News. I am from the Salem area. That is about, I guess, about three-and-a-half, four hours apart. And my district goes another four hours south and west, and we have a lot of commonalities in that we are

having a hard time finding necessary people. In fact, one of my hospitals has an arrangement through telehealth to provide mental health services with a doctor out of Charlottesville, and I think she exclusively works for that Carilion health care system, but it reaches deep into southwest Virginia, even though she is located in Charlottesville.

I will say that I am very proud to have been a part of telehealth and the telehealth movement before telehealth became cool. I was the house patron of _ in 2015 I introduced the telestroke bill, and it became law in 2018. I am very proud of that, and I recognized early on that this was a way that we should go to get fast services to people, and also particularly in rural areas or underserved areas where you don't have all the specialties.

That being said, Dr. Schwamm, I believe it has been positive. I think your testimony indicates it is positive. But has the telestroke program been positive, and is there anything else we can do to expand upon telestroke?

*Dr. Schwamm. Thank you for your previous support and for that question.

You know, I think it may not have been completely clear

in some of our comments. Some of the work we are describing is hospital-to-hospital tele capabilities, bringing specialists to patients who are hospitalized in a rural setting, or in a community suburban hospital where they don't have access to expertise. Or they might have a generalist neurologist, but not an MS expert.

The other big part of this is direct to home, direct to the consumer in their environment. So telestroke was life-changing, and has become one of the most important and newest areas of development and growth within the stroke community. It is now a global paradigm for care delivery, and it makes perfect sense because if you are at point A and you are three hours away from point B and you are having a stroke, by the time you get to point B your opportunity for treatment is over.

*Mr. Griffith. Right.

*Dr. Schwamm. So in time-critical situations, there is no question.

I think when you _

*Mr. Griffith. Let me interrupt you because my time is running out. But _

*Dr. Schwamm. Sorry.

*Mr. Griffith. _ so that folks back home can understand, there is a _ I call it the magic drug, TPA, that will break up most strokes, but you have to have some testing done in order to make sure you don't have the kind that TPA is damaging to you.

*Dr. Schwamm. Correct.

*Mr. Griffith. And you get that done, but you can do it while you are on your way to the hospital if somebody is able to assess what kind of stroke you have had. In most of the strokes TPA will help.

That being said, I should also make it clear that when I said that we are getting services out of Charlottesville, my district is a good two hours away from Charlottesville at the tip of the district, at the northern edge of the district, and a good four or five hours further down the district. So it really does make a difference.

And because my time has run out, I will just say we have got to continue with audio-only because I don't have _ in my district, rural mountainous areas, I don't have the ability to do full video and audio, but I can always do audio.

I yield back, Mr. Chairman.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Mrs. Dingell for five minutes for questions.

*Mrs. Dingell. Thank you, Mr. Chair.

As we have discussed today, telehealth services have become an essential part of our health care system. You have all testified to it, that is eradicating barriers to care, alleviating mobility and transportation challenges, and it makes it easier for Americans to access care in the comfort and safety of their own homes.

Last Congress the Advancing Telehealth Beyond COVID-19 Act, legislation I led along with my colleague, Liz Cheney, was included as part of the omnibus funding package. And this bill extended Medicare's telehealth flexibilities through the end of 2024. As that deadline approaches, it is critical that we think seriously about how we are going to ensure that Americans can continue accessing these important telehealth services.

And I am grateful three bipartisan bills I am leading and co-leading are included as part of today's hearing. Taken together, these bills will ensure that patients and

their families have that continued access to telehealth services they need that you all are talking about.

So I am leading the Advancing Access to Telehealth Act, H.R. 7711, with Representative Bergman, as well as the Telehealth Modernization Act, H.R. 7623, with Representatives Carter, Morelli, Blunt Rochester, Steube, Miller-Meeks, and Van Drew to ensure Medicare beneficiaries can continue using the important telehealth services they have come to rely on. Both bills will permanently extend telehealth flexibilities for Medicare beneficiaries beyond the 2024 deadline, and expand access to telehealth services that began during the pandemic.

Ms. Ashlock, how would extending the telehealth flexibilities impact the quality and the continuity of care for patients like yourself?

*Ms. Ashlock. Well, thank you for the question.

For patients like myself, it is essential to have that tool and, you know, in our health care, to have telehealth. Because some of us, you know, you see me with MS, but it is like a snowflake disease. All of us are different. Some have mobility issues, some have _ can't get, you know,

transportation, living in a rural area. So it is important, you know, you have to drive three hours to go to a neurologist, that is three hours one way and three hours back. You have a caregiver that has to take off.

So with telehealth, they can limit those trips. They can be able to see their doctor. I can still get the care that I need without the stress and have to go into a doctor.

*Mrs. Dingell. Thank you. These bills will expand access to telehealth services that began during the pandemic and eliminate the in-person requirements under Medicare for these services, including medical health treatment. This would include telehealth services received from federally-qualified health centers and rural health clinics.

Dr. Cunningham, can you speak about the challenges that in-person requirements for mental health treatment present for patients and the quality of care they receive?

*Dr. Cunningham. Yes, thank you so much for the question.

I can tell you that we have a very large tele-mental health and tele-psychiatry program, and a very passionate group of clinicians and providers that truly believe that the

way forward in meeting access to care for mental health is with virtual care.

It is estimated that 65 percent of non-metro areas of this country do not have a psychiatrist living in that community, which means that if a requirement is made for a patient to have to be seen in person to establish mental health care, then they have to travel a long distance and they have to find a clinician that will actually see them in person, which is also a significant challenge when it comes to mental health.

There is no compelling reason why these visits have to be done in person, as most mental health services are verbal conversations between a clinician and a patient and does not require an in-person physical exam.

*Mrs. Dingell. Thank you. I am going to get one last question in.

The COVID-19 pandemic underscored the urgent need to expand mental health care. One in five Americans are estimated to have a mental health condition, so it is critical to make sure we all have equitable access to high-quality mental health services. That is why I am leading the

TREAT Act alongside Representative Latta, which will allow patients to access these services.

Dr. Schwamm, can you share more how the current licensing laws affect the quality and the availability of telehealth services for mental health care?

*Dr. Schwamm. Thank you, I am happy to.

I think we have to recognize that not only are there reimbursement barriers, but the licensure requirements are onerous. Even the compact, which allows you to apply for a license in multiple states, does not diminish the administrative complexity of managing that license.

I would like to propose a radical solution to this problem that hasn't been discussed frequently, which is to change the definition of the site of care to where the provider is located, rather than the patient. It makes no sense to anchor it where the patient is located, the care is being rendered and prescribed where the provider is located. There would still be a tremendously robust circumstance to keep providers accountable for the care they deliver, and it would dramatically simplify all of these logistical hoops that we jump through for what is effectively an arbitrary

decision of locating it where the patient is.

*Mrs. Dingell. Thank you.

I am out of time, Mr. Chairman, and I will yield back. But we need to really be talking about these issues.

*Mr. Guthrie. Thank you. The gentlelady yields back, and the chair recognizes Mr. Latta for five minutes.

*Mr. Latta. Well, thank you, Mr. Chairman, and thanks for our witnesses for being here today. And this is a really important topic.

I can still remember being on a _ in a meeting probably about six, eight weeks before COVID hit. And there was a discussion going on with all these professionals saying this: telehealth will never work. And when we, unfortunately, were in the early throngs of COVID, I will never forget because I was on a Zoom call with about 60 _ maybe 40 or 60, something like that _ providers across the country. And this is what I was hearing: If we didn't have telehealth, we would be sunk already.

And I know in my district that it is very important because I was out, of course, during the work period recently. And in one of my smaller rural hospitals I was

talking with one of the nurses that provides mental health services, and not only in person but also for those folks out there on the telehealth side, because it is absolutely essential, because, you know, a lot of _ we don't have any public transportation in a lot of areas. And so, if you don't have a friend or a neighbor or a family member that can get you where you have to be, you are not going to get that help. And so I know in talking with her how essential it was for her individuals that she meets with either personally or in face [sic] or with _ and telehealth. So it is absolutely important because, again, when I look at my district _ because I go from very, very urban to very, very rural.

So with that, Dr. Cunningham, you know, I am proud that my _ the TREAT bill that I am leading with my colleague, the gentlelady from Michigan's 12th district, was included in today's hearing. During a national emergency we needed an all-hands-on-deck approach, especially in mental health services.

A student in my district who was receiving mental health therapy while attending the university in a different state, and then due to that _ due to the pandemic they had to leave

that campus and also return home, subsequently relinquishing their mental health services in the midst of the crisis. This shouldn't have happened. Would you be able to elaborate on why temporary mental health services across state lines during a national emergency will help our most vulnerable?

Would you elaborate on why temporary mental health services across state lines during a national emergency would help our most vulnerable?

*Dr. Cunningham. Yes, absolutely. I mean, I think my colleagues here have also spoken to the challenges we have around licensing and credentialing and the administrative burden involved in that. And we know that our patients, our patients are _ I don't want to say they are transient, but they travel, they go on work trips, they have vacations, they go to school in other states and other _ you know, university in other states. They work, they have conferences.

And so health doesn't just exist in the state that you live in, health exists wherever you go. And so we need to be able to meet access to care where our patients are. So anything we can do to reduce the burden of being able to deliver care to our patients where they are and provide that

consistency is greatly beneficial.

*Mr. Latta. Well thank you.

Dr. Mehrotra, prior to the pandemic CMS restrictions prevented patients from engaging in telehealth visits from their home. And again, as I mentioned, my district goes from very, very urban to very, very rural. Would you be able to discuss the impact that rolling back these restrictions would have on the ability of patients to access health care?

*Dr. Mehrotra. As _ I think it is a really critical issue that telehealth has been _ and as has been articulated so nicely by other people on the panel of how it has been a lifeline for so many patients. And removing that right now, I think, would have a really serious negative impact on our health care system and the health of Medicare beneficiaries. So I think it is really critical that we extend these _ the capacity to provide care in the home.

*Mr. Latta. Well, you know, and I am not sure _ I am sorry we have two different subcommittees running right now at the same time today, but are there any statistics out there to show what has happened on the mental health services from pre-pandemic to where we are today?

Because I know, for instance, in my district, when I had one of the chair _ or one of the commissioners from the Federal Communications Commission, one of them, you know, they went from _ this place went from 400 visits to 16,000 in less than 5 months. But are there any statistics out there _

*Dr. Mehrotra. Yes, I think that _ I really appreciate you really focusing in on mental health treatment, because if there is one clinical area where we have seen just a dramatic transformation, we are seeing anywhere from 40 to half of all visits still in the United States for mental health provided via telemedicine. It has really transformed how the average American is receiving mental health treatment. And so _ and I think it really emphasizes where, in that particular area, in the context of a terrible mental health crisis we are having in the United States, how telehealth has been so critical.

And I really appreciate your _ also the focus on licensure, because that allows people to potentially get that mental health services from a patient _ or from a clinician who might be 100 miles away, but happens to be across a state border.

*Mr. Latta. Well, thank you very much.

Mr. Chair, my time has expired and I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back and the chair recognizes Mr. Sarbanes for five minutes for questions.

*Mr. Sarbanes. Thanks very much, Mr. Chairman. Thanks to all of you.

Obviously, we learned a lot of lessons in the pandemic, and it also pushed _ in this industry it pushed providers and patients and government to new ways of doing things, new opportunities. Obviously, telehealth is a prime example of that. And now we want to try to make sure we figure out the right balance in terms of all of the delivery mechanisms for health care that we can bring to bear on behalf of patients out there.

And this is an outstanding group of stakeholders. We have got providers, patients, advocates all assembled here, making arguments for this pretty extensive list of proposed legislation, which I think is trying to learn those lessons in a very positive way.

We know the access to care in terms of the impact there,

and health outcomes for millions of Medicare beneficiaries has certainly benefitted from this new set of flexibilities. And as we are considering another extension of, in particular, Medicare telehealth flexibilities, it is critical that we assess the impact of the expansion of these services, when it comes to the Medicare program, to providers and patients.

Dr. Mehrotra, in your testimony you outlined several things Congress should consider in any extension of telehealth flexibilities to ensure that optimal balance of cost and quality and access. Just touch again _ I know you have been doing it in response to questions, but can you briefly discuss this balance and how we can support continued access to telehealth services at a sustainable cost, while also ensuring that we preserve the option for in-person visits for seniors who may prefer them? Because we don't want to force the telehealth option onto patients or into situations where it is not what makes sense for the benefit of those patients.

*Dr. Mehrotra. First, to emphasize what was said before, that we are seeing clinical benefits in terms of

greater availability of telehealth in terms of patients' health, and so that is really important.

