Questions for the Record for Ateev Mehrotra, MD

House Committee on Energy & Commerce, Subcommittee on Health
Hearing on "Legislative Proposals to Support Patient Access to Telehealth Services"
Committee Hearing on April 10, 2024

Thank you to Chairman Guthrie, Vice Chair Buchshon, and Ranking Member Eshoo for the opportunity to respond to these questions.

The Honorable Robert Latta. *Hospitals have patients in the pediatric, adolescent and adult age groups who leave the state temporarily for school, work or other reasons, and need guidance from their caregiver while away. Right now, hospitals cannot offer care to our established patients with chronic medical and mental health conditions if their provider is not licensed in the state the patient is located at the time of the visit. The focus of this question is for established patients seeking care from their PCP and medical home regarding chronic issues such as depression, anxiety, chronic heart and lung conditions, auto-immune conditions. These issues cannot be addressed via local urgent care, and patients have a much higher risk of being referred to the Emergency Room or not seeking care at all. How can we solve this issue at the federal level to protect the primary care relationship with patients, and deliver high quality, value driven coordinated care?*

Response: Thank you for this important question, as it highlights a major problem. Many Americans who travel to another state for work, vacation, or college are cut off from their PCP or other physicians due to barriers in licensure.

During the early-pandemic period (through mid-2021), in the context of waivers of temporary licensure waivers, there was substantial use of out-of-state telehealth.[1] Most of these visits were between patients and clinicians with an established relationship. The use of out-of-state telehealth was highest for those who lived near a state border and in more rural states.

Most of these temporary regulations have expired, and there is ongoing confusion about what care a physician can provide to patients in another state. For example, is a pediatrician allowed to call and provide advice for one of their patients visiting a grandparent in another state? The issue centers on how to define the "practice of medicine." Some lawyers have interpreted that a follow-up phone call constitutes the "practice of medicine" and must be limited to patients in a state

where the physician is licensed. For example, the governing code in Texas defines practicing medicine as "diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method" and notes that any "person who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state…that would affect the diagnosis or treatment of the patient, is considered to be engaged in the practice of medicine."[2] Texas is not unique; similar definitions and rules exist in other states.

Unfortunately, reforms such as the Interstate Medical Licensure Compact, a process for making it easier for physicians to get a full license in multiple states, or the use of special state telehealth licenses have had limited uptake. I therefore recommend that Congress build on prior and create a narrow exception to licensure that allows physicians to provide follow-up care to their patients in other states.[3] Such an exception would be a commonsense solution to the current problem. A physician only needs to be aware of the limitations of exceptions and that one cannot initiate a physician-patient relationship using an exception. From a patient perspective, such exceptions would allow most patients to use telehealth when needed. A student who is away at college can still see their psychiatrist in their home state. Patients traveling for work can keep in touch with their PCP regardless of location.

Many states have already created similar licensure exceptions. For example, Arizona allows a physician licensed in another state to provide telehealth to a patient in Arizona "[t]o provide after-care specifically related to a medical procedure that was delivered to a person in another state." The problem with the current state-by-state approach is that it has created a patchwork quilt of rules that are almost impossible to navigate. Many exceptions use vague language and limit follow-up care exceptions to care that is "infrequent," "irregular," or "short term.[4]" Some states, such as Michigan and Maryland, limit use of follow-up care to physicians located in adjacent states. The ideal solution, therefore, would be a federal exception. Under this exception, any physician could provide telehealth across state lines if they have a prior relationship with that patient. The advantage of federal legislation is that it creates a clear set of rules for physicians and patients.

Use of exceptions is consistent with prior federal legislation. In the Sports Medicine Licensure Clarity Act, Congress created reasonable exceptions for licensure when clinicians travel with a sports team to another state and provide care, even if they are not licensed in the state where the sporting event occurs. Likewise, in the Mission Act, Congress created exceptions for care within the VA such that a VA physician can care for a veteran in any other state.

