Charting the Path Forward for Telehealth

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

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Chair Doggett Announces Health Subcommittee Hearing on Charting the Path Forward for Telehealth

House Ways and Means Health Subcommittee Chair Lloyd Doggett announced today that the Subcommittee will hold a hearing on "Charting the Path Forward for Telehealth" on Wednesday, April 28, 2021 at 2:00 PM EDT.

This hearing will take place remotely via Cisco WebEx video conferencing. Members of the public may view the hearing via live webcast available at www.waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMdem.submission@mail.house.gov.

Please ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, by the close of business on Wednesday, May 12, 2021.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written

comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its events accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories are available [here].

WITNESSES

Sinsi Hernández-Cancio, JD

Vice President for Health Justice, National Partnership for Women and Families

Witness statement

Ellen Kelsay

President & CEO, Business Group on Health

Witness statement

Thomas Kim, MD, MPH

Chief Behavioral Health Officer, Prism Health North Texas

Witness statement

Ateev Mehrotra, MD, MPH

Associate Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School

Witness statement

Joel White

Executive Director, Health Innovation Alliance

Witness statement

CHARTING THE PATH FORWARD FOR TELEHEALTH

Wednesday, April 28, 2021

House of Representatives,

Subcommittee on Health,

Committee on Ways and Means,

Washington, D.C.

The subcommittee met, pursuant to call, at 2:00 p.m., via Webex, Hon. Lloyd Doggett [chairman of the subcommittee] presiding.

*Chairman Doggett. The committee will come to order. Good afternoon, and welcome. We have a great turnout this afternoon, I think over 20 members participating in this.

While many of us are scattered across the country, and a few in Washington, we are holding this hearing virtually, in compliance with the regulations for remote committee proceedings, pursuant to House Resolution 8. This authority has allowed us to continue to do our work on behalf of the American people, while keeping our staff, families, and broader communities as safe as possible.

Before we turn to today's important topic, I want to remind members of a few procedures that help us navigate this virtual hearing.

First, consistent with our regulations, the committee will keep microphones muted to limit background noise. Members are responsible for unmuting themselves when they seek recognition, or when recognized for their five minutes.

Second, members and witnesses must have their cameras on throughout our hearing. If you need to step away from the proceeding, please turn off your camera and audio, rather than logging out.

And one last bit of housekeeping: Mr. Thompson will be authorized to take over as chair in the event that I experience any technical difficulties down here in Texas.

Let me then offer a few opening comments, and then I will call on our ranking member, Mr. Nunes, to do the same.

Telehealth is a term that has become so prominent in health care during our ongoing pandemic. Today we are trying to chart a path forward on telehealth. And, unlike some of the terms we have become so familiar with over the last year that we are ready to retire, like "Let's Zoom," or, "six feet apart," and the recurring guidance that we will probably hear again today, "please unmute yourself," unlike these, telehealth is a concept and a term that is here to stay. Yet we need to fully explore how it stays, and at what cost, in both dollars and quality of health care,

to preserve patient choice, protect beneficiaries from fraud and exploitation, and avoid exacerbating, longstanding health disparities.

Far more than just a pandemic buzzword, telehealth has allowed essential health care workers to provide primary care, specialty care, patient monitoring, case management, all of these, while reducing the spread of COVID-19. This expansion has demonstrated that telemedicine can be integrated into health plans, and help establish physician-patient relationships, and that that can be a way to assess the patient's needs.

Predating the pandemic, telehealth's promise has long been available, but the past year has charted a path forward for better quality and more comprehensive use of it. For Medicare, the transformation was made possible thanks to waivers that were granted by CMS to cover 144 telehealth services during the public health emergency. This is flexibility that allowed for a rapid and prolific expansion of services for our 24 million Medicare beneficiaries last year, just from mid-March to mid-October alone.

Depending upon how we implement it, telehealth can either make matters worse, or make them much better, with reference to health inequities. Barriers like transportation or affordable childcare are removed. It's a potential, with telehealth, to improve the patient experience by expanding language access and providing culturally competent care. It has also allowed family members to facilitate their telehealth appointments and be there to serve as advocates for vulnerable loved ones.

But the availability and cost of technology and broadband are crucial to make telehealth a successful care delivery model, particularly for economically disadvantaged individuals, or those with disabilities, for people of color, for people who are just not very tech adept. While audio-only visits can increase access, we also need to avoid a two-tiered system where affluent patients receive video and in-person visits, and low-income beneficiaries just get a phone call.

In his American Jobs Plan, about which we will hear more tonight from President Biden,

he has outlined an ambitious, $100 billion expansion of broadband infrastructure, a provision that appears to have garnered some bipartisan support.

With CMS telehealth waivers currently extended through the end of this year, we need a plan in place to assure no abrupt suspension. Though recognizing the great promise of telehealth, the Medicare Payment Advisory Commission, MedPAC, as we refer to it, last month noted that our understanding of the impact of telehealth is largely limited to data and experience covering only a very few months. It recommended that Congress initially provide a limited extension to permit a little additional time for gathering evidence about the impact of telehealth on access, quality, and cost. And while pay parity between telemedicine and in-person care has spurred rapid adoption, we also need to evaluate the impact on Medicare spending, and ensure a telemedicine appointment is not duplicating an in-person visit.

A number of our colleagues have introduced telehealth-related legislation. I particularly salute Mr. Thompson and Mr. Schweikert for their proposals for forming a telehealth caucus, and for their longstanding telehealth advocacy. While not a markup today, I hope that this hearing will enable us to move forward on a full committee markup on several bills in this area.

To implement the Medicare recommendations and -- MedPAC recommendations, rather, I will be introducing a bill of my own to extend existing telehealth waivers following the conclusion of the public health emergency. This will permit MedPAC and HHS to evaluate the impact on health care delivery, Medicare spending, utilization, as well as access to quality care in order to provide evidence-based recommendations to Congress regarding likely permanent changes to Medicare.

With Medicare representing, really, the primary subject matter jurisdiction of this Health Subcommittee, we are the stewards of Medicare, with a special responsibility to protect both vulnerable beneficiaries and taxpayers from telehealth fraud schemes which predated the pandemic and are not all that dissimilar from fraud that has impacted traditional health care

delivery.

The Department of Justice has reported that 50 physicians were responsible for $1.2 billion in taxpayer losses after ordering unnecessary back, shoulder, and knee braces. In another scheme, Medicare was fraudulently billed 2.1 billion for a cancer genetic test. I believe we can mitigate these scams by requiring an in-person appointment prior to ordering high-cost, durable medical equipment or major clinical lab test.