But I think your question really emphasized the aspect of how do we maintain that correct balance so that we make sure that we _ and in particular, allow Medicare beneficiaries to have the access for in-person visits.

And one of the points that I like to emphasize is that we _ this payment, paying less for telehealth, can help with that because we don't want to create distortions in the market, where we are encouraging clinicians to give up their physical practice because they don't have to pay the rent, et cetera, to maintain that, and they can _ so that is why one of the things I have been advocating for is paying less for telehealth visits to ensure that we don't create those distortions.

*Mr. Sarbanes. Thank you. No matter what approach Congress decides to take in this matter, we have to include robust consumer protections for our seniors, and make sure the telehealth policies are not used to undermine network adequacy standards. And this this is a temptation, obviously, because telehealth, if it is not deployed well,

can be used to cut corners in ways that negatively affect patients' health. So it is vital that seniors continue to have access to a full range of providers and have the ability to choose whether they seek in-person or virtual care. We don't want our seniors to be getting, again, pushed into a place that is actually working against their interests.

Mr. Riccardi, can you briefly discuss the importance of maintaining network adequacy standards, especially in the Medicare Advantage program, where these impulses can get traction?

And comment on how we can promote policies that protect choice of providers and care setting for our seniors.

*Mr. Riccardi. Yes. I like to remind myself that these broad flexibilities came about to protect older adults from illness. And now we have some time to fine-tune telehealth measures.

I agree with Dr. Mehrotra on the payment policy, that we have to make sure that we are not inadvertently steering people to care that is clearly unexamined at this point.

In respect to Medicare Advantage, network adequacy standards are in place to ensure that beneficiaries have

continued access to care. Plans are being paid, and we have to make sure that we don't allow telehealth companies to meet those standards and inadvertently erode access to in-person care. I think it is extremely important.

*Mr. Sarbanes. Thanks very much. I appreciate it.

And I yield back.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Dr. Bucshon for five minutes for questions.

*Mr. Bucshon. Thank you, Mr. Chairman.

I was a heart surgeon before I was in Congress, so I have been following medicine since medical school, obviously, and I won't tell you when, but it has been a long time ago.

[Laughter.]

*Mr. Bucshon. Look, the COVID pandemic increased the rate of acceptance of telemedicine services. Everybody said it can't be done, right, and we have proven that it can be done.

We also know patients, both younger and older, have become to appreciate telemedicine. And in 2022, in Medicare, over 8 million Medicare fee-for-service beneficiaries had at least 1 telehealth visit.

It is important that this committee obviously reauthorize existing telehealth authorities with the upcoming expiration dates, because patients and their doctors need certainty that these services will continue.

So Dr. Cunningham, because current telehealth payment policies expire soon, it must be _ I am just guessing it must be difficult for hospitals and providers to engage in long-term financial planning, and that is a reality. Can you discuss the importance to your organization of having long-term consistent payment policy?

*Dr. Cunningham. Yes, thank you so much for that question. That is actually one of the things that I think I am hearing from the members here is, do we do an extension versus do we create permanency in the reimbursement?

And when you do an extension, one of the things that you have to think about is, number one, patients aren't tracking on an extension, okay? Patients aren't thinking about an extension. Patients expect this model of care. It is a new standard of care. And so we really need permanency in our ability to deliver this type of care.

In addition, for health systems, when we build out some

of these programs _ for example, Hospital at Home, remote patient monitoring, tele-physical therapy, or other types of broad programs that we want to grow, there is an investment involved. And when you have uncertainty as to whether or not there will be permanency in reimbursement, you are going to be hesitant to make the investment to build that out.

*Mr. Bucshon. Yes, I would thank you for that, because I was president of my medical group and, you know, when you _ when we didn't know the doc fix was coming for sure, you know _

*Dr. Cunningham. Right.

*Mr. Bucshon. _ we had to make plans.

I am also excited _ and you mentioned this _ some of the opportunities the committee has to build upon existing telehealth infrastructure and promote telehealth use in more areas in the practice of medicine. For example, H.R. 1406, which was considered by the subcommittee at a previous hearing, would allow seniors to receive critical cardiac and pulmonary rehab services virtually. It is my belief that these services, like these follow-up rehab services, even though they technically add a service provided by Medicare,

create efficiencies in the program that can save money by reducing costly hospitalizations.

*Dr. Cunningham. Right.

*Mr. Bucshon. It is not just in rehab.

So, Dr. Schwamm, do you believe that, in addition to patient benefits, which are clear, there are financial benefits to the system associated with the use of telehealth?

And can you provide any examples?

*Dr. Schwamm. Yes, I think it is a really important point. And thank you for emphasizing it.

As I mentioned earlier, if health systems have uncertainty about the future of payment, they can't repurpose leases, they can't restructure how care teams are deployed. They can't even restructure how care is delivered within their network of their own hospitals. It doesn't make sense to have a specialist who goes idle 70 percent of the time because there aren't enough patients in that community to occupy them full-time to spend money on specialist after specialist after specialist.

Now I want to recognize and balance the need for ensuring access to care in person when in-person care is

appropriate. But we learned from the pandemic we got a tremendous amount of care delivered through telehealth in neurosurgery, orthopedics, neurology, not just in behavioral health. And we didn't see a crisis of secondary failures in care. We didn't see spikes in admission for misdiagnoses or for poor outcomes.

So I think it is incredibly important for the health of the health care ecosystem that we modernize. And, you know, we have a revolution coming with artificial intelligence that is _

*Mr. Bucshon. Yes, sure.

*Dr. Schwamm. _ going to reshape how we deliver care, and may yield additional benefits that can further enhance the value of telehealth.

*Mr. Bucshon. Yes. I mean, I personally believe that, you know, the preventative _ potential preventative nature of utilizing telehealth for people that otherwise may or may not have access to care at all will reduce costs in the long run because it prevents hospitalization.

I want to comment on the payment situation, and I know that can be controversial, but I can just tell you that we

cannot pay substantially less for telehealth services _ there is a balance here _ because that will discourage providers from offering them at all. Providers will just quit doing it because it is just supply and demand. It is just the finances, the way it works, right?

So Dr. Cunningham, do you think that if telehealth were reimbursed at a rate _ for example, half what was paid _ for in-person visits, hospitals and physician practices _ and it may be specialty-specific _ would continue to offer it?

*Dr. Cunningham. That is a difficult question. I will tell you that I think that the challenge that we have _ and I think Dr. Schwamm brought this up, as well _ just because we are offering visits virtually does not mean that we have a significant change in our overhead costs. As a leader over a P&L that is responsible for our operations, I can tell you that we still have to pay all of our overhead costs, regardless of whether or not we are providing a mix or a hybrid of in-person and virtual care.

And in addition, for virtual care there are expenses that need to be considered. There is expenses involved in standing up programs, the implementation, the workflow

redesign, the change management, licensing, credentialing, ensuring that you have billing and compliance, and administrative costs, as well, that you have to _

*Mr. Bucshon. My time is expired.

*Dr. Cunningham. Yes.

*Mr. Bucshon. So I appreciate that answer because I think we can be short-sighted. And if we _ look, I understand people _ it is _ people think it costs less. But if we substantially decrease reimbursement, telehealth will go away.

*Dr. Cunningham. Correct.

*Mr. Bucshon. In my view. Thank you.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Cardenas for five minutes for questions.

*Mr. Cardenas. Thank you, Chair Guthrie and Ranking Member Eshoo, for holding this important hearing.

I just wanted to compliment Mr. Bucshon on his excellent question, and thank you, Dr. Cunningham.

Who is to say we are even reimbursing at the proper rate already? That is the real underlying issue here on the

answer to that question, and thank you for outlining just a few top lines, Dr. Cunningham.

I would like to say that, you know, the discussion has been amazing from all the witnesses. And thank you for your testimony about your experiences and your thoughts and your opinions on these matters and your expertise.

During my time in Congress I have advocated for improving access to care for underserved communities through the development of sustainable and accessible systems. And when I say underserved, I mean rural, I mean whether you are in a big city, whether you are low-income, whether you are a family of color, et cetera, or a community of color, all across the board.

I have also worked to ensure individuals that may speak a first language other than English are receiving care at the same standard as all other people in America. In this Congress I am proud to co-lead the bipartisan Supporting Patient Education and Knowledge, otherwise known as the SPEAK Act, of 2023, along with Representative Steel and a number of my colleagues on both sides of the aisle. This bill would require HHS to create a task force with stakeholders

dedicated to improving language access and health care for Americans with limited English proficiency.

The task force would develop recommendations and best practices for addressing barriers to care for people with limited English proficiency. Determining best practices to make health technologies more usable for the 25 million non-English speakers across our country will maximize access to essential services, improving quality of life for those we represent.

A 2023 report from Health and Human Services identified Hispanic beneficiaries, dually enrolled Medicaid beneficiaries, and those with disabilities to have highest use of telehealth in 2021. These trends in telehealth, using _ usage by populations that have historically struggled to access care highlight the importance of the work we are doing here.

As Congress considers strategies to uphold the benefits of telehealth while ensuring quality and accessibility, it is important to understand the impact of telehealth services on underserved communities. As I said before, it is important that we protect all people in America, especially rural

America, where in some cases someone may have to drive several hours just to see a regular physician, much less a specialist.

Dr. Cunningham, Providence was among the first hospital systems to integrate telehealth on a larger scale, and you mentioned in your testimony that it has become an integrated part of your care delivery system. Can you elaborate on the impact telehealth services had on your ability to provide care to underserved populations versus what it looked like prior to these flexibilities?

*Dr. Cunningham. Thank you very much for the question.

I would say that we had early experience prior to the pandemic with our telestroke program which does provide reimbursement for those services, and I gave the example of being able to reach 30 critical access hospitals and 42 non-Providence hospitals in small communities across 7 states by having this innovative care delivery program.

Since the pandemic we have been able to expand other specialty services similar _ in a similar fashion across large geographies. I spoke to mostly hospital-based services. We have tele-ICU, tele-infectious disease, tele-

psychiatry, where we are reaching underserved communities, smaller facilities, or smaller community hospitals, and we are extending expertise out, and it is extremely impactful and very important for patient flow, for patient care, for patient satisfaction, and keeping patients in the communities.

*Mr. Cardenas. And Providence has provided care for both rural and urban communities, as well?

*Dr. Cunningham. Correct. We provide all the way from the largest urban centers in Los Angeles to small critical access hospitals with 15 beds so _

*Mr. Cardenas. Thank you. I don't own stock in Providence, or I have no financial interest in Providence.

[Laughter.]

*Mr. Cardenas. But I just got to say you are doing an amazing job in my community, as one of the biggest hospitals in my community. And that is where my wife, Norma, and I have chosen to have the care of our children and also the delivery of our children, as well. So thank you for what a wonderful job you have done. And they are all healthy and well. Thank you.

*Dr. Cunningham. Many thanks.

*Mr. Cardenas. I yield back.

*Mr. Guthrie. The gentleman yields back, and the chair recognizes Mr. Carter for five minutes.

*Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. This is extremely important.

You know, I often say that, when it comes to health care, all of us in Congress want the same thing. Whether you are a Republican, a Democrat, or an independent, we all want affordable, accessible, quality health care. I mean, there is no difference between any party or anyone up here. We all want to have that, and it is _ that is why I consider telehealth to be one of the great benefits of our health care system.

And I think we all realize that during the pandemic _ you know, I have always said there is a difference in knowing something and realizing something. We all knew how important telehealth was. We all knew that it was a wave of the future. And then, all of a sudden, during the pandemic it became the wave.

I mean, it was no longer a wave, it was an integral part

of our health care system, and it now is an integral part of our health care system and it is very important, particularly for people like me, who represent a district that has a lot of rural community in it. I represent the entire coast of Georgia, but I also represent a lot of south Georgia, and there is a lot of rural area in south Georgia, and it is very important. It also helps addressing the health care shortage that we have, the provider shortage.

The benefits go on and on about telehealth, and that is why we expanded the Medicare telehealth flexibilities during the pandemic. And now they are set to expire at the end of this year, and that is why, along with my good friend from Delaware, Representative Lisa Blunt Rochester, who I have worked very closely with on this committee, and I am going to miss very, very much when she goes over to the Senate, but we have introduced the Telehealth Modernization Act, and that would, of course, make these flexibilities permanent, and it needs to be passed.

And I thank all of you for being here. I want to start with Ms. Ashlock.

I want to ask you a question. What would happen in your

health care situation if Medicare stopped covering telehealth and these flexibilities expired? What would that _ what kind of impact would that have?

*Ms. Ashlock. Thank you for the question. The impact that it would have is I would not get the immediate care that I am getting now. I would have to wait for in-person appointments. And with specialists that is, like, three months in advance. You know, you have to wait for me to see my neurologist, where I could be having a symptom going on where I need to see the neurologist, like, yesterday.