There is also wide support for the use of exceptions. The American Medical Association supports the need for greater use of exceptions for out-of-state telehealth follow-up care. The Federation of State Medical Boards believes there is a need for exceptions that "permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located. Again, these licensure exceptions would only be focused on established medical problems or ongoing workups and care plans."[5]

The Honorable Lisa Blunt Rochester *The COVID-19 pandemic allowed us to make rapid progress in expanding access to telehealth. Delaware patients now rely on the flexibility provided by telehealth, which allows individuals in rural or underserved areas to receive accessible care for their complex health needs. Losing access to this care or failing to properly reimburse telehealth services will have ripple effects. How does timely telehealth access to high-quality primary care and behavioral health reduce the likelihood of hospitalization, ER visits, invasive procedures, and complications? Medicare reimburses health centers for telehealth at 50 percent of the in-person rate for the same service. How do disparities in reimbursement for telehealth affect access to care?*

Unfortunately, we do not have robust evidence that increased telehealth availability decreases the risk of hospitalization, ER visits, and complications. Some research has found that greater telehealth availability was associated with a small decrease in ER visits, but other research has found no change in ER visits.[6] Other research has found that greater telehealth availability may be associated with *increased* hospitalization use.[7]

Rep. Blunt Rochester also asked whether telehealth reimbursement differences will affect access to telehealth. While it makes intuitive sense that lower payment will translate into lower service availability, surprisingly, this relationship is not always clear. For example, despite much higher commercial prices, access to care does not differ significantly between Medicare and commercially insured beneficiaries.[8]

There are two potential paradigms for determining payment for a given service type. Under the incentive paradigm, one sets payment until one reaches the policy goal. For example, if we want colonoscopies to be easily accessible, we would increase payments until we get the supply that we judge to be adequate. This other approach is a cost paradigm, which focuses on setting payment equal to cost. For example, the price for a colonoscopy would incorporate the average time and resources required by the physician and endoscopy center to deliver a colonoscopy. The current Medicare payment system uses the cost paradigm. Payment is based on data on the time and resources required to deliver a service. The availability of a service does not influence the payment rate.

As I articulated in my testimony, given the lower costs of a telehealth visit, I recommend that telehealth visits be paid less than in-person visits. The correct difference in payment between a telehealth visit and an in-person visit is unclear. I believe it is critical that Medicare collect more data on the practice expenses necessary to provide telehealth visits.

Thank you again for giving me the opportunity to respond to these questions.

[1] Andino, J.J., Zhu, Z., Surapaneni, M., Dunn, R.L. and Ellimoottil, C., 2022. Interstate Telehealth Use By Medicare Beneficiaries Before And After COVID-19 Licensure Waivers, 2017–20: Study examines interstate telehealth use by Medicare beneficiaries before and after COVID-19 led to relaxed licensure rules. Health Affairs, 41(6), pp.838-845. Mehrotra, A., Huskamp, H.A., Nimgaonkar, A., Chaiyachati, K.H., Bressman, E. and Richman, B., 2022, September. Receipt of out-of-state telemedicine visits among medicare beneficiaries during the COVID-19 pandemic. In JAMA Health Forum (Vol. 3, No. 9, pp. e223013-e223013). American Medical Association.

[2] Occupations Code Chapter 151. General Provisions. https://statutes.capitol.texas.gov/Docs/OC/htm/OC.151.htm

[3] Consensus Statement for Telehealth Licensure Reforms. Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics . https://chlpi.org/wp-content/uploads/2023/11/Consensus-statement-Circulation-AMH_FINAL.pdf

[4] Shachar, C., Wilson, K. and Mehrotra, A., 2024. Increasing Telehealth Access Through Licensure Exceptions. JAMA.

[5] Federation of State Medical Boards, The Appropriate Use of Telemedicine Technologies in the Practice of Medicine. April 2022. https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf

[6] Nakamoto, C.H., Cutler, D.M., Beaulieu, N.D., Uscher-Pines, L. and Mehrotra, A., 2024. The Impact Of Telemedicine On Medicare Utilization, Spending, And Quality, 2019–22: Study examines the impact of telemedicine use on spending, quality, and outcomes. Health Affairs, 43(5), pp.691-700., Saharkhiz, M., Rao, T., Parker-Lue, S., Borelli, S., Johnson, K. and Cataife, G., 2024. Telehealth Expansion and Medicare Beneficiaries' Care Quality and Access. JAMA Network Open, 7(5), pp.e2411006-e2411006.

[7] Saharkhiz, M., Rao, T., Parker-Lue, S., Borelli, S., Johnson, K. and Cataife, G., 2024. Telehealth Expansion and Medicare Beneficiaries' Care Quality and Access. JAMA Network Open, 7(5), pp.e2411006-e2411006. Wang, B., Huskamp, H.A., Rose, S., Busch, A.B., Uscher-Pines, L., Raja, P. and Mehrotra, A., 2022. Association between telemedicine use in nonmetropolitan counties and quality of care received by Medicare beneficiaries with serious mental illness. JAMA Network Open, 5(6), pp.e2218730-e2218730.

[8] MedPAC, 2024. Physician and other health professional services, March 2024 Report to the Congress. MedPAC.