The anti-fraud provisions of my legislation would also authorize CMS to audit outlier physicians ordering DME and lab tests at high rates, and recover fraudulent payments, as well as to ensure that CMS tracks who is billing for DME and lab tests by requiring that any clinician who is able to bill Medicare directly use their own national provider identifier, the NPI, when they deliver telehealth services to a beneficiary.

I look forward to our hearing today from a strong panel of witnesses, from whom we have intentionally sought diverse views for what is, I believe, a bipartisan hearing. We look forward to your expert counsel in offering a blueprint for how to best chart a path forward on telehealth by building a system that promotes equity, expands access, and upholds program integrity to ensure that patients receive virtual care with tangible results.

[The statement of Chairman Doggett follows:]

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

*Chairman Doggett. And now I would like to recognize our ranking member, Mr. Nunes, for his opening statement.

*Mr. Nunes. Well, thank you, Chairman Doggett. I really appreciate you holding this hearing. Today we meet to discuss the future of a vital health care benefit and a crucial critical lifeline for millions of patients, and that is telehealth.

CMS data shows that, early in the COVID-19 pandemic, the national weekly average of telehealth users jumped from 13,000 per week to around 1.7 million. This dramatic increase partly stems from the unprecedented increase in telehealth flexibilities provided by Congress and the Trump Administration during the COVID-19 emergency.

Together we waived geographic restrictions to benefit patients nationwide, we removed originating site restrictions, so they can use telehealth to communicate with their doctor from their home, and we expanded the range of services that are accessible via telehealth, and we increased the number of providers who can use telehealth to reach their patients. We also increased technology options, which now include video conferences on a connected portal, FaceTime calls on an iPhone, and audio-only calls.

As a result, millions of beneficiaries who traditionally have been restricted in Medicare have received care via telehealth. Now we face a policy turning point. Today, after Operation Warp Speed led to the development of multiple COVID-19 vaccines, over 230 million Americans have been vaccinated. As even more Americans get vaccinated, and the country emerges from this awful pandemic, what is next for telehealth?

Ways and Means Republicans believe telehealth is a powerful tool that can improve access to care, empower patient choice, and, ultimately, make our health care system more effective and efficient. When we think about the future of health care, the health care system, one that is personalized, portable, and pays for value, there is no doubt that telehealth must be a key component.

For years Congress has incrementally integrated telehealth into Medicare through a series of strategic investments. And now the pandemic has allowed us to see and experience the positive benefits of telehealth unleashed through the Medicare program, and what they can deliver for patients. It would be a missed opportunity to turn back now.

This does not mean telehealth is perfect. There are still barriers to overcome. We know the Congressional Budget Office has historically scored telehealth bills at cost. We must also be vigilant for waste, fraud, and abuse. And we must realize that telehealth expands access to care for many people. Some seniors, though, face obstacles, such as lack of access to a reliable Internet connection, or difficulties operating the technology. I believe that, if we work together, these are all challenges we can overcome.

Telehealth has always been an area of bipartisan agreement, and I hope it will remain that way. Last Congress I released a discussion draft charting a way forward for telehealth.

Mr. Doggett, I want to thank you again for holding this hearing, and I think there is a lot of opportunity here for bipartisan work. And this is a huge issue that faces our whole country, especially during a public health emergency. So hopefully, this is the first step of many, and I look forward to, hopefully, having a bipartisan compromise, and perhaps a markup soon.

[The statement of Mr. Nunes follows:]

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

*Mr. Nunes. I yield back, Mr. Doggett, thank you.

*Chairman Doggett. I look forward to working with you on this.

Let's see if I can get unmuted myself here again. I think so.

Thank you for your helpful comments. I hope we can work together on this.

And I understand some of my opening comments were -- we had technical difficulties on them. Just in summary, I believe the members understand the procedures we are operating under today, and I will remind if we need that at any point along the way.

I think that telehealth, as I mentioned, is a term that is here to stay. We have an opportunity here to expand on it, benefit from it, as the ranking member has just said. And at the same time, we want to be sure, as we move forward and make some of these provisions more permanent, that we have assured good quality of care and have dealt with the issues. And that is why I think the MedPAC recommendations are particularly helpful.

I would also, of course, as is our normal procedure, if any other members have opening statements, they will be made part of the record.

And at this point let me welcome an excellent, diverse panel of witnesses to discuss our path forward for telehealth coverage: first, Dr. Sinsi Hernandez-Cancio is vice president for health justice with the National Partnership for Women and Families; Ms. Ellen Kelsay, who is president and CEO of the Business Group on Health; Dr. Thomas Kim, a Texan, who is a practicing psychiatrist and chief behavioral officer of Prison Health North Texas, who is here on behalf of the Texas Medical Association; Dr. Ateev Mehrotra, who is a physician and associate professor of health care policy at the Department of Health Care Policy at Harvard Medical School; and Mr. Joel White, who is the executive director of the Health Innovation Alliance.

We are pleased to have all of you here. Each of your statements, your written statements, have been circulated to the members of the committee, and will be made part of the record in its entirety.

I would ask you to summarize your testimony in five minutes or less. You may hear a gentle tapping here, on my part, as you near that time. To help you with the time, please keep an eye on the clock that you should be able to see, pinned to your screen. If you do go over your time, I will notify you.

So, Ms. Hernandez-Cancio, if you could, begin for us.

STATEMENT OF SINSI HERNANDEZ-CANCIO, JD, VICE PRESIDENT FOR HEALTH JUSTICE, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES

*Ms. Hernandez-Cancio. Good afternoon, Chairman Doggett, Ranking Member Nunes, and members of the committee. My name is Sinsi Hernandez-Cancio, and I am vice president for health justice at the National Partnership for Women and Families, which has been fighting for health and economic security for 50 years. I am honored to be here today to discuss how to make sure that the broader implementation of telehealth reduces, rather than intensifies, longstanding health inequities.

We believe that every single human being in this country has a right to live a healthy life. Yet our nation is plagued with persistent health and health care inequities that inflict worse health on and shorten the lives of Black, Latino, Asian American, Pacific Islander, and American Indian communities.

Many factors drive these inequities. One is a health care system that often fails us by making health care unaffordable, inaccessible, lower quality, and sometimes even biased. It can strip us of our agency, rob us of our dignity, and ignore our pain.