*Mr. Carter. Right, right.

Mr. Riccardi, let me ask you. The Telehealth Modernization Act will make these flexibilities _ or certain flexibilities _ permanent. What kind of potential adverse impacts and _ or implications for seniors would you see if these provisions were not extended, or were not made permanent?

*Mr. Riccardi. I think, you know, four years in we have millions of people who are entitled to this benefit, and we cannot leave older adults and people with disabilities behind. People are used to receiving this type of care in

their home. They are also able to live in different areas, whether it is urban, suburban, or rural. I think it is extremely important that we keep these core aspects of the benefit.

There is great promise of telehealth to reduce health disparities also, but I think there also needs to be accountability. We must fund the agencies, CMS to examine the clinical effectiveness of that. And so we will know what services are high-value, high-impact, and can ensure quality outcomes.

*Mr. Carter. Thank you for that. Very quickly, with the little time that I have left, I want to talk about the audio-only coverage.

Dr. Cunningham, if we increase accessibility and particularly in rural communities that have limited or no broadband at all _ and there are those out there, there are some in my district, and I hate to say, but there are _ does this provide an optional or additional option for many older adults who struggle with the technology?

*Dr. Cunningham. Yes, thank you for that question. I think this is a question that comes up specifically in rural

areas where there is sometimes lack of connectivity or technology barriers for the patients in those communities.

I would say, obviously, ideally, we always want to try to do a virtual visit with a video interaction with a patient. But when that is not available, the next best thing is to be able to be _ provide an audio-based visit. And so I think it is really important and critical that we include that in whatever legislation comes through.

*Mr. Carter. Good, good.

Mr. Chairman, I want to again thank you for this hearing. What you have heard here, I think, all throughout today proves to us why we need to support the telecommunication _ the Telehealth Modernization Act and make these _ make this permanent. It needs to be permanent. This is an integral part of our health care system now, and it needs to continue on.

Thank all of you for being here.

And Mr. Chairman, I yield back.

*Mr. Bucshon. [Presiding] The gentleman yields back. Now I recognize Dr. Ruiz for five minutes.

*Mr. Ruiz. Thank you, Mr. Chairman.

Rural, underserved communities face unique challenges in accessing high-quality health care. Geographic distances can lead to transportation barriers, with the nearest health care facility sometimes taking up to an hour or more to get to.

Additionally, rural communities disproportionately experience the burden of health care workforce shortages. For example, in my hometown of Coachella we _ I did some research several years back. We found that there is one full-time-equivalent physician per 9,000 residents. To be a medically underserved area it is one per 3,500. The recommendation is one per 2,000.

So telehealth services are a game-changer for many of these communities. They are life-savers for the patient who lives too far from the nearest clinic, for the visually impaired patient who has difficulty navigating public transportation and would otherwise miss an in-person appointment, for the expecting mother with a high-risk pregnancy, where the only maternity ward in the region has been closed, for example, and for so many more.

So expansions to telehealth services during the COVID-19 public health emergency helped improve patient access to

essential care. It is important that Congress continues to expand access to telehealth to ensure our most vulnerable patients do not fall through the cracks, and I would like to thank the committee for bringing these bills up for consideration today.

Ms. Ashlock, thank you for sharing your personal experiences with telehealth services during the COVID-19 public health emergency. Why do you believe that telehealth should continue now that the public health emergency has expired?

And I know you have answered that a lot, but what can you _ what is the recommendation, if you were to have one major change on the way we use telehealth and our policy towards telehealth, what is that most important change that you would recommend to Congress?

*Ms. Ashlock. Thank you for the question. The most important change I would have is let the decision be between the doctor and the patient.

*Mr. Ruiz. In terms of?

*Ms. Ashlock. In terms of the care, should it be telehealth or should it be in person. Let them have that

discussion if they should go in or they should do telehealth.

*Mr. Ruiz. Okay. And across the nation the health care workforce has experienced burnout and challenges in recruiting and retaining physicians and other health care workforce, especially in rural and underserved areas.

Dr. Cunningham, in communities experiencing physician shortages like mine, especially shortages of specialists, what is the opportunity for utilizing technology such as telemedicine and wearable technology to identify high-risk medical situations?

And I know we have had that conversation, as well, during this committee. So I am going to narrow it down to what would be the most important change that you would make to help foster more specialists, as well as the utilization of telemedicine with specialists.

*Dr. Cunningham. Yes, yes. So thank you very much for that question.

I would tell you that, number one, we see tremendous promise with remote patient monitoring. So the more we can do to promote this model of care _ I know I didn't talk about it as much during this call, but _ during this meeting, but

tremendous promise for remote patient monitoring and for managing chronic diseases _ and remote therapeutic monitoring, as well.

In addition, I would say the biggest thing is if you create permanency and reimbursement for telehealth services, and don't create barriers for us to be able to deliver the care in this fashion, the rural communities are only going to benefit more and more from that.

*Mr. Ruiz. Thank you. And while it is important to ensure access to telehealth services, we must not forget the importance of also ensuring access to affordable, reliable broadband Internet access. And without reliable broadband and access to the required technology, telehealth doesn't work. So, Dr. Schwamm, what can be done to overcome technological barriers to accessing and providing telehealth services, and what is the number-one recommendation you give?

*Dr. Schwamm. So I think you are pointing out another really important barrier, particularly for the rural population, where broadband is not readily available.

So I think strong government incentives to expand the broadband availability, much like the Rural Electrification

Act under Eisenhower, is a vital part of ensuring access to care. As I said before, health care is becoming increasingly digital. It is not just telemedicine, it is your health care portal. It is access to the Internet. It is the ability to view your medical record online. So I think that is really important.

And I would emphasize this issue of licensure can't be under-estimated because in a rural area what is the justification for me to go ahead and get that license in Iowa, or in Arizona, California, whatever? You have to make the specialists more accessible by making the procedure of being available less burdensome.

*Mr. Ruiz. Thank you, and I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Dr. Dunn from Florida for five minutes.

*Mr. Dunn. Thank you very much, Mr. Chairman, for holding this hearing and to discuss the future of telehealth policy in the United States.

Many lessons were learned as we adapted to the SARS-CoV-2 pandemic, and as a result many innovations were introduced. I think it is incumbent upon us to assess the

effectiveness of these new policies, determine which were effective, and decide how to promote those policies, where it makes sense for the taxpayer, the patient, and the providers.

An unfortunate consequence of sweeping lockdown policies was missed doctor appointments, recommended preventative screenings, and severe disruptions to the mental health care appointments. Telehealth did provide an opportunity to return to regular medical visits, but also opened a can of worms, so to speak, regarding the potential for systemic abuse. Fortunately, the HHS OIG has evaluated that risk, the waste, and they are putting forward recommendations shortly that should provide checks on some of that.

It is apparent that many of the proposals before us are going to need offsets to be viable for House passage, but there is robust support for permanent extensions. Having said that, incremental extensions of telehealth flexibilities may allow us the opportunity to research our public health agencies, evaluate best practices, and make data-driven decisions about telehealth going forward.

Dr. Schwamm, thank you for sharing your experience as a practicing physician. Your practice of telemedicine related

to stroke care, do you see patients across state lines?

*Dr. Schwamm. Yes, I do, and I recently moved from the Mass General Brigham Health System to Yale. But when at the Mass General Brigham _

*Mr. Dunn. Oh, okay. Well _

*Dr. Schwamm. _ I was licensed in multiple states.

*Mr. Dunn. I hope you are as happy or happier. Does Connecticut belong to the Interstate Medical License Compact?

*Dr. Schwamm. Yes. So I was licensed in multiple states in New England, and I have cared for many patients in rural parts of New Hampshire and Maine. And I will tell you _

*Mr. Dunn. Well, I want to make a point on the liability here, so stick with me. I have got some more for you.

*Dr. Schwamm. Yes, please.

*Mr. Dunn. It is my understanding that under the compact a single state license provides the ability for providers to practice medicine across state lines, including telehealth. Correct?

*Dr. Schwamm. Actually, not quite correct. The compact

allows me to apply for a license in multiple states with one application, but I must maintain a medical license in each of those states and comply with all of their requirements.

*Mr. Dunn. In each state you have your license.

*Dr. Schwamm. Correct.

*Mr. Dunn. So are you proposing that as the compact? Because I think that Florida right now is entering into a compact which does not require additional state license, just registration.

*Dr. Schwamm. Yes, there are some regional compacts that the governors of those states have entered into which require _ which support what Dr. Mehrotra referred to as license reciprocity. Reciprocity gives you full rights and opportunity in that state, but those are _

*Mr. Dunn. That is a licensure, not a registration, right?

*Dr. Schwamm. Correct.

*Mr. Dunn. Okay. So _ but in this _ in our southeast, I guess, region what we have is simple registration across state lines, a single state license. All right? So that is a little different, but it is also the situation that is

going to obtain in Florida if we go forward on the current route.

And it is my understanding, then, in that case the physicians remain subject to the CME requirements in the single state in which they are licensed, and not the state the patient resides in, correct?

*Dr. Schwamm. Yes.

*Mr. Dunn. Okay _

*Dr. Schwamm. In states _ limited states that allow registration.

*Mr. Dunn. Okay. So an MD who then would be subject to their home state medical board regulations, but the disciplinary actions of all of the state medical boards where they see a patient. In Florida, during this past legislative session, the legislature agreed to join an interstate medical licensing compact, and they are in the process right now of implementation. Since 2021, however, to practice telemedicine in Florida the only requirement was just pay a fee, register, and be in good standing in your home state where you are licensed, and register with the Florida State Medical Board.

Out-of-state providers were thereby disciplined by the Florida Board of Medicine by having their telemedicine registration revoked. However, I think it set standards of practice across state lines now where you can have a field day with, you know, medical malpractice suits. And I wondered, you know, that is _ that poses a problem. I ran a large practice, a lot of doctors.

How do we manage that liability across state lines? I think that the liability ought to stay where the license is.

*Dr. Schwamm. That goes to my prior comments that care should be considered to be rendered where the provider is located, and the provider should be disciplined by the medical board in that state. And any other medical board should be able to bring an action to the Home Medical Board if they raise concerns _

*Mr. Dunn. Excellent.

*Dr. Schwamm. _ about out-of-state care.

*Mr. Dunn. You and I are in agreement, Dr. Schwamm, and I think that is an important distinction for us, as physicians.

And with that, Mr. Chairman, I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Ms. Kuster for five minutes.

*Ms. Kuster. Thank you so much, Mr. Guthrie and Ranking Member Eshoo, for holding this very, very important hearing.

I sometimes think that telehealth was the biggest change in our life to come out of the COVID-19 pandemic, and I can certainly say that for my largely rural district in New Hampshire. To access primary care and behavioral health services, patients in my rural communities have to travel long distances over mountains with difficult weather conditions, taking time away from work, having to find reliable child care, and often leading to delayed or forgone care. But during the pandemic, Congress stepped up. We passed the bipartisan CARES Act to expand access to telehealth, and it made a critical difference to my constituents.

These expanded flexibilities have allowed Federally-Qualified Health Centers and rural health clinics to deliver timely care in a convenient setting for their patients. These health centers serve the country's most vulnerable populations, and the expansion of telehealth has helped to

shorten wait times, reduce no-show rates, enabling health care professionals to provide quality care to their patients, regardless of where they live.

Without further congressional action, as you all know, by the end of this year patients will no longer be able to use telehealth and services that they have come to rely upon in access to their health care. My bill with Congressman Thompson, the HEALTH Act, will allow FQHCs and RHCs to continue delivering virtual care, and will implement a permanent payment system for telehealth services, ensuring that even our most rural communities can continue to receive the care they need and deserve.

Now, Ms. Ashlock, I know you have talked a lot already today about your condition. But just briefly, is there anything else you would want to add on what would change in your life if Congress fails to extend telehealth policies?

*Ms. Ashlock. Thank you for the question.

What would change in my life would be the comfort, the _ and not have the stress to go to my doctor's appointments, finding parking spaces, just the ease of being able to get an appointment and also being able to have my family to join an

appointment with me. That would all go away.

*Ms. Kuster. Yes, that is an important consideration, as well. Thank you, and thank you for being with us today.

Dr. Cunningham, in your testimony you shared that telehealth has helped vulnerable and underserved communities to access high-quality care. Can you speak to the need to _ for Congress to establish a permanent telehealth policy for safety net providers such as rural health clinics?

*Dr. Cunningham. Yes, thank you for the question. That is such an important issue.

At Providence we have _ like I said, we provide services to 30 critical access hospitals, and we have 14 rural health clinics in our health system. And these are some of the most underserved patient populations. They don't have enough health care providers in their geographies, and they don't have enough volume, sufficient volume, a lot of times, to support a permanent specialist living in that community. So the only way that they can access care is through virtual care.

So it is really, really critical that we continue to support providing these services in those communities, as it

is a lifeline.

*Ms. Kuster. Absolutely, and that is certainly true in my district.

So there is one other issue that this committee grapples with in a different subcommittee, in the telecommunications subcommittee, but the issues overlap here, which is access to quality, affordable broadband communication. I have heard from some of my colleagues who are concerned about the quality of audio-only visits. And I do want to say about audio-only visits _ this is a personal experience from myself.

I was skeptical at first, but in the aftermath of January 6 I was dealing with some post-traumatic stress issues myself, from being one of the last members to be evacuated safely from our chamber. And I had the benefit of our employee health services and an audio-only therapist who was outstanding, and helped me to get through those several months from night terrors and everything else that was going on in my life. And so I have changed my view on audio-only, and particularly for people who don't have access to video I think it is a critical consideration for us to take into

account.

But just access to quality broadband Internet is a significant barrier to video telehealth accessibility. And I just want to remind my colleagues that programs like the Affordability Connectivity Program, what we refer to fondly as ACP, helps to close that gap. This critical program has helped over 40,000 Granite Staters in my district access reliable, affordable Internet, and I hope my colleagues today will join me in supporting extending the ACP, as well.

So I thank you for your work. I thank you for being with us today. It is critically important, and I urge the committee in a bipartisan way to move forward. Thank you.

*Mr. Bucshon. The gentlelady yields back. I now recognize Dr. Joyce, five minutes.

*Mr. Joyce. I would like to thank Chairman Guthrie and Ranking Member Eshoo for holding this important hearing, and to our panel for testifying.

During the COVID-19 emergency we saw the rapid expansion of virtual care service for Medicare beneficiaries. Many of these COVID-19 telehealth flexibilities that were extended in the Consolidated Appropriations Act of 2023 are set to expire

at the end of this year. There is an especially pressing need to reauthorize waivers for patients in need of cardiopulmonary rehabilitation services.

Currently, only rehab provided in physician offices, which is less than five percent of available programs, are covered under Medicare. As part of telehealth extensions, the other 95 percent of cardiopulmonary rehab is provided as an outpatient service, coverage of which expired along with the public health emergency. And so seniors are left behind with very little access to virtual care.

I appreciate that this subcommittee considered legislation that I introduced with Representative Scott Peters, H.R. 1406, the Sustainable Cardiopulmonary Rehabilitation Services in the Home Act, during a previous hearing focused on strengthening patient access to care in Medicare.

As we consider the need to maintain virtual access to care, we shouldn't forget about access to services that are already lapsed, and I look forward to continuing to work to advance this important piece of legislation. There is a real need for these services. Cardiac rehab at home done through

telehealth has been shown to reduce hospitalizations by approximately 30 percent.

Dr. Schwamm from the American Heart Association, how will increasing access to virtual services aid in uptake of these rehab services for Medicare beneficiaries?

*Dr. Schwamm. Thank you so much for the question. I think what you are highlighting once again is an example of patients who need a repeated high frequency series of visits to achieve the best health outcomes. In those circumstances, the burden is disproportionately placed on those patients, particularly elder Americans who have had a stroke, an MS flare, a recent heart attack. And so the ability to provide services in the home with qualified, supervised individuals increases the access to the care.

We are talking a lot in this room about the fear of over-utilization, but we should also be talking about under-utilization.

*Mr. Joyce. And to that point, can you speak how increased access to cardiopulmonary rehabilitation will ultimately improve overall health outcomes?

*Dr. Schwamm. We know that cardiac rehab helps to

prevent relapses and repeat hospitalizations after acute events.

*Mr. Joyce. Let's stay on that. So you say _ and please repeat for this hearing _ that there will be fewer rehospitalizations because of cardiopulmonary rehabilitation done virtually.

*Dr. Schwamm. I don't know that I can provide evidence to you that virtual delivery of cardiopulmonary rehabilitation is as effective as in-person rehabilitation. I would have to check on that for you. But I can tell you it is way better than nothing, which is right now what most Americans who have a heart attack experience.

*Mr. Joyce. As we look at increased impact on Medicare and the resources, do you feel that the addition of extending the cardiopulmonary rehabilitation will ultimately allow cost savings to the Medicare system?

*Dr. Schwamm. And, you know, I will make a slight analogy. My car gets better health care than I do. It tells me when it is running low on gas. It tells me when the engine needs to be serviced. It tells me when I need a new spark plug. That happens for me as a person when I am on the

side of the road with steam coming out of my engine, I have a heart attack _

*Mr. Joyce. Well then, can telehealth be that vehicle? Can telehealth allow that vehicle to give us the warnings?

*Dr. Schwamm. Absolutely. Move away from random episodic events of care to more of a continuous embrace of our patients. Ensuring they adhere to our evidence-based therapies will ultimately lower costs.

*Mr. Joyce. Do you feel, Dr. Schwamm, that payment stability of permanent Medicare coverage affects health care practitioners looking to build more on comprehensive telehealth services?

*Dr. Schwamm. I have said it before, and I would, yes, reinforce that with an exclamation point. It is certainty of reimbursement that will drive innovation and adoption.

*Mr. Joyce. And I think American patients, I think our constituents realize that innovation is the cornerstone of American health care, and telehealth services are part of that innovation that Americans seek.

Thank you. I think this virtual access is necessary because we do not have enough cardiac rehab centers: about 1

center per 100,000 adults. Improving access to this care will ultimately lead to better health outcomes and reduce costs to the Medicare system through reduced hospitalizations and reduced emergency visits.

Mr. Chairman, I ask unanimous consent to include this letter from the American Association of Cardiovascular and Pulmonary Rehabilitation for the record.

And thank you, and I yield.

*Mr. Bucshon. The gentleman yields. I recognize Ms. Kelly, five minutes.

*Ms. Kelly. Thank you so much for holding today's important hearing.

There has been a substantial increase in telehealth utilization, particularly among Medicare beneficiaries, during the pandemic. Feedback from health care providers and patients across the urban, suburban, and rural sectors of my district highlight how the use of these services during the COVID-19 public health crisis has not only enhanced access to care, but also addressed workforce shortages, led to improved health outcomes, and saved lives.

Mr. Riccardi, what safeguards do you believe are

necessary to ensure both the equitable access to telehealth services and the monitoring of the quality of these services, especially for vulnerable populations such as those residing in rural areas?

*Mr. Riccardi. Thank you for that question.

The vast majority of our clients and our most time-intensive issues that we work on are for people who are duly eligible for Medicare and Medicaid, for people who are very low-income, may not be enrolled in programs. So there continues to be barriers that exist for them in accessing telehealth. Maybe it is broadband, digital literacy. So we can _ also have to continue to make investments in other programs to strengthen those areas.

The Older Americans Act programs, including state health insurance programs, and we also have to have safeguards in place where, in particular, vulnerable populations still have access to in-person care. So we need to address workplace shortages and not look to telehealth to solve that long-term.

So I think, in respect to transparency, we also have to measure the clinical effectiveness. I absolutely agree that care should be decided between a physician and their patient,

but we must rely on the agency to look at telehealth and see whether or not it is as good as or better than in-person care. And when we are thinking about audio-only, we still need that service because many people lack access to AV.

*Ms. Kelly. Thank you so much.

Dr. Schwamm, as a physician specializing in treating patients with complex stroke conditions, you have emphasized the advantages of telehealth, particularly in evaluating patients' recovery from their own homes. Can you elaborate on how telehealth has facilitated your ability to access patients' progress, to assess patients progress in their home setting in ways that were previously challenging during traditional face-to-face appointments?

And how do you foresee telehealth continuing to influence patient experiences and outcomes?

*Dr. Schwamm. Thank you for the question. You know, many of my patients have significant mobility limitations after stroke. They may have family members who are unable to join them at their visits. And we see so much variation in the degree of recovery, patient to patient, that we know that social drivers of health, environmental factors, even their

home, the way their home life is organized, can have a significant impact on their outcome.

Seeing my patients in their homes, often with their family members, maybe their favorite pet gives me a different kind of connection to them. It is like the house call that doctors used to make years ago that we don't make anymore. And I think that it affords us the ability to also see those patients, again on short notice, when they have had a significant deterioration, and make the decision about whether or not further, high-cost imaging or an admission to the hospital might be necessary.

So I think it is a really vital part of delivering the highest quality health care.

*Ms. Kelly. Thank you so much.

Dr. _ I am going to say Mehrotra. Okay. Telehealth offers solutions to workforce shortages and flexibility for providers, but concerns about fraud and abuse persist. How can legislation strike a balance between the benefits of extending telehealth access and implementing measures to counteract fraud, abuse, and improper utilization?

*Dr. Mehrotra. Right. I think it is important to first

emphasize that, while we should be very, very cognizant of fraud and abuse, I don't want to exaggerate its impact. It hasn't been a major issue with telehealth. But I do think it is important to address, and I think giving Medicare the flexibility to require or put in regulations to address fraud and abuse _ the one that I have been enthusiastic about is, given some concerns of a small number of clinicians who are inappropriately ordering high-cost tests, it may be appropriate for certain tests to require an in-person visit to address that.

*Ms. Kelly. Thank you so much, and I will yield back.

*Mr. Bucshon. The gentlelady yields back. I recognize Mrs. Harshbarger for five minutes.

*Mrs. Harshbarger. Thank you, Mr. Chairman, and thank you for being here today. Excuse my voice. It is just allergy season, but I am a pharmacist and I am working on fixing myself. We will start with Dr. Cunningham.

Prior to 2020, providers like physical therapists, occupational therapists, speech language pathologists, they weren't authorized to provide telehealth care to Medicare patients. The expanded Telehealth Access Act that I

introduced with Representatives Sherrill, Blunt Rochester, and other members addresses this issue and allows PTs, OTs, and others to permanently provide telehealth services in Medicare.

And my question is, what would you consider to be the potential benefit of continuing telehealth flexibilities for providers that have traditionally provided hands-on, in-clinic care?

And what is the private sector doing with regards to these providers?

*Dr. Cunningham. Thank you so much for the question. Actually, we just launched a tele-physical therapy program at Providence. Part of the reason we did that is because we did not have enough brick-and-mortar facilities to accommodate the need, and we don't have _ it is very capital-intensive to build these types of facilities out.

*Mrs. Harshbarger. Yes.

*Dr. Cunningham. And we have had a tremendous experience with this program. We are planning to scale it across the organization. It is a collaboration between our on-site physical therapists and a vendor that we work with

that provides the tele-physical therapy in the home for the patients.

We have been able to demonstrate really great outcomes with these patients and, in fact, a lower utilization rate in the sense that typically in-person visits and episodes for tele-physical therapy are 6, on average, per episode, and we are experiencing 3.4 per episode for our tele-physical therapy program. So actually, a potential reduction in cost is what we may be realizing over time.

*Mrs. Harshbarger. Looks like it's a good idea.

*Dr. Cunningham. So I think there is a lot of exciting work happening in this space, and a lot of great potential.

*Mrs. Harshbarger. Well, good, good thing I introduced that bill.

Mr. Riccardi, I have heard from constituents and see more and more news stories that facility fees have been a challenge for patients, and that patient co-insurance can be pricey. And my question to you is, what are your thoughts about facility fees?

And should we prohibit facility fees for telehealth?

*Mr. Riccardi. Thank you for that question. Cost

sharing is a major issue that we also hear in our helpline. Sometimes our beneficiaries are confused as to why they are being charged a co-pay or multiple co-pays _

*Mrs. Harshbarger. Yes.

*Mr. Riccardi. _ or why one visit results in an additional visit.

And so I think first we need to have clear notification to beneficiaries about the cost of telehealth. And I look to the agency to consider the rates that are paid for telehealth in comparison to in-person visits. There are costs associated with telehealth, of course, and there are other costs associated with in-person.

*Mrs. Harshbarger. Yes, exactly. I will go back to Dr. Cunningham.

We have learned many important lessons in the central role telehealth has played. I am a big advocate for that. It is almost a year after the official end of the public health emergency, and we are continuing to look at these lessons learned and how providers and patients utilized telehealth and virtual care. We know that more than eight million Medicare fee-for-service beneficiaries had at least

one telehealth visit.

So how can these telehealth visits be used to reduce unnecessary emergency room visits and bolster preventative care services is my question.

*Dr. Cunningham. Yes. So, I mean, we have some really great examples. For example, we have a remote patient monitoring program that specifically targets congestive heart failure, hypertension, and diabetic patients.