The pandemic has highlighted the structural challenges and underscored the urgency of rebuilding healthcare so it better serves everyone. The explosion of telehealth during the pandemic is an extraordinary example of our health care system's adaptability and innovation. Telehealth is and will continue to be integral to the future of health care, and it offers tremendous promise for improving access and addressing inequities. For women, especially, given the many needs we have during our lives, from maternal health, to mental health, to being caregivers, telehealth has the potential to be transformative.

However, telehealth is not a panacea. We must understand and guard against potential pitfalls and unintended consequences, especially in communities whose experiences tend to be

overlooked by those with power and resources.

This is a critical moment, and Medicare can lead the way in an equity-focused telehealth transformation. So I am here today to respectfully request that you take a pause, interrogate assumptions, and make sure decisions do not add insult to injury for people of color and other underserved communities through a vicious cycle of inequities that beget even deeper disparities.

I invite you to, instead, build a health equity virtuous cycle that -- to ensure that we all thrive together. It is not just the right thing to do, it is the smart thing to do. It is not only possible, but necessary to design health care delivery with equity at its center, and that includes telehealth. To do this, we must understand how policies and programs are implemented in many different contexts. By identifying barriers, we can proactively design opportunity structures to overcome them. I would like to flag three of these concerns.

First, we must -- the digital divide, which is deeper and wider than many believe. This became painfully clear as millions of families struggled with remote learning. And we cannot assume that everyone has the technical literacy and confidence to use the technology for something as critical as health care. So, for example, program design and reimbursement must support audio-only visits. For many people it is a critical access point, and patients should be allowed to choose.

Second, the intersection of quality and equity requires strong guardrails to prevent the proliferation of low-quality care through a two-tiered system, where some communities' health care needs are segregated to only telehealth. Telehealth must be an option for patients that complements, but not substitutes, high-quality, affordable, in-person care. To monitor this, we need quality measures and patient experience assessments, specifically for telehealth settings, as well as data that is disaggregated by race, ethnicity, subgroup, and other key factors.

Third, telehealth must be made affordable for patients and providers, many of which made significant investments to deploy telehealth during the crisis. Equitable telehealth requires

upfront investment, so that all providers can offer it, and cost sharing that is both predictable and affordable for patients.

We must pursue equity by design to fulfill the promise of expanded telehealth. This means that our concept of value-based quality care must evolve to center equity and person-centeredness. Let's start by investing in equitable infrastructure and passing President Biden's American Jobs Plan. Let's require and support collecting better disaggregated data to ensure that we prioritize the communities that are often left behind. Let's leverage technology to foster positive, trustworthy relationships between patients and providers, and expand culturally responsive care.

In short, let's pursue next-generation health care that closes gaps, not widens them. Our future shared prosperity depends on ensuring that we all thrive together. Thank you for your time.

[The statement of Ms. Hernandez-Cancio follows:]

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

*Chairman Doggett. Thank you so much for your testimony.

Ms. Kelsay, would you please proceed?

STATEMENT OF ELLEN KELSAY, PRESIDENT AND CEO, BUSINESS GROUP ON HEALTH

*Ms. Kelsay. Chairman Doggett, Ranking Member Nunes, and members of the Health Committee, thank you for the opportunity to testify on the current and future role of telehealth.

I am Ellen Kelsay, president and CEO of Business Group on Health, a nonprofit organization representing over 430 large employers who provide health and other benefits to over 55 million employees, retirees, and their families. Our members have employees in all 50 states, and they represent a wide range of industries. The Business Group's primary focus is to develop and advocate for innovative solutions in health, well-being, and workforce strategy rooted in employer-sponsored benefit offering. My testimony today will focus on telehealth utilization and design trends, and our recommendations for ensuring sustainable integration of telehealth into the health care system.

For years, Business Group members have been at the forefront in adopting innovative benefit designs, including virtual care and telehealth. Well before the COVID-19 pandemic, over 90 percent of our members were already offering some form of telehealth through their group health plans. In 2020, 78 percent of large employers saw increased utilization of virtual care solutions. Our members believe that these changes are likely to be permanent, with over 80 percent indicating that virtual care will significantly impact future health care delivery.

Although Business Group members are optimistic about telehealth, we must note that virtual care and telehealth are still in the early stages of development. Our data reveal that, while telehealth utilization nearly doubled from 2019 to 2020, there was a wide range of utilization rates across large employers, from 1 percent to 30 percent in the first half of 2020. We also note that the median utilization rate among our members was 5 percent as of mid-2020. This means that, first, there is room for much greater uptake and utilization of telehealth in coming years.

And second, that the long-term cost and quality effects of large-scale telehealth utilization remain to be seen.

Our members have identified the following reasons to exercise caution.

First, safety and quality. Inevitably, for some health care services, in-person, rather than virtual care, will be more medically appropriate. We believe that rigorous study of health outcomes and patient experience is necessary to ensure patient safety and quality of care.

Second, cost. We cannot ignore the high cost of health coverage. Virtual care and telehealth show promise in improving efficiency and cost effectiveness. But we also want to be cautious of ways that telehealth might increase costs over time. For example, our members have expressed concern that, for some health care services, a telehealth visit is often followed by an in-person visit for the same purpose, resulting in the employer and employee essentially paying twice for the same or very similar services. Again, we believe that rigorous study of telehealth and associated downstream cost is necessary to ensure that virtual care and telehealth do not, in the long run, result in costs that outweigh the benefits of this modality.

And third, equity and uniform availability. We encourage the subcommittee to consider the need for uniform availability of telehealth services, from a planned design and health equity standpoint. Our members strive to provide health coverage that is uniformly available and of uniform quality in all locations where they have employees. However, disparities in availability of providers, health care infrastructure, and broadband access often present obstacles in under-resourced communities and locations. We believe that employer-sponsored plans and governmental entities should continue working toward telehealth services that are uniformly available and of uniform quality across the country.

To address these concerns we recommend that the subcommittee members, other Members of Congress, and regulatory bodies consider the following.

First, expanding access to virtual care and telehealth by permitting interstate licensure of

providers, permitting telephone-only services when medically appropriate, and encouraging a national framework for telehealth for multi-state employers. We believe these measures are important steps toward expanding and maintaining equitable access to critical services.

Second, permanently extending flexibility to offer telehealth services on a pre-deductible basis to participants enrolled in high-deductible health plans paired with a health savings account. Again, this is a measure to ensure equitable access to telehealth services.