*Mrs. Harshbarger. Yes.

*Dr. Cunningham. We have had so many great catches that we never would have caught if we hadn't had this program deployed, where the patients would have ended up hospitalized.

We have seen a 3X increase in guideline-directed medical therapy for our congestive heart failure patients, which is associated with a 70 percent reduction in mortality.

*Mrs. Harshbarger. Yes.

*Dr. Cunningham. So, I mean, the impact is significant. We have early signals for reduced EMS calls and reduced ED visits and readmissions in these patient populations. So huge promise as we scale this program out.

*Mrs. Harshbarger. Yes, that is amazing. You know, I represent a very rural district in east Tennessee, and we are a border district. I mean, I touch Virginia, Kentucky, North Carolina. And when you have the flexibility to practice across state lines, it is huge.

You know, and I am also co-chair of the congressional bipartisan Rural Health Caucus because, with a member on the other side from Hawaii, you know, we have the same issues all across the country, and a lot of members like me are particularly focused on how virtual health care can fill the gaps in care for rural health and underserved communities. And I feel that telehealth can be used to address the shortage of medical professionals in rural areas.

I mean, for goodness sakes, I am a pharmacist. We would love to have provider status. But is there another way that Congress can encourage more telehealth usage among rural providers, specifically in smaller, independent practices that have fewer resources than larger systems?

*Dr. Cunningham. I would go back to some of the comments that Dr. Schwamm and I have made, which is when there is uncertainty in the reimbursement model _

*Mrs. Harshbarger. That is _

*Dr. Cunningham. _ where you are kicking the can down the road one year, the next year, there is a hesitancy, especially from these smaller practices, to really kind of go all-in because there is an investment involved in making that transition.

*Mrs. Harshbarger. Yes.

*Dr. Cunningham. And so they need to have that reassurance that reimbursement is going to be stable _

*Mrs. Harshbarger. Yes.

*Dr. Cunningham. _ so that they can make the investment in making those transitions _

*Mrs. Harshbarger. I got you. I appreciate it. I am over my time.

So with that I yield back, Mr. Chairman.

*Mr. Bucshon. The gentlelady yields back. I recognize Ms. Barragan for five minutes.

*Ms. Barragan. Thank you, Mr. Chairman. I want to thank the witnesses for being here today, for your important work to protect and expand access to telehealth services, especially for older Americans enrolled in Medicare. And I

want to give a special shout out to Dr. Cunningham and the rest of the team at Providence. Not only have they been very helpful, but Providence is a not-for-profit health care system that operates over 1,000 hospitals and medical clinics across multiple states and, of course, including in my very own district in San Pedro.

Every year I go and take a tour and see the latest of what is happening out there and the care provided to constituents. So thank you, Dr. Cunningham. My question is for you, Dr. Cunningham.

Seventy percent of households in my district report that they speak a non-English language at home as their primary language, and they are less likely to use telehealth services, compared to individuals whose primary language is in English. What can Congress _ what can we do to bridge that digital divide and promote equitable access to telehealth services for non-English-speaking communities?

*Dr. Cunningham. Thank you so much for the question, and thank you for your support, as well, for Providence.

We are huge proponents of the SPEAK Act, which develops best practices to improve language access for patients with

limited English proficiency. And we fully and wholeheartedly are all in on supporting that legislation.

In addition, for our telemedicine services we offer interpreter services when they are needed for any patient in any of our geographies. So we are very committed to ensuring that that service is available to our patients, not just telehealth, but also brick-and-mortar and in-patient, as well.

In addition, we also support bringing in a family member. I know that was brought up with some of the other folks that were testifying today, that it is very nice to be able to not only bring in the interpreter, but to also be able to bring in a family member that can listen in on the visit if they are not physically with the patient at the time.

So those are some of the things that we are supportive of.

*Ms. Barragan. Great, thank you. I am also a cosponsor of the SPEAK Act, so I think it is a good tool to have a task force help identify some of the best telehealth practices for Americans who are not English speaking.

Dr. Cunningham, 60 percent of adults in the United States now live with at least 1 chronic condition which accounts for $4.1 trillion in health care spending every year. During your testimony you mentioned how Providence uses technology to remotely monitor patients with diabetes in their own homes. Can you talk about the potential cost savings of chronic disease management programs that are provided via telehealth?

*Dr. Cunningham. Yes, I mean, that was some of the data points that I brought up earlier with _ we have remote patient monitoring specifically targeted on the big four diagnoses, which constitutes a large portion of the disease burden, which is congestive heart failure, diabetes, and hypertension. And then soon we will be rolling out COPD, which is pulmonary disease.

And we have been able to see an improvement, significant improvement in quality of patient care as a result of having these programs. The average blood glucose of our diabetic patients has gone down significantly, also with the hypertension cohorts. We have seen a significant reduction in the blood pressure, average blood pressure, for those

patients. And an increase in guideline-directed medical therapy for our congestive heart failure patients, which is directly correlated with all-cause mortality. If you can get those patients in good control, you can reduce their morbidity and their mortality.

The same thing goes with _ specifically with diabetic patients. If you get their glucose in good control, your risk of having long-term complications with diabetes goes down. And we know that there is a significant amount of expense and cost related to complications of diabetes. So these types of programs are so important.

And I go back to one of the things that Dr. Schwamm brought up, as well. You can't effectively manage chronic diseases in a office visit that lasts 20 minutes every 2 to 3 months. It is this very frequent interaction, where you can titrate and maintain and monitor your patients and kind of tinker with their management to get them into good control that really is going to be a key to success in managing chronic disease.

*Ms. Barragan. Thank you. The last thing I just want to mention is the Affordable Connectivity Program, which

helps connect people to the Internet has _ is about to expire. And this Congress has to do a better job of making sure we re-up that. And I hope my colleagues across the aisle will see the importance of that and its tie to telehealth.

Thank you, I yield back.

*Mr. Bucshon. The gentlelady yields back. I recognize Mr. Bilirakis for five minutes.

*Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it. And I want to thank the panel for their testimony.

As we know, today's hearing is about the future of telehealth and maintaining readily-available ways for Medicare beneficiaries to access the care. This can often be preventive care to help keep patients out of more acute and more expensive settings. I was glad to partner with Representative DeGette on the PREVENT DIABETES Act, which would expand the diabetes prevention program and authorize a virtual component so we can put in strategies to catch seniors early in the pre-diabetes stage.

Beyond that, I am glad and fully supportive of the proposals here today that extend the COVID-era telehealth

waiver authorities, as it provides an important resource for seniors in my district, particularly in the rural areas and in the field of mental health care. The question _ the first question will go to Ms. Ashlock.

I am encouraged to hear that telehealth was so valuable to you, and allowed you to get the mental health care you needed. Broadening telehealth access for mental health and behavioral health services is something I worked on for many years through the enactment of the provisions of my Ease Behavioral Health Services Act during the pandemic.

From your experience, how has telehealth access made reaching out and receiving mental health care easier for patients?

*Ms. Ashlock. Thank you for the question. Sorry, I didn't hear my name.

*Mr. Bilirakis. That is okay, that is okay.

*Ms. Ashlock. Reaching out for mental health, it was _ at first it was hard because, like I said, when I reached out it was in the middle of COVID, and I think a lot of people were reaching out for mental health at that time. So at first it was hard to get an appointment, even to get, you

know, to talk to someone at an office because they were not in the office.

But once I did find someone, you know, that _ like I said, that wasn't close to me, it was _ that experience of just feeling like I was in my living room and being able to have that mental therapy was a plus for me, especially dealing with depression during that time.

*Mr. Bilirakis. Thank you. Thanks for sharing your experience, very helpful.

Dr. Cunningham, one requirement that is currently in place but is set to expire at the end of the year is an in-person requirement for mental health and behavioral health every six months. While it is well intentioned, I am concerned this policy might make it harder for patients to receive the care they need. And I know we have a proposal before us today. I am concerned about the rural areas more specifically.

But again, I know we have a proposal before us today from Representative Matsui that would get rid of that particular requirement. Has there been anything learned from our experiences during the pandemic that justifies allowing

this requirement to go back into effect?

*Dr. Cunningham. Thank you for the question, and the answer is no. There have not been any learnings from the pandemic that would require this. There is no compelling clinical reason to require that there has to be an in-person visit within six months of establishing care for mental health. And in fact, it will become a barrier to access to care, especially in rural communities where 65 percent of non-metro communities do not have a psychiatrist living in those communities. So if you require this, then you will severely limit access for many of those patients.

*Mr. Bilirakis. Well, thank you very much, very helpful. Thanks for answering that directly.

Dr. Schwamm, you mentioned in your testimony that telehealth being reimbursed has allowed providers to increase their capacity to help improve access to telehealth to populations that have unique needs and might not have traditional access. This may include seniors who need a multi-purpose video call or audio-only telehealth visit, or individuals with limited English proficiency. I was glad to be a co-lead on Representative Steel's bill that requires HHS

to provide guidance to providers regarding these challenges.

What are some of the ways providers can reach these populations, and what will happen to access in these communities if we don't continue the current telehealth flexibilities? If you could answer that, I would appreciate it, Dr. Cunningham, please. Sorry.

*Dr. Cunningham. Sorry, you said Dr. Schwamm.

*Mr. Bilirakis. I am sorry, I apologize. Dr. Cunningham.

*Dr. Cunningham. So yes, it is extremely important for us to continue to have the benefit of being able to provide virtual care services, to provide capabilities for patients to be transported where they need to go, and to continue to support the legislation moving on.

*Mr. Bilirakis. Yes. Well, thank you very much. I think it would be devastating. I have talked to my constituents, and they really benefit, particularly for behavioral health services. But _

*Dr. Cunningham. Absolutely.

*Mr. Bilirakis. Yes. Thank you so much. I appreciate it.

*Dr. Cunningham. Thank you.

*Mr. Bilirakis. I yield back, Mr. _

*Mr. Bucshon. The gentleman yields back. I recognize Dr. Schrier for five minutes.

*Ms. Schrier. Thank you, Mr. Chairman. Dr. Chairman, I am so glad you are back. I was _ I want to thank all the witnesses for coming today.

And first, I would just like, Mr. Chairman, to submit the Children's Hospital Association statement for the record. It talks about the importance of telehealth for people who live in rural communities and have serious, complicated diseases, and their need to see specialists without traveling across states.

As a doctor, I know firsthand the importance of telehealth for patients and for providers. My district covers 10,000 square miles. So for many of my constituents, the flexibility that comes with telehealth that is currently in place has been critical to their access to quality care.

As we consider how to move forward with telehealth beyond this year, I would urge this committee to remember the lessons that we learned during the pandemic. And the reality

is that delivering health care should not be entirely virtual, but it also doesn't have to be entirely in person. And we need to provide patients with the flexibility to decide with their physician which care, which type of care, would work best for their condition and circumstances.

My first question is going to be for you, Dr. Schwamm. With widespread physician shortages and burnout, telehealth may help maintain the physician workforce that we currently have, and alleviate some burnout. According to an NIH study, 76 percent of physicians felt that telemedicine increased flexibility and control over patient care. However, there were also studies that showed telehealth added to doctors' already substantial after-hours charting and messaging with patients, which has increased, also known to us as pajama time.

So, Dr. Schwamm, what lessons have we learned from the pandemic when it comes to telehealth and provider burnout?

And how can we optimize telehealth, maybe with additional staff support or better technology to ensure that physicians aren't taking on even more burden and more stress and more time away from their families?

*Dr. Schwamm. Thank you so much. That is a really insightful observation, and I think it is a reflection of the fact that we largely launched telehealth services in response to the COVID crisis, and focused exclusively on the face-to-face time component of the physician or provider-patient relationship, and much of the pre-visit and post-visit work we simply were going to let it be figured out by somebody. And what that resulted in was a lot of what you call pajama time, right, which is after-hours work, picking up the pieces, ensuring the continuity.

As we have said before, I think two things. Number one, permanent payment allows us to invest in those other pre and post-visit experiences. The overhead of providing the care shifts from in-person, but it still needs to happen.

I think the second thing is that we are poised to implement technologies like ambient listening, which is artificial intelligence-powered scribing, so that much of the work of documentation can be occurring during the visit, rather than at night after you have put the kids to bed. So I think it is an important point, and we need to make the system more resilient.

*Ms. Schrier. It is great, unless it is like the technology that I currently use, where I have to edit it afterwards and it doesn't necessarily save time.

Now I want to talk about patient experience, too, because I know, at least as a community pediatrician, I need a height, a weight, a growth chart. I need blood pressures. I need the pre-work before I walk into the office. I am just wondering how many diagnoses have been missed because you didn't see a mole on the skin, or a curve in the back, or a falling off on a growth curve?

*Dr. Schwamm. Yes, you know, we looked at this a little bit. It is hard to find this data in claims data. And since we don't randomize patients to a telehealth versus an in-person experience, it is very hard.

I think, anecdotally, many of our primary care physicians commented on the fact that when they got patients back in the office and did a physical exam, they found a lump that, you know, maybe hadn't been there before. But that was, quite frankly, true in person, as well.

And as we have heard over and over again, so many patients don't get access to care currently that, yes, we

might miss some things, but in comparison to what? In comparison to perfect in-person care? For sure. But in comparison to reality? I think we are more likely to pick up signs and symptoms because we are actually interacting with the patients.

*Ms. Schrier. Thank you, that is very helpful.

I wanted to just note a quick experience that I had about the balance of telehealth and in-person visits. My first visit with a physician recently was a telehealth visit, but I wanted the second visit to be in person. When I called to arrange that appointment, granted, I have a difficult schedule, but _ it was difficult for both. The wait for a virtual appointment was about a month, and the wait for an in-person was about three-and-a-half months. And so I am wondering if that is a common scenario _ with my eight seconds left _ and how clinics should be balancing this to meet doctors' needs and patient needs.

*Dr. Schwamm. Yes, again, I think if we have a runway where we know what we are going to get paid and that we are going to get paid, we can start to balance the availability of these various services. We can try to decant the simpler

follow-ups that don't require an in-person visit, so that we can create more availability in the in-person space. We can also count on having the in-person space, because unless we have a permanent roadmap we have to balance _ we have to pay for both the telehealth space and the in-person space, and we end up spending more money.

*Ms. Schrier. That is great, great points. Thank you.

I yield back.

*Mr. Guthrie. [Presiding] Thanks, the gentlelady yields back. The chair recognizes Mr. Hudson for five minutes for questions.

*Mr. Hudson. Well, thank you very much, Mr. Chairman. Thank you for hosting this timely hearing. Thank you to all the witnesses for your great testimony and insight on the importance and the benefits of telehealth.

You know, while the COVID pandemic was a terrible, drawn-out experience for this country, it is safe to say there were a few silver linings, including the expanded use of telehealth. And I think we saw before COVID some providers were hesitant to use it, some patients probably were concerned about how it would work and whether they could

use it. But I think during the pandemic we all became very comfortable doing a lot of things online and online settings like that.

And so, with the expansion of telehealth during this public health emergency, there is no doubt, you know, without the expansion, there would be thousands more health issues that would have gone unnoticed, undetected, unaddressed, especially in the area of mental health. I think that is an area where there is a lot of potential growth.

You know, I represent a rural district in North Carolina, and I have heard dozens of seniors tell me stories of having trouble. They are having long drive times to go for a specialty evaluation or diagnosis. I have heard from providers who are struggling with workforce challenges and shortages, and I have heard how we use this new ability with telehealth to treat and diagnose at a faster and more efficient rate.

With that being said, patient access and exceptional care is my number-one priority. So when we evaluate, analyze, and look to reauthorize our expanded access to telehealth, we must ensure there are proper guardrails in

place to protect patients. For example, I am concerned if, say, a dentist were to bill for a routine cleaning via telehealth, and getting reimbursed at the same rate as an on-person visit. That, to me, might be a little questionable.

So I would ask Dr. _ either Dr. Schwamm or Dr. Mehrotra, either one, if you would like to maybe answer, what are some guardrails we can implement to ensure that patients are still receiving quality care through virtual services?

*Dr. Schwamm. I will speak briefly, and then turn it over to my colleague.

I think we have to recognize that we are not going to be able to legislate when, for most services, when in-person versus virtual is appropriate. There are so many components to an engagement that can be addressed virtually, but I would agree with you, a tooth cleaning seems like the kind of thing that you have to lay your hands on in person, and we can identify and should identify and try to capture a category of visits where we really believe that service must be provided in person.

But I really urge you not to try to legislate broad categories of ICD-10 codes or subspecialty certifications.

Many of us provide behavioral health services to our patients even if we are not licensed psychiatrists. So oversight is very important, but we also don't know the quality of that cleaning when it is done in person, quite frankly. So we have a very high bar for proving value in virtual care, but we don't really extend that same scrutiny to in-person care.

*Mr. Hudson. Dr. Mehrotra?

*Dr. Mehrotra. Yes, and I do think that _ but monitoring is critical. So I think that one of the points that I like to emphasize is that in the _ within the context of the Medicare program, ensuring that Medicare can track these services and appropriately identify circumstances where there might be inappropriate care is critical, and that requires some changes to regulations.

So, for example, I have raised the concerns about virtual-only companies. We need to be able to better track the care that is being provided by those companies so that we can make sure that they are providing high-quality care.

*Mr. Hudson. Okay, I appreciate that from _ feedback from both.

But Dr. Schwamm, it sounds like you are saying we

shouldn't look at different reimbursement levels for certain procedures. You know, is there a case where you should get, you know, maybe 100 percent reimbursement for an in-person procedure or visit, but less than that if it is a virtual?

*Dr. Schwamm. I mean, this is a thorny issue. I think it has come up a couple of times in this conversation.

If you price it too low, you will discourage utilization because providers simply can't take a 50 percent pay cut when they could be seeing an in-person patient at full rates. Remember, we have unmet demand. My office could be filled from now until the cows come home with patients.

So I think we have to recognize that we have to tie it to the true cost of providing the visit. Right now the cost is actually higher, because we have to remain full in-person capability and telehealth capability. If we have a permanent roadmap, we can start to actually readjust the expense base and figure out ways to deliver telehealth at lower cost.

So I would be in favor of a ramp that would take us from full parity down to a lesser value. But as my colleague, Dr. Mehrotra, has said, we need to study very carefully where that price point is so that it balances utilization, rather

than creates perverse incentives.

*Mr. Hudson. Great. And I am about to run out of time, but maybe you all could respond in writing. Have there been any checkpoints to allow data analysis and learning as a way to align incentives like you talked about? Is there a way for us to collect data?

*Dr. Schwamm. I think, you know, as my colleague said, requiring some form of modifier codes that allow us to know who is providing the care and that it was provided over telemedicine will at least give you the ability to look through claims data to understand the proportions.

But as I said before, if you don't randomize patients to the two different treatments, it is very hard to tell because the patients who were sicker might do telehealth, and the ones who were healthier might come in person, and suddenly it looks worse. So it is a challenge.

*Mr. Hudson. Thank you.

And I am over time, so I will yield back.

*Mr. Guthrie. I thank the gentleman, he yields back, and the chair recognizes Mrs. Trahan for five minutes for questions.

*Mrs. Trahan. Thank you to the chair and the ranking member and to our witnesses here today.

Missed health care appointments or no-shows serve as a stark reminder of health disparities. Historically, individuals from low-income backgrounds, Medicaid beneficiaries, those belonging to minority groups have consistently exhibited the highest rate of no-shows. Factors such as limited access to transportation, affordability issues, lack of child care, inflexible work schedules disproportionately affect these groups, contributing to their higher rate of missed health care appointments.

Now, while the COVID pandemic was undeniably devastating on numerous accounts, it also catalyzed some positive changes to the way we deliver care, including expanded telehealth flexibilities for patients. Greater Lawrence Family Health Center, which is located in the district I represent, is a community health center that caters to a culturally diverse patient population, with approximately 70 percent of its patients being non-English-speakers. As of March 2021, the center had been _ had seen an increase in overall appointments compared to the previous year, which many

providers at the center attributed to the expansion of telehealth services.

Patient no-shows cost the health care system billions of dollars, with a single missed appointment estimated to cost $300, or around $200. But in a $3.5-billion industry, the total impact of no-shows across the U.S. health care system accounts to approximately $150 billion annually.

Dr. Schwamm, how will permanently implementing the telehealth flexibilities in this hearing reduce both direct and indirect costs to the health care system, while ensuring continued access to care for low-income patients?

*Dr. Schwamm. Well, I think you have highlighted a really important point, and thank you for surfacing it in this committee, which is that this burden disproportionately impacts vulnerable patients. And part of the reasons are the social drivers of health. Part of the reasons are that we don't have the same kind of robust and almost brute force reminder monitoring, encouraging embrace of those patients.

And I do firmly believe that if we pivot toward a permanent approach to telehealth, hospital systems will be incentivized to ensure those patients show up for their

appointments.

I think one thing that I was not aware of that we found out when we did surveys of community members is that for many low-wage workers, they don't have anywhere in the workplace that they could take a telehealth visit, which means they have to take the day off from work for their telehealth visit and lose a day of wages, which is really criminal.

So one thing that the committee could consider would be incentives for employers to create workspaces that incorporate, just like we have lactation rooms for nursing mothers, spaces that could be used by employees, particularly lower-wage employees, to access health care services.

I think viewing missed appointments and no-shows as a form of medical harm is an attitude we should really consider, because every visit that goes by with a provider ready and no one in that room means someone had a delay in diagnosis or a delay in their treatment. So thank you for surfacing that.

*Mrs. Trahan. No, thank you for your response. I think the committee will take all of that under consideration.

Last year my colleagues and I expressed concerns about a

proposed DEA rule that would have limited patient access to buprenorphine, and encouraged an evidence-based approach to make permanent the use of audio-only or audio-visual telehealth technology for the initiation of this drug for treatment of OUD. While I am pleased the agency has extended telehealth flexibilities for OUD treatment until the end of 2024, I think it is critically important for Congress to address this issue through a legislative fix.

So, Dr. Schwamm, again, I am proud to be the cosponsor of H.R. 5163, the TREATS Act, which allows for medication-assisted treatment, mainly buprenorphine, to be prescribed via telemedicine for OUD treatment. Can you please speak to the importance of telehealth and audio prescribing for hard-to-reach patient populations, including unhoused, rural, and tribal populations?

*Dr. Schwamm. We know that the pandemic exacerbated what already was existing extraordinary health disparities. It just made them much more visible and palpable for the community.

There is no question that particularly in behavioral health and opioid or substance use disorders, that frequent

contact is a critical component, as is the ability to prescribe these medications. The DEA requirements are onerous, not just out of state for physicians who have to license in another state, but even within state. And the potential requirement that patients being prescribed controlled substances would have to come in and be seen in person for those prescriptions to continue is completely non-feasible. We don't have the space. We would have to do drive-through, like we did for COVID testing, to literally see all the patients who need this ongoing support.

So I think it is critical that the DEA reevaluate its policies around this, and align them with what really reflects patient need and the incredibly powerful, beneficial impact of these medicines like buprenorphine.

*Mrs. Trahan. I have one final question for _ I will submit for the record for Ms. Ashlock. But I know how important telemedicine is for the MS community, so I will submit that for the record.

[The information follows:]

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

*Mrs. Trahan. And I will yield back. Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentlelady yields back and the chair recognizes Mr. Pence for five minutes.

*Mr. Pence. Thank you, Chairman Guthrie and Ranking Member Eshoo, for holding this hearing. And thanks to all the witnesses here today.

I am glad to see this committee is continuing our work to advance initiatives to expand telehealth access for Hoosiers and, of course, all Americans. It is critical for patients in southern Indiana that our community build upon the success of the flexibilities provided for telehealth services during the pandemic. My colleague Congressman Buddy Carter's legislation, which I am proud to cosponsor, the Telehealth Modernization Act, would make permanent several of these flexibilities.

Likewise, the advancement of telemedicine for mental health services could greatly expand access to patients in need, especially those in areas like mine, rural Indiana, which the VA is actually doing.

I continue to hear about workforce shortages in my

district across the health care industry: doctor's offices, hospitals, everyone has got the problem. During the Trump-Pence Administration, HHS, USDA, and the FCC came together under a MoU for purposes of expanding access to telehealth services. Together these agencies collaborated to utilize their collective expertise so that rural patients in underserved areas could be connected to the care they needed whenever they needed. I have continued to encourage this Administration to build upon this success.

I am going to ask all of you the same question if we have enough time. At the onset of the pandemic, hospital systems in Indiana such as IU Health successfully ramped up various types of telehealth services, and Hancock Regional Hospital utilized patient monitoring services and portable camera systems so that doctors could maintain constant access to these patients.

As you know, treating some types of heart conditions using telehealth services could require constant patient monitoring or hybrid care integration. In 1988 I worked to a man _ worked with a man who plugged into his dial-up telephone, and it checked his heart. And wouldn't that _ I

would call that telehealth medicine, right? And now we are trying to decide where we are going to go with telehealth medicine. It worked for him, and it worked great.

So Dr. Schwamm, you said that this was an untapped potential. Okay?

And if you could all give me a quick, 30-second answer, can AI play a role in expediting telehealth?