Third, permanently extending flexibility to offer telehealth services to employees who are not enrolled in an employer's group health plan. This flexibility will extend telehealth services to employees and their dependents who may not otherwise have access to these services.

Fourth, conducting independent study and analyses of health outcomes and costs associated with telehealth services, as compared to in-person services. Public-sector programs such as Medicare are in a unique position to conduct large-scale studies that will provide valuable, practical information on the costs and benefits of telehealth.

And fifth, extending telehealth flexibilities in the Medicare system that were originally authorized in response to the COVID-19 pandemic. This extension would expand availability of telehealth across the country and give agencies time and data to evaluate the costs and benefits of such availability.

These are preliminary steps that we believe will move the health care system toward evidence-based, efficient, and equitable telehealth services. As these services continue to expand, additional study, design changes, and policy changes may be necessary. We at the Business Group will continue on behalf of large employers to advocate for and disseminate best practices in virtual care, telehealth, and employer-sponsored coverage as a whole.

Thank you for the opportunity to testify today. We look forward to working with the subcommittee and other Members of Congress to promote and implement telehealth designs and best practices that improve access to high-quality health care for all Americans.

[The statement of Ms. Kelsay follows:]

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

*Chairman Doggett. Thank you so much.

Dr. Kim, would you proceed?

STATEMENT OF THOMAS KIM, MD, MPH, CHIEF BEHAVIORAL HEALTH OFFICER, PRISM HEALTH NORTH TEXAS

*Dr. Kim. Thank you, Chairman Doggett, Ranking Member Nunes, and members of the subcommittee. My name is Thomas Kim, an internist and psychiatrist from Austin, Texas. I am privileged to testify on behalf of myself, Prism Health North Texas, where I am the chief behavioral health officer, and the Texas Medical Association.

I am fortunate to have worked in telehealth for 18 years, and I wish to commend you on the intention to chart a path forward. This is analogous to my psychiatric work, assisting patients on their path to better health and wellness. And in an effort to seek simplicity on the other side of complexity, I would like to offer some potentially helpful framings for your consideration.

Every journey travels along a path, and for telehealth the path is broadband. You will likely know -- you likely know the importance of broadband, not only for health care, but for commerce, education, and more. The profound importance of a connected nation cannot be understated.

But just as profound is the challenge of constructing an adequate, accessible network. I am gratified by the FCC's emergency broadband benefit program, but please consider that our broadband need is more than just about access. Parts of our country are without available service, but for the three-quarters of Medicare beneficiaries who live in urban areas, it is an issue of under or non-utilization, rather than access. A broadband development strategy, therefore, must recognize the value of broadband beyond just health care, and consider collaborative solutions that better utilize existing and future resources.

Journeys typically have a destination and require skilled orienteering. For those in health care, our hoped-for destination is value-based care. It has been suggested that telehealth can help, but value-based care is more than one thing. My testimony is based on a career caring for

vulnerable populations, including incarcerated juveniles, the military, the elderly, people living with substance use disorders, and/or HIV. These experiences inform what I believe to be the true value of telehealth.

Telehealth is about the right doctor with the right information at the right time. We know the delivery challenges we face, which typically trace back to patients too often having to wait until an issue is a crisis, resulting in higher costs and poorer outcomes. Technology-enabled care offers opportunities to mitigate or avoid crises. And like orienteering, I submit telehealth is best understood as a skill to be mastered. I believe that the right doctor, your doctor, is best equipped to support you. Having your doctor skilled in telehealth improves the chances that they can be with you when you need them most.

There is no better example than Prism Health, the largest community health center in North Texas, specializing in the treatment and prevention of HIV. Prism implemented telehealth last year, hoping to sustain a trusted source of care. In about a month, Prism restored visit volumes to pre-pandemic levels, reduced no-show rates, and, more recently, achieved a patient-centered medical home designation with a distinction in behavioral health.

But that is not what is most interesting. Over time, the number of completed telehealth visits organically settled to about 30 percent of total visits. Claims data in Texas shows telehealth represents closer to 20 percent of all visits. The point to be made here is that, when your doctor is skilled with telehealth, they will utilize this means when indicated or necessary. But telehealth is neither a replacement solution, nor is it strictly additive to conventional care.

Health care regulations serve as guardrails to preserve public safety. Historically, telehealth led many to view it as something else, requiring separate rulemaking, which often led to rules that suppressed further development. Then the global pandemic led to the relaxation of rules. The result was, to coin a phrase from patient, a gift from the pandemic.

Years of progress were condensed into months. The question at hand is, what now?

I invite you to examine the legislative history of Texas. The 2017 session yielded an agreement that telehealth, or, more accurately, telemedicine, was medicine. Questions around telemedicine guidance were referred to existing medicine guidance, including demonstrating a therapeutic relationship. The 2019 session led to service parity. Payers are free to cover any service, with the understanding that it does not matter how, so long as regulatory expectations are met. In our current session, the conversation is payment parity. Payers are once again free to cover any service, but a covered service should be paid at the same rate, whether conventional or telehealth.

Texas highlights that the long road to regulatory guidance can be developed without reinventing the wheel, and simple is preferable. To suggest a return to pre-pandemic complexities around rules or reimbursement would be akin to detouring a traveler onto a dirt road. No one would willingly choose this route, and any benefit from telehealth would likely be lost.

I am also aware of additional concerns around telehealth adoption. But in the interest of time, I would say that some of these concerns, such as fraud, are not exclusive to telehealth. And other concerns, such as over-utilization or licensure, can be productively worked through with some of the framings I have shared.

I appreciate the subcommittee's efforts and ask that we work to support all my colleagues in creating an environment for telehealth that provides timely, informed care, expands their reach, and is proactive, rather than reactive, in the care of all of us. Thank you.

[The statement of Dr. Kim follows:]

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

*Chairman Doggett. Thank you for your insights, Doctor.

Dr. Mehrotra, would you proceed?

STATEMENT OF ATEEV MEHROTRA, MD, MPH, ASSOCIATE PROFESSOR OF HEALTH CARE POLICY, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

*Dr. Mehrotra. Well, thank you, and I thank the members of the subcommittee for inviting me to speak to you, all of you, about a topic of such importance to Americans and their health. My name is Ateev Mehrotra, I am a physician at the Beth Israel Deaconess Medical Center, and a professor at Harvard Medical School, where my research focuses on telemedicine. Today I wanted to focus -- emphasize several points from my written testimony that the committee members might consider as they shape the future of telemedicine policy.

I think the first key issue is, given there are so few regulations and payment policies specific to in-person visits, why do we even need telemedicine-specific policies? The key point here is that telemedicine's ability to make care more accessible, the key to its enormous potential to improve the health of many patients, may also be its Achilles heel. It can be too convenient in some circumstances, and this convenience translates to more care and increased spending, and this puts government payers and insurers in a very difficult situation: How do we build upon the remarkable success of telemedicine during the pandemic to improve access, without substantially increasing health care spending?

And the likely path forward is to compromise, to expand telemedicine coverage beyond what was available prior to the pandemic, but not maintain the current broad extension. How can this compromise be achieved?

In my testimony I argue that value should be the lens by which telemedicine policies should be evaluated, and value simply means that how much improvement in outcomes or access is observed, and what cost. However, value is an abstract idea. What does this mean, concretely?

A high-value use of telemedicine could be a patient living in a rural community with poorly controlled depression, who receives care from a specialist they otherwise could not see, or a patient with diabetes, who struggles to get to appointments, who can now check in with her primary care physician more frequently and improves the control of her sugars.

But what do low-value applications look like? A person with well-controlled depression who has a weekly check-in with his social worker. It is so easy; he doesn't have to worry about the inconvenience of travel. Or a person who thinks they have a cold, but just checks in with -- has a video visit, because it is so easy to get an appointment. The point I wanted to emphasize with these low-value applications is they are not malicious, but, in aggregate, they may greatly increase the amount of care that Americans might receive, without substantially improving their health.

In my written testimony I outlined a number of policies that I hope will encourage higher-value uses of telemedicine, and discourage low-value uses of telemedicine, and I wanted to touch upon two particularly thorny issues: audio-only visits, as well as payment parity.

Audio-only telemedicine visits are a fancy name for a phone call. And it is key to recognize that many people in the United States, in particular those in rural communities and poorer communities, cannot have a video visit because they don't own a computer, or they don't know how to use their smartphone, or they have no high-speed Internet. And for these Americans, a phone call may be the only form of telemedicine they can receive.

However, I think there are appropriate concerns that a phone call may not be adequate to address many clinical problems, and that phone calls are more prone to overuse and fraud. As Chairman Doggett outlined, we risk a situation where we create a two-tiered system. The wealthy receive video visits, and the poor have phone calls. And I believe the longer-term solution is not to pay for phone calls, but rather, ensuring all Americans have access to video visits.

So I have advocated for a temporary period, one to two years of covering phone calls, with the hope that this time will be used to accelerate the efforts we have in the nation to expand the availability of needed technology for broadband coverage.

I have also advocated that we pay for telemedicine visits at a lower rate than for in-person visits. Critics argue that lower payment rates will mean that no providers will use telemedicine. I disagree. While I recognize that implementing telemedicine requires investment in the short term, I believe, in the longer term, a provider's cost for telemedicine visits will be lower, due to less overhead per visit. And payment should reflect those lower costs.

Thank you again for this opportunity to speak today before you on this critical topic, and I look forward to your questions.

[The statement of Dr. Mehrotra follows:]

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

*Chairman Doggett. Thank you, Doctor.

Mr. White, would you proceed?

STATEMENT OF JOEL WHITE, EXECUTIVE DIRECTOR, HEALTH INNOVATION ALLIANCE

*Mr. White. Thank you, Chairman Doggett, Leader Nunes, and members of the subcommittee. I want to thank you for inviting me to testify today.

My name is Joel White. I am the executive director of the Health Innovation Alliance, or a HIA. HIA was started in 2007 as a diverse coalition of advocates who support the adoption and use of data and technology to make health care basically work better. Our membership agrees that one of our top priorities is to improve care by expanding telehealth, and I think, you know, telehealth and other digital health tools have been gaining traction in Medicare and in the private sector, literally, for decades.

But COVID really changed everything. It changed the willingness of doctors and hospitals to deliver care at a distance, and to monitor patients remotely. It also changed consumer attitudes towards receiving care in their homes. And at the same time, these silly government rules that have been in place for several decades were waived by both Congress and the Administration so that people could use telehealth effectively in the middle of a pandemic. And I think what we have seen has been absolutely remarkable.

HHS, MedPAC, IQVIA data all show that, as in-person visits plummeted in the early days of the pandemic, telehealth visits increased. Basically, telehealth filled the gap. And for example, just in primary care, before the pandemic one percent of primary care visits were delivered via telehealth. Immediately after COVID came ashore, primary care visits were delivered via telehealth more than 40 percent of the time. But then, several months into the pandemic, I think the situation began to change. Restrictions on voluntary care were loosened, and people became basically more comfortable returning to physician offices and hospitals, and in-person care increased as telehealth care abated, particularly in the Medicare program.

So this natural experiment has taught us some things. And you know, you asked the question: What have we learned?

Well, I think, first, we learned that telehealth improved access to care for many. It is a solid investment.

Second, I think we saw longstanding health disparities laid bare. And I think we learned that the need to invest in tools like broadband for underserved populations, really, is becoming readily apparent.

And third, I think we learned that, as Congress and Medicare took the reins off, and really eliminated these restrictions, and basically paid telehealth the same rate, in many cases, as in-person care, the total care of costs -- the total cost of care didn't explode. In fact, total diagnosis visits in 2020 are about 20 percent less than where they would have been without COVID. And, according to some economists, they are estimating that total health care spending in 2020 is about 2 percent less than it was in 2019. So these numbers require more precise examination, but the cost explosion doesn't appear to have happened the way some thought it would.

So, considering these lessons, HIA members make three primary recommendations.

I think, first and foremost, we must modernize the Medicare program. The silly rules that we have talked about, that have been put in place very long ago, should be updated to reflect modern-care standards. Congress should permanently extend flexibilities enacted during the public health emergency.

Secondly, I think Congress should also require MA payments to be risk-adjusted for audio-only visits, not just video.

And third, I think Congress should pass the Schweikert-Rush-Kelly START Act to provide telehealth-enabled, at-home COVID testing.

So that is modernizing Medicare. The second bucket of recommendations we make is -- we know there has been concerns about over-utilization and fraud. We make three

recommendations here.

First, you know, I think we are always going to have bad actors, whether that care is delivered in person or remotely. Congress should provide more resources to the OIG to audit the top five percent of billers for telehealth. Outliers can be flagged for subsequent investigation. This is pretty standard practice for the private sector.