*Dr. Schwamm. Absolutely. You know, so many of the things we do, we still do manually today, not just on the front end, but also on the back end. The processing of the claims, the prior authorizations.

We have a huge opportunity to declutter and reduce administrative burden that allows clinicians to practice at the top of their license and to focus on creating care pathways for how your care should proceed after you leave the office that AI can help power a journey for you with reminders in the format that would be best for you _ a phone call, an email, a text message _ and monitor your progress. And if you don't deviate, you don't need another human touching you on that journey.

*Mr. Pence. Yes, it is Representative Hudson, in his _

he kind of had a two-tier system, right? In person or telehealth, but maybe AI is a third tier. Is that possible?

*Dr. Schwamm. Absolutely. This is hybrid, integrated care. This is what care should be.

*Mr. Pence. Okay. So _

*Dr. Mehrotra. And I would also just emphasize _

*Mr. Pence. So right to left.

*Dr. Mehrotra. _ that AI is already here. Hundreds of hospitals in the United States are already using AI to, say, diagnose certain conditions such as stroke, pulmonary embolism, and so forth. And the hope is, obviously, and the appeal is that we can actually identify diagnoses that would have been missed. So I just want to emphasize it is already reality.

*Mr. Pence. Good. Dr. Cunningham?

*Dr. Cunningham. Thank you. I would just say that AI is not necessarily a different layer of care. AI augments care, whether it is in person or it is virtual. And there are many different technologies with a lot of promise to facilitate in augmenting care delivery to make it more efficient both for the patients and for the clinicians.

*Mr. Pence. Ms. Ashlock?

*Ms. Ashlock. I am sure the Society staff would be happy to provide more details about that question, and my experience is more personal.

*Mr. Pence. Okay.

*Ms. Ashlock. And I am happy to answer any questions related to that.

*Mr. Pence. Okay, and you, last but not least.

*Mr. Riccardi. Quickly, I think we just need to urge and have caution with the use of AI. I know that when medical decisions are made, they really should be between the physician and the patient. And that is _ in-person care is the gold standard, and telehealth should be a supplement to that. So I just urge caution as we roll out AI initiatives.

*Mr. Pence. Okay. Thank you all very much.

Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Mr. Crenshaw for five minutes for questions.

*Mr. Crenshaw. Thank you, Mr. Chair. Thank you all for being here. It is a really interesting conversation with some trade-offs. I think everybody is in favor of

telehealth, and we are a little spooked sometimes when we see the CBO score, that it is going to increase costs because it is going to increase utilization.

And we have heard a lot of good counter-arguments to that today, namely how can you increase utilization when your demand is already at capacity?

And are you taking into account the preventative care that is occurring because of telemedicine?

You know, just speaking kind of as a veteran who is constantly needing some sort of treatment for, you know, issues, it is much easier to text your doctor than it is to make a VA appointment. And so I think there is a lot of patients, certainly on the patient side, that would much prefer a simple conversation.

And then, you know, how much do we rely on common sense to establish what should be an in-person visit versus what should be a telehealth visit? And that is very hard to legislate, as was just pointed out.

But it is still true that you could see some bad actors, you know, getting a text message from a patient and saying, well, there is $300, and billing Medicare for that, and

increasing costs. So is that the concern?

And how do we _ and Mr. Riccardi, you are the one with concerns about all of this, so maybe you can outline those for us.

*Mr. Riccardi. Thank you for that question.

In respect to utilization, I don't think, whether it is telehealth or in-person care, that people seek medical care unless it is needed. I think that beneficiaries have other ways that they prefer to spend their time.

I think there are ways to ensure monitoring and oversight of fraud. Telehealth is one service that is potentially prone to fraud, but we can support the agency in monitoring that.

*Mr. Crenshaw. Any fee for service is subject to fraud, right? So I am not even sure how telehealth _ telehealth, I guess, might be easier.

*Mr. Riccardi. In respect to payment structures and cost share _ and we know, depending on what the payment for a service is, or how much a person has to pay for, it can influence behavior. So that is where we should look to the agency to set those rates so we can make sure we can keep a

balance. And we are still figuring out what is the right balance of telehealth to in-person _

*Mr. Crenshaw. Do we have any data? CBO says it costs more money. Okay, got it. There are economists that are working with the data they got. Do we have data that shows that it might increase costs significantly?

*Mr. Riccardi. I think there is some data, as Dr. Mehrotra presented, that there is a potential increase to cost, a small percentage.

And I just do want to point out _ I will submit this after the hearing _ there was a GAO study that is very clear that currently CMS doesn't have the capacity to analyze the outcomes. And so I think one thing that we are generally concerned about is we don't want to exacerbate any health disparities when telehealth really should be in a place to supplement care and reduce them.

*Mr. Crenshaw. I would _ and I think the argument would be that it would reduce disparities, right? There is general agreement on that? Okay.

*Mr. Riccardi. I think we still are waiting for some of that information.

*Mr. Crenshaw. You are a skeptic, got it.

*Mr. Riccardi. Thanks.

*Mr. Crenshaw. One of the _ so I am up here talking about direct primary care quite a bit, because I think that is _ one, I like focusing on primary care because there, as a non-doctor, that is easier for me to understand, but also it is the patient's first step into health care, so I think it should be our legislative first step into health care policy. So that is why I am a strong advocate for direct primary care.

The other reason it is helpful to this conversation is because it eliminates this problem that we are talking about right now, this sort of fee-for-service problem, because direct primary care means you are paying a subscription service, basically, to your doctor to get full access to your doctor whenever you want. So it doesn't matter whether it is in person or over the phone, it doesn't matter. It doesn't add to any costs. And so really, that is a statement more than a question.

But maybe, Dr. Cunningham, you could talk about alternative payment models such as direct primary care, and

how that could be affixed to this payment problem that we have identified.

Or anybody could take that if _

*Dr. Cunningham. Go ahead.

*Dr. Mehrotra. Something in my written testimony I described just _ sorry for interrupting you _ but really emphasized that the current fee-for-service _

*Mr. Crenshaw. Harvard people.

*Dr. Mehrotra. _ is very poorly suited to doing telehealth. You don't want to pay for each portal message, phone call, and so forth. And so giving clinicians the flexibility is really critical in telehealth, and that is not going to come from fee-for-service payments. It is going to come from more bundled payments, capitation fees as you describe them.

So I think the growth of telehealth has emphasized the need for those payment _ different payment models. We are already seeing some of those for remote patient monitoring. We are paying a bundled payment. And my hope is that we see more telehealth, will push towards more of those, and we can address some of the pajama time issues that we also

discussed, which is, you know, how do we pay for clinician time which currently isn't reimbursed face to face.

*Mr. Crenshaw. Right.

You had something to add.

*Dr. Cunningham. So I guess the comment I would make is that at Providence we are definitely committed to trying out different types of payment models. We participate in MSSP, we have one of the largest in the country. We participate with Medicare Advantage. And direct primary care is another option.

The one thing to keep in mind is 70 percent of our patient population accesses Medicare and Medicaid. If there is a subscription fee, a fee that the patient has to pay, that could be cost prohibitive for many patients in our population. So we would have to think about how that care model could work with our underserved patient populations.

*Mr. Crenshaw. Yes.

*Dr. Schwamm. Just one thing I want to add. When we look at trying to control costs within our health system, we are not worried about ambulatory visits. The drivers of cost for us are emergency room visits, admissions, and high-cost

imaging and drugs. That is what drives cost.

So yes, I am sure that making telehealth more accessible may increase utilization a small amount. That is not the utilization we should be focused on. It is _

*Mr. Crenshaw. Yes.

*Dr. Schwamm. _ can that reduce the utilization of these much more expensive _

*Mr. Crenshaw. Right, and more accessible primary care absolutely keeps people out of the ER.

*Dr. Schwamm. Absolutely.

*Mr. Crenshaw. Okay, I am out of time, I yield back. Thank you.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Dr. Miller-Meeks for five minutes.

*Mrs. Miller-Meeks. Thank you, Mr. Chair, and I really want to thank all of our witnesses for testifying before the committee today.

As a physician, military veteran, and a former director of public health, I think that this discussion is fascinating, and you have actually answered some of my questions as we have gone along.

I am glad to see the committee include my bill with Mr. Carter, the Telehealth Modernization Act, in the hearing today and your mentioning of that bill. This bipartisan legislation expands audio-only telehealth access for seniors and maintains provisions and originating site restrictions for rural patients.

As a matter of fact, as a state senator I was able to pass in one session a bill that included schools as a site of service for behavioral health and for mental health for middle school and high school students.

Amongst other policies, the legislation allows Federally-Qualified Health Care centers to furnish telehealth services. UnityPoint, a hospital system in Iowa with locations and clinics in my district, had 1,689 providers, served 76,268 patients via telehealth in the past year. This resulted in over 160,000 telehealth visits, with 94 percent of them occurring in the outpatient setting, with high levels of patient satisfaction. And part of this was not just the pandemic, but part of this was technology reaching the platform where multiple people and imaging was at the level. So those things happened concurrently with the pandemic and

led to high rates of success.

It also allows seniors, and especially those in rural areas, to have consistent and reliable access to their physicians, which is critically important for individual and public health.

And Dr. Mehrotra, I very much appreciate your talking about the cost structure, the reimbursement. I have long _ even though I have advocated for telehealth and was part of getting the exemption prolonged, the waivers for the exemptions during the pandemic, trying to make those permanent, I also don't believe 20 percent reimbursement for telehealth is adequate, nor do I believe 100 percent reimbursement for telehealth is appropriate, either. And I have been very honest with my providers and hospitals to that.

And also, when we are talking about how we look at telehealth, there is an increased cost in the numbers of visits. There is some over-utilization. I think we have seen that when you look at the numbers of visits. And, you know, are there things that we should do to either limit providers or limit visits?

Incident-to billing was brought up. And I think what is important to say is that we need to have data and research that shows if in a certain specialty there are increased numbers of visits versus face to face, do those increased numbers of visits lead to better outcomes, less hospitalization, less emergency room visits?

So this question is for Dr. Schwamm and Dr. Mehrotra. One of the most pressing concerns that I hear from my colleagues in _ regarding program integrity and the potential for fraud in the telehealth space. What are your thoughts on this issue?

What systems has your organization implemented to reduce fraud potential?

What policies do you recommend that the subcommittee use to address the potential for telehealth fraud?

*Dr. Schwamm. Well, I am going to go out on a limb here and say this is sort of like the boogeyman. I just don't see it.

I mean, you know, like I said, we did millions of visits just in that first six months. I just think that, in general, most providers are just trying to get through the

day, see the patients who need to be seen, accommodate the unexpected sick visits. And the ability of telehealth to help us leverage those backfill appointments _ the ones we just talked about before, it is such a waste if a no-show goes unfilled _ I just don't see the fraud, and I haven't seen any articles and any published evidence to support the issue of fraud, and everyone has been looking for it.

So I think it is incredibly important to be vigilant about fraud, but we already have mechanisms in place. We have audits. Providers have to attest to the level of complexity or the time spent. We could potentially have even more sophisticated auditing, since these visits are actually measured in terms of the amount of time that was spent on the platform.

So I think it is a little bit of a fascination, but I am not sure that there is real gold there.

*Dr. Mehrotra. But I think we should be monitoring. It is just to emphasize the point that we do need to make sure that the Medicare program has the ability to track these visits very carefully, identify some outliers that might be _ and give the Medicare program the ability to remove

providers where there is questionable behavior.

For example, we have seen some cases where there has been some questionable prescribing behavior. The Medicare program needs the tools to track that and then remove those clinicians or those companies in case when those do occur.

*Mrs. Miller-Meeks. Since my time is expiring, I am going to pose this question and ask Dr. Schwamm and Dr. Mehrotra and Dr. Cunningham and Ms. Ashlock if you would respond in writing.

So if telehealth access were made permanent, which my legislation does, how would this impact your health care system?

And the follow-up to that, what would _ what should Congress keep in mind this year as we contemplate telehealth permanency?

And if Congress were to do another extension of the telehealth flexibilities to have more time to contemplate permanency, how long, in your opinion, would an efficient amount of time to maintain certainty and not discourage the use of telehealth?

So I will give that to our staff, and if you could

respond in writing, I would appreciate it.

[The information follows:]

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

*Mrs. Miller-Meeks. And with that I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back, and the chair recognizes Mr. Obernolte for five minutes for questions.

*Mr. Obernolte. Thank you, Mr. Chairman. Thank you to our witnesses. I found this an incredibly interesting hearing, and it is on a topic that is very personally important to me.

I represent one of the largest geographic districts in the country. Telehealth has been a complete game-changer for my constituents. It has enabled them access to health care that they just didn't have before, and particularly for the more impoverished portions of my district, where the ability to get in a car and drive for a couple of hours to see a specialist just does not exist. It is an economic impossibility for people.