Second, care that is delivered remotely uses systems that are able to better track and monitor what is being done by who, to whom, when, and for what reason. And many industries use advanced analytics and artificial intelligence to quickly identify and stop fraud before it happens. HHS should be directed to expand the use of these tools, specifically for telehealth.

And third, any participant in an alternative payment model and fee for service should be allowed to use whatever modality they wish to use. Incentives help ensure appropriate care.

And then my last point is to urge you to address issues outside of Medicare. There are five times as many Americans in employer plans than in Medicare fee for service.

First, I think we need to allow workers to permanently use first-dollar coverage for telehealth services as part of an account-based plan.

And secondly, we really need to update our medical licensure laws, and flex things up for employers and others.

So thank you for the opportunity to testify today. I am happy to answer any questions you might have.

[The statement of Mr. White follows:]

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

*Chairman Doggett. Thank you for your insights.

Without objection, each member will now be recognized for five minutes to question our witnesses. I will be calling folks in seniority order. We will be switching back and forth between majority and minority members. If we get too out of proportion later, we may go to two and one. But for now, just back and forth.

Members are reminded to unmute yourselves when you are recognized for your five minutes.

Before I begin my own questioning, I do want to draw the attention of all of our committee members to other statements in addition to those we just heard orally. We couldn't hear everyone orally, but we have some important statements that I have circulated on the topic of today.

Dr. Ashley Garling, who is a clinical assistant professor of pharmacy at the University of Texas, has been designing telehealth training for new health care providers on how to provide culturally and competent quality care.

We also have a statement from Dr. Norm Chenven and Dr. Daghestani from Austin Regional Clinic -- that is a major physician group that I know well here in Austin -- who have described their experience, and the high patient satisfaction that they have had with their first principal use of telemedicine this past year.

Additionally, we have important statements from the American Physical Therapy Association, the American Occupational Therapy Association, the American Medical Association, the American Academy of Neurology, and the American Hospital Association.

All of these have been circulated to members and to your staff.

I do appreciate the testimony that each of our witnesses has provided, as we explore telehealth in this telehearing setting. The COVID-19 pandemic has, of course, presented such immense challenges for us. We begin to get in today to how we will deal with a post-pandemic

America when it comes to delivery of health care services. So let me begin my questions now, and I will begin with our first witness, Ms. Hernandez-Cancio.

I appreciate your thoughts about taking a pause and interrogating assumptions, as you presented them. What do you view as being the best way to deal with getting physicians to deliver culturally competent and high-quality telehealth services to vulnerable and economically disadvantaged communities?

*Ms. Hernandez-Cancio. Thank you so much for that question. Telehealth is a powerful tool to extend health care beyond the medical office, but that means that all of the underlying gaps and issues in health care system could also extend into people's homes.

So it is really critical that we monitor access, use, and outcomes, not just on average, but really disaggregated data. And that means gender, race, ethnicity subgroups within these categories, and other important factors like English fluency, literacy, and disability status. So that way we can identify pain points and correct.

But that said, we really need to ensure that, across the board, not just for telehealth, medical professionals and their staff are fully trained on issues such as implicit bias, the impact of toxic stress, including racism, and how to provide respectful, trustworthy communications with patients, and patients that can be very, very diverse. This is a starting point.

And then, on top of that, we need to layer on specific training about providing high-quality telehealth. And for that we need a nationally recognized telehealth curriculum that also allows for more focused training on issues of highest concern in particular regions and communities.

So communities know what it is that they need, and communities are the ones that know where the pain points are. So ensuring that it is not just a national curriculum, but that there is also real consumer and patient and community engagement to make sure that the issues that are most problematic for their -- for specific populations are addressed by the providers that are

trying to care for them.

*Chairman Doggett. Thank you so much.

Ms. Kelsay, I have heard even a suggestion that some would want to replace in-person care with video or teleconferencing and telehealth only, and that the plans could be changed to offer only that benefit. Can you describe some of the challenges that your members currently face in integrating telehealth benefits and ensuring patients' regular physicians have their comprehensive medical records?

Describe the importance of providing employees comprehensive health coverage, with telehealth as one alternative, but as not -- not as a total substitute for their regular doctor.

*Ms. Kelsay. Absolutely. I think it really speaks to the power of integration, and the importance of integration, and that telehealth services should, ideally, be a part of a comprehensive health coverage offering, rather than the only source of coverage.

Telehealth, really, should be incorporated into the delivery system overall, not viewed as separate or adjunct to it. It is a modality within the delivery system. And to that end, it is critically important that coordination and integration occur, both from a care delivery perspective, but then also from a data and reporting perspective, regardless of who it is that is providing the services, whether it be their traditional in-person provider, or an on-demand telehealth provider.

For some services, on-demand providers may actually be desirable to some employees. But again, that should not be viewed as separate and distinct. One example might be mental health, where they would prefer to seek counseling through a virtual arrangement, rather than going in person. But again, the importance of coordination, both in the care and data perspective, really are critical at this point.

*Chairman Doggett. Thank you very much.

Dr. Kim, I wonder if you might comment on how, in your experience, the care offered by

these on-demand telehealth services differ from what you -- the type of service you have described that you provide to your patients.

And don't you believe that, in most circumstances, in establishing that patient-physician relationship, it is important that there be an initial physician -- a physical visit with the physician?

*Dr. Kim. Thank you, Chairman Doggett. Like most good questions, the answer is not easy or simple.

What I can say is that my particularly -- the way that I frame telehealth, as the right doctor with the right information at the right time, is sort of a hard-fought realization after 18 years of effort. And over those years what I have witnessed is telehealth differentiate into more than one thing.

And while I think that the intent of telehealth can include all of the various forms and models of care, perhaps the most stark difference in comparing the work that I do -- right doc, right information, right time -- with someone else would be sometimes you get a doctor with limited-to-no information at the right time, which is certainly an improvement over no doctor, no information, and no time.

And so what I can say is that, in my general approach, if our destination is value-based care, we have our quadruple aim of quality, cost, equity, and wrapped up in a patient-centered wrapper. I believe that we will have more positive impact by supporting an environment for the over-one-million licensed practicing physicians to cultivate the skill of telehealth, to be able to, in their existing and future therapeutic relationships, be able to be that right doctor with the right information at the right time, and in doing so, move us further towards that destination.

As has been commented before, there is a role for all manner of models and approaches. But the one that I choose to pursue is this.

*Voice. Your membership was drawn to receive a complimentary stay.

[Pause.]

*Chairman Doggett. Thank you, Doctor -- interruption here at home. Let me then turn to Dr. Mehrotra.

Doctor, I guess, really, my question is what do we not know now about telehealth that we need to know in order to proceed with permanent legislation?

Or, put another way, what are the major relevant questions?

Because we do have considerable information, both before the pandemic and during the pandemic. What else do we need to know that would require further study, before having more permanent legislation?

*Dr. Mehrotra. Yes, I think we were learning a lot before the pandemic and during the pandemic. But I think one of the critical questions that we don't know the answer to is, what will be the impact of telemedicine on total utilization?

Unfortunately, I don't think we can really use the experience of the pandemic to really answer that question. People are appropriately -- Americans are appropriately a little nervous about getting care right now. And I think what we need is the experience after the pandemic, with a broader expansion of telemedicine, to really inform our future policy.

So one of the things I have been advocating for is a short-term expansion of telemedicine, use that experience, as you and others have articulated, for MedPAC, CBO, academics like myself to learn from that experience, and then inform the future policy permanently after that.

*Chairman Doggett. Thank you very much.

And now, Mr. Nunes, would you proceed with your questions?

*Mr. Nunes. Well, thank you, Mr. Chairman. Just to make this go a little bit easier here, because of the technical challenges, I am going to gear all my questions to Mr. White, the Republican witness.

*Chairman Doggett. Great, I am sorry I didn't get to reach him myself.

*Mr. Nunes. All right. I am going to direct all my questions to Mr. White, here.

And Mr. White, I am going to have three different questions for you, and then I will just let you kind of take your time and my time to answer them.

So we have a lot of witnesses today. I think everybody has general optimism, but some people were kind of concerned about making these -- overcoming some of these challenges and had some concern about making these flexibilities that we have done in the last few years permanent. So I wanted to know if you could, first, kind of address some of the issues that some of the other folks who testified today had.

Second would be that MedPAC has suggested that Congress extend telehealth flexibilities to gather more information about how it would impact Medicare, and whether or not -- the second question would be whether or not Congress would need to make a temporary extension so that we could study this issue more.

So, as you can see, both question one and two are related.

And then, you spoke in your testimony about licensure, and that makes health care more personalized and portable. I think, just for the record, if you could, give us some more detail about licensure flexibilities that you mentioned among VA, DOD, and employer plans.

And with that, Mr. White, I will give you what time I have left to, if you could, answer those questions for the record, please.

*Mr. White. Yes, thank you very much. They are important questions.

I think that, you know, when I think about the permanence issue, I think we need to move quickly to make these flexibilities, in fact, permanent. You know, we have been grappling with some of these issues, in some cases, for decades, Leader Nunes. When -- a long time ago, when I was actually on the committee staff, we were dealing with many of these same issues, and that was 20 years ago.

And I think what we know is that, during the pandemic, when the rules and the reins were

taken off, consumers leaned on this technology very heavily. And so it fills a very critical gap in access for a lot of people. And that was, you know, 100 percent critical for populations, patient populations, throughout the pandemic. So we know that.

I think we don't -- we have less information on cost, but as I indicated in my oral testimony, we don't see the cost explosion that we were expecting, even though we were paying, in many cases, the same rate as in-person visits. So you eliminated the restrictions, and you paid the same rate, and you really didn't see what we thought we were going to see, at least not yet. We don't think so.

And the third thing that we don't know is some of the quality issues, and I think those are particularly related to sub-populations, but that is not a reason not to go forward permanently. And I think the MedPAC report -- and I think this is very important -- MedPAC did not make a recommendation. They have a policy approach that was issued in their March report. The commissioners haven't voted on it yet. They put it into, you know, in their report for congressional consideration.

I think the big thing for me is that one of the recommendations is that it would reverse the flexibility around cost sharing for Medicare beneficiaries. So we would go back to charging full cost sharing for patients as they access telemedicine, and that is a cost increase. And for people who are concerned about low-income, certain demographic categories and classes, that is going to be a hit, and that is going to harm access.

So I don't think we need to consider this anymore. I don't think we need to study it anymore. I think we need -- Congress needs to move forward and permanently authorize this. And if there are challenges or problems going forward, Congress can adjust the law. So I am a strong proponent for permanency. I don't think we need to study this anymore.

On the licensure question, I think there is a couple of things you can do. The least thing you can do is the TREAT Act. The TREAT Act was introduced by Congressmen Latta and

Dingell, and basically it would say that, if you are a physician in good standing and licensure, you could treat anyone across the U.S. without having to get a duplicate state license.

I think these, you know, state licensures -- it is not like medicine or science is different in California than it is in Texas. There are different norms, there are different cultural competencies and things that people use in treating people, but the science is the same. And so, you know, basically, the TREAT Act would say you can do what you can do in Texas and California, and vice versa, without having to get duplicate state licenses.

What we have seen in the DOD and VA world is that -- we said it is a federal program, with doctors who are providing a federally defined benefit to beneficiaries all across the country, in some cases the world. And so we had a movement to a single licensure model in both programs that Congress authorized. And what we have seen, as a result, is an increase in telehealth, and an increase in care delivered, and an increase in improved care outcomes in both programs. So that is a model that you could replicate in Medicare and, probably, elsewhere.

*Mr. Nunes. Well, thank you, Mr. White, and welcome. I should have welcomed you back to the Ways and Means Committee. I know you are excited to be back here, a long-time staff member. And I know -- I am sure you miss it, but it looks like you are doing well. And I remember working with you on these issues back when you were on the Republican staff of the Ways and Means Committee. So I am glad to see that you are still working hard on these telehealth issues.

And thanks for -- thanks to all the witnesses for appearing today.

Mr. Chair, I will yield back.

*Chairman Doggett. Thank you. Thank you, Mr. White and Mr. Nunes.

Mr. Thompson?

*Mr. Thompson. Thank you, Mr. Chairman, and thank you for holding this hearing.

As you know, I have been working on telehealth for almost 30 years now, and this is the

first time since I have been on the committee that we have dived into the subject. So it is great that we are doing this. I am grateful to you, and for the excellent witnesses that we have today.

You know, more than two years ago I introduced the bipartisan, bicameral legislation called CONNECT for Health Act. That bill included language allowing HHS to expand telehealth in Medicare during emergencies. And six months later, the pandemic started, and that language was signed into law as part of the very first COVID response package. That was over a year ago.