But I want to talk about something that is going to be a painful topic for me, but it is something I think is a reality that we have to face. It is one that has been raised by the last couple of speakers, and I would like to continue that discussion, and that is the issue of cost.

Dr. Mehrotra, you _ in your testimony you said that you thought _ it is undeniably true that telehealth raises health care costs, not lowers them, and this is a problem for us, right, because we already have Medicare and Medicaid spending as the largest, fastest-growing portion of the Federal budget. And our budget is in deficit by about 30 percent. I mean, the cupboard is bare, the alarm symbols are clanging, and all the low-hanging fruit has been picked. You know, the only choices that are left are the hard choices.

So my question, Doctor Mehrotra, is it your thinking that it is just the short-term costs that go up, which is what the CBO is saying? Or do you think that long-term costs also go up?

Because the argument in opposition is that if you can, in the long term, reduce ER visits, treat some of these chronic medical conditions earlier, that is going to save money in the long term. Do you subscribe to that or do you disagree?

*Dr. Mehrotra. No, I think that I would try to reframe. When we talk about a new drug or a new device that comes out, we never talk about does it reduce spending or not. We say,

"Is it providing a sufficient value?'' And that is the way I think we think about telehealth.

I think that it likely is a great new technology that improves the health of Americans, but it is likely to come at a cost. But I think you raise a critical issue. How do we do that in a sustainable way?

And we have talked a lot about in this hearing about different ways to do that. And one of the other ways I just want to emphasize again is how much we pay for those visits. Because we are going to develop and lead to a more efficient health care system _ I think in the long term we need to try to encourage lower-priced ways of providing care, and luckily we have a great option before us, telehealth, which can both improve access but also be _ provide care in a more efficient way.

So that is why _ but to answer your question more directly, I don't think in the long term it is also going to reduce spending.

*Mr. Obernolte. Yes, so this is a problem, right? Because I think everyone _ to address, first of all, your specific comment about reimbursement rates, I completely

agree with you. And I think most of the people on this dais would agree. The problem is that our reimbursement rates for inpatient visits are so low that even achieving cost parity, you know, really isn't fair to either in-person or telehealth, right?

So, I mean, it would be an easier conversation to have if in-person reimbursement was high enough to be adequate. And then you could say, well, telehealth should be 75 percent.

But the bigger issue here is that we can't argue about better outcomes and better values anymore, because we cannot spend more than we are spending on health care. We spent 18 percent of GDP on health care last year, more than any other country in the world, twice as much as countries that have similar health care outcomes as we do _ the UK spends 10 percent _ 3 times as much as countries with better health care outcomes, like Singapore.

I mean, so at some point we have to say, how do we reduce our overall health care spending? And then we can talk about what is a better value and what increases outcomes. But, I mean, the spending, we have maxed out the

credit card. We can't go any further.

So Dr. Cunningham, I was interested in your testimony. You kind of touched on this issue, but what would your response to that be? How does telehealth integrate into our fiscal world in that sense?

*Dr. Cunningham. Thank you for the question.

I mean, I would just say that just because the visit is taking place in a virtual manner doesn't mean us _ me, as a health care provider, that my cost is lower. We still have significant amount of costs that we have to cover for, whether it is an in-person or a virtual visit that we have to provide for.

And when we don't have permanency in telehealth reimbursement, it stifles the innovation. It stifles the ability for us to be able to really scale out and grow some of these programs.

And I would counter that I do think that there is a lot of promise with some of the outcomes that we are seeing specifically with remote patient monitoring. I referenced the tele-physical therapy program that we have, where we are seeing promise towards a reduction in total cost of care.

So I think we need to be looking at this not just at the individual visit level, but at the total cost of care level when we are thinking about implementing these types of programs and creating permanency and reimbursement.

*Mr. Obernolte. Right. Well, I am out of time. I would love to continue the discussion.

But, I mean, I am hopeful that telehealth can be a mechanism for lowering overall costs. So I hope we can all put on our thinking caps and figure out a way to make that happen.

I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentleman yields back. That does conclude all members of the subcommittee, but we had a couple of members of the full committee ask to ask questions. So at this time we will begin that.

And Mr. Balderson, you are recognized for five minutes.

*Mr. Balderson. Thank you, Mr. Chairman. Thank you all for being here today. My first question is for Dr. Cunningham.

Dr. Cunningham, 90 percent of the nation's 4 trillion in annual health spending is on care for people with chronic and

mental health conditions. Again, I am relaying what Mr. Obernolte said.

I believe patients with chronic mental health conditions have the most to gain from telehealth and digital technologies. I first introduced the Keep Telehealth Options Act in 2020, when we were beginning to see the increased value of telehealth in the wake of the COVID-19 pandemic. My constituents in Ohio's 12th congressional district particularly benefit as telehealth helps seamlessly connect patients in rural and Appalachia, Ohio with their providers. The Keep Telehealth Options Act simply requires reports and recommendations on telehealth utilization and policy improvements.

I look forward to continued consideration of two of my other bills, the Medicare Telehealth Privacy Act and the Expanding Remote Monitoring Access Act.

I will focus my first question on the one valuable digital health technology, Remote Patient Monitoring, or RPM. Studies find that RPM reduces hospital readmissions by 76 percent. RPM saved one Alabama ACO $1,300 per member per month. One Maryland health system estimates that their RPM

program saves 10 million a year in avoided hospital admissions and ER visits.

Dr. Cunningham, I was glad to see that you mentioned the value of RPM for your patients. Can you describe how a Providence patient enrolled in an RPM program can improve their health?

*Dr. Cunningham. Thank you so much for your question, and I would have to say that Remote Patient Monitoring, while we have a tremendous number of valuable and amazing telehealth programs in our portfolio, it is one of the programs that I am most excited about because of the promise of the outcomes that you are describing.

So currently, we are taking a population health approach to enrolling patients with chronic diseases in our Remote Patient Monitoring programs. We specifically are targeting patients that fit in a certain criteria with congestive heart failure, hypertension, diabetes, and soon for pulmonary disease for COPD.

We don't offer this program to every single patient, okay? I mean, not every patient that is in really good control needs to be in that type of program. Thus, we want

to avoid over-utilization. We want to give this program, offer this program to the patients who benefitted the most, and who we have seen demonstration from our results that they can benefit the most and have the greatest impact in improving their compliance and their improvement with their disease burden.

And I would say that we are experiencing a similar type of outcomes that you are describing, improvement in guideline-directed medical therapy, improvement in diabetes, blood pressure and blood pressure management, and indications for reduction in ED visits, readmissions, and EMS.

I would say one of the key things that have been secret to our success is enrolling these patients in their primary care clinics before they become very sick, so really trying to get in front of the disease state before the patient decompensates. And then on the flip side, we can enroll them at discharge, as well.

*Mr. Balderson. Thank you. My follow-up to that would be would you agree that your model is one that can be scaled to help patients across the country at a time when 6 in 10 Americans have at least one chronic disease?

*Dr. Cunningham. I would say that it is _ it can't be scaled fast enough.

*Mr. Balderson. Thank you for that response, I appreciate that. My next question is for Dr. Mehrotra.

Sorry about that, sir, I didn't mean to change that.

You frequently discussed options to reform RPM payment systems. For other telehealth flexibilities Congress allowed Americans to maintain access to care they like, while letting policymakers gather data to demonstrate value. Do you think this is a model for RPM policy to follow?

*Dr. Mehrotra. Yes. First of all, I want to share the enthusiasm with Dr. Cunningham for the model itself. But I also think that the emerging evidence that we are seeing also highlights ways that we can improve the value of Remote Patient Monitoring.

For example, we talked about targeting. We also talked about time-limited use of Remote Patient Monitoring. I think these are the ways that we can actually maintain the benefits of these programs, as well as making it more financially sustainable. Because in our research we find that it does increase health care spending right now, even despite those

clinical benefits.

*Mr. Balderson. Okay. I am going to be out of time, so thank you very much, all of you.

Mr. Chair, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back, and the chair recognizes Mr. Pfluger for five minutes.

*Mr. Pfluger. Thank you, Mr. Chair. I appreciate you letting me waive on. And to all our witnesses, thank you.

I represent a rural district that is about 320 miles from east to west, and a lot of rural areas. And in fact, in the back here we have got some health care professionals from Texas Tech University, and we have worked with them in the past couple of years to improve access to telemedicine. They have some phenomenal ideas about how _ in public places and with schools that they are partnering, and we are very proud of the work that is being done.

I will start with Dr. Schwamm, and these questions probably have been asked in some areas, but please forgive me if they haven't, and expand if they have. But in which areas have you seen demonstrated effectiveness in enhancing health care access in rural communities?

*Dr. Schwamm. I think one of the most profound ways in which expanded access has affected rural communities is in some of the programs we have discussed earlier, like telemedicine for acute stroke care, where we are largely connecting facilities in rural areas that do have adequate broadband connectivity to urban and academic health care systems that can provide instant access to lifesaving and disability-reducing therapies. There is no question that that has been incredibly impactful.

I think also the use of audio-only telemedicine visits to support individuals with behavioral health issues or with opioid use disorders has been a lifeline in this country. And I think even just the fact that health care can be delivered into a rural community so that a 30-minute visit with a primary care doctor or a specialist requires 40 minutes of commitment from the patient, 5 minutes before, 5 minutes after, instead of 6 to 10 hours out of their day arranging elder care, child care, losing income from being away from their job, if we lived in a patient-centric health care system, that wouldn't happen and we wouldn't have things like waiting rooms, right?

We live in a provider-centric health care system and we need to change that.

*Mr. Pfluger. Please go ahead.

*Dr. Mehrotra. I just wanted to add one thing that, well, one of the things in some work that I actually did with Dr. Schwamm really highlighted that both the benefits in rural communities for a program like telestroke _ but also something that hasn't come up here is that the hospitals that benefit the most from that technology, those in small rural communities, are often those that are least likely to have that technology available. And in our conversations with CFOs of those hospitals, it is often that they don't have the resources, the cost, you know, upfront costs, the cost to devote to that services.

So I think as we think about the huge benefits we can see in rural communities, there may need to be targeted investments to support those hospitals to invest in a technology like telestroke, because right now, unfortunately, it is not happening.

*Mr. Pfluger. Thank you very much.

Dr. Cunningham, when it comes to _ I guess in what ways

has the removal of either geographic restrictions or the originating site limitations facilitated the enhanced access for rural communities?

And feel free to expand on the previous question, as well.

*Dr. Cunningham. Is this specifically related to the licensing question?

*Mr. Pfluger. No, just in general.

*Dr. Cunningham. Oh.

*Mr. Pfluger. Yes.

*Dr. Cunningham. The originating site for the _

*Mr. Pfluger. Yes.

*Dr. Cunningham. Yes, for the clinician or for the patient, or _

*Voice. Removing the originating _

*Mr. Pfluger. For the _

*Dr. Cunningham. Yes. Oh _

*Mr. Pfluger. Yes, how does that impact the access for rural patients?

*Dr. Cunningham. Well, I mean, it is _ having that in place creates a significant barrier for us to be able to

deliver the care. So _ and it really doesn't make any sense to have that restriction in place, and we have been able to demonstrate that through the pandemic and beyond. So I would suggest that we not go back in time to that place.

*Mr. Pfluger. So for anybody on the committee, because we have the Texas Tech University Health Science Center folks that are here and we are working closely with them, just any thoughts, ideas on what it means to have a public-private partnership, are universities participating in this?

And then how that impacts the cost. And I will start down here with those that we haven't asked questions to, but we have got about 40 seconds left.

*Mr. Riccardi. I think, you know, just to back up what Dr. Cunningham just shared, I think the most minimal thing that can be done is to waive the originating site restriction. We want to expand access to people who are receiving care at FQHCs, at rural health centers. Also important that people can receive the care at home.

And I just want to also make a point that, you know, half of beneficiaries are living on very low incomes of $30,000 or less. So we have to be really careful with those

_ with any charges they might incur.

*Mr. Pfluger. Very good. My time is expired. Thank you for being here. I am sorry we didn't get a chance to complete the panel.

But I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back, and that concludes all members present for _ here to ask questions.

And we have a documents-for-the-record list, and I ask unanimous consent to insert in the record the documents including on the staff hearing documents list.

Without objection, that will be in order.

[The information follows:]

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

*Mr. Guthrie. And I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on April the 24th.

So thank you so much. I know it has been a long hearing, but extremely informative. You can see people coming in to ask questions not on the original subcommittee, so thank you for what you do. Thank you for your interest. Thank you for your time.

And we will now _ without objection, the subcommittee will be adjourned.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]