Thirteen months later, telehealth is one of the few silver linings of our COVID-19 experience. And because Congress acted swiftly, millions of Medicare beneficiaries have been able to visit their doctors remotely, without risking exposure to the virus. And millions of providers have been able to stay afloat by providing care virtually.

I can tell -- I can't tell you how many people have come to me from my district and from across the country, urging Congress to make these services permanent. And that is why, as we round the corner from COVID-19, it is time for Congress to act once again.

I have another bill making permanent much of the expansion of telehealth in Medicare that we have seen over the last year. I am proud to have written that bill with my colleague on this committee, Mr. Schweikert, and am pleased at the robust, bipartisan support we have received so far.

I know there are important questions still to answer, many of which our witnesses have been speaking to. In particular, it is critical for us to focus on three points.

First, we need to maintain the stability of the Medicare Trust Fund. When done right, telehealth saves money. It should not simply drive-up utilization costs.

Second, we need to expand telehealth equality. Telehealth can help address so many of the inequities in our health care system, many of which are a top focus of our committee. But we need to do this right. We can't let telehealth become another division between the haves and the

have nots.

And third, we need to monitor the quality of care. If we are going to send taxpayer dollars -- spend taxpayer dollars on telehealth, those services need to work. This is, first and foremost, about patients and health care make more sense in some areas than care in -- than others (sic). And that is what I would like to ask our witnesses about. And I will start with Dr. Mehrotra.

Dr. Mehrotra, in your testimony you called for making permanent much of the telehealth flexibilities in place during the pandemic. But you also highlighted, with admirable precision, the challenge posed by high-value versus low-value health care. Can you talk a little more about how Congress can balance those priorities?

In other words, how can we make as much of the telehealth flexibilities in place permanent, while incentivizing high-value care whenever possible?

*Dr. Mehrotra. Well, thank you, Representative Thomas -- Thompson, for doing all your work in this area. I think it is so critical, and the caucus's work.

Specifically on the high-value versus low-value applications, the other area that the Congress could consider, and has already done so, is to consider selectively expanding telemedicine for select conditions. Now, in the FAST Act you have expanded telemedicine for stroke care. In the SUPPORT Act you did it for substance use disorders. And more recently, you have expanded access for mental illness. And in the same way that the Congress could say, "These are certain conditions for which we feel telemedicine is most important," maybe the one that I would focus on is chronic illness.

We all recognize in the United States how poorly conditions such as diabetes, hypertension are controlled. And it could be, just as several states have done, that the Congress could expand telemedicine for those high-value applications.

*Mr. Thompson. Thank you very much. And Dr. Mehrotra, we have always kind of

focused telehealth on dealing with problems in underserved areas. But is it fair to say that well-served areas can benefit from this, too, as a time management tool, better access to health care, while managing family needs and job needs?

*Dr. Mehrotra. I think that is a really critical point. As we all recognize, getting to your doctor's office, coming to see me in clinic, is a pain. It takes a lot of time out of people's -- valuable time out of people's lives. And so we should always emphasize and recognize that, in many cases, if the visit can happen via telemedicine and save Americans time, that is going to be a very valuable benefit of telehealth.

*Mr. Thompson. Thank you --

*Dr. Mehrotra. Especially for poor communities.

*Mr. Thompson. Thank you very much.

And again, thank you, Mr. Chairman. I yield back.

*Chairman Doggett. Thank you very much.

Mr. Buchanan?

*Mr. Buchanan. -- very important hearing today. I agree with you, this is a real opportunity for bipartisanship. Telehealth is a very important topic. I hope that this hearing is the first step in our subcommittee's path forward to forging a strong bipartisan consensus on a robust telehealth policy framework for the future.

I am privileged to represent one of the oldest congressional districts in the House. There are more than 225,000 seniors in my district. For my constituents, telehealth has been a lifeline for them, so they could stay at home and still access medical services.

Mr. White, let me ask you. Many of my colleagues and I recognize the importance of long-term expansion of telehealth and have legislative proposals to enact permanent telehealth guidelines that last after the pandemic subsides. What can we do to ensure that the standards of care remain uncompromised if Congress enacts a long-term expansion of telehealth, Mr. White?

*Mr. White. Yes, I think that the protections that we have in place in Medicare to ensure that the medical professions and societies and -- are respected, need to be listened to. We don't want the CMS bureaucracy necessarily determining what is appropriate, what is not appropriate. I think that, you know, when we think about COVID, in many cases some people experience it as cold or flu-like symptoms. I think, if we say that that is low-value care to be accessed, or maybe denied access via telehealth, that is not a good thing, because we want people -- we want to catch that, and appropriately quarantine people early on.

And so, you know, I would recommend keeping it in the medical professionals and the societies, so that we -- you know, we have medicine and science driving the determination, versus program rules and bureaucrats.

*Mr. Buchanan. Yes, let me ask the other thing. One of the big things that we are all concerned about is the -- how do we bend the curve on health care?

You touched a little bit on cost. As someone that has been in business for 40 years, and provided health care, I see myself and others over the years. A lot of the cost goes up for small businesses, but at the same time some of that cost can't be totally absorbed by the small businesses, so it is pushed through to working families and individuals. And many times it could be $500 or $600 a month that they don't have. And that has been going on in the last 10 years. It is slowly moving that way, that direction, I would say, in the last 20 years, based on the experience, what I have seen out there.

So you touched on cost. Do you see this as a way of having some benefit, and moving costs lower in terms of providing health care more efficiently?

Because I am very concerned about, you know, the whole thing on Medicare and cost just imploding if we don't find a way to start being more thoughtful about this. I think telehealth is an area where it could make a big difference. What is your thoughts?

*Mr. White. I would agree with you, Congressman, and I think that, you know, one of

the reasons why we see employers and health plans in the commercial markets moving aggressively to adopt telehealth is because they know it saves money. They wouldn't adopt it, otherwise, in my opinion.

So it is really a strategy that helps to treat someone in the home, versus having them go to the emergency room, which we know is 10, 20 times more expensive than the simple telehealth visit. So there are smart ways to go about doing this that really could have long-term fiscal and budgetary -- you know, employer budget and family budget -- implications, but we need to do this smart.

I think one of the challenges we are wrestling with here is that these rules apply to Medicare fee for service, and fee for service carries with it incentives, in many cases, to over-prescribe or over-utilize, whereas the traditional employer plans, or more managed care-type arrangements, or value-based-type arrangements really don't carry the same incentives.

That is why our recommendations include moving very quickly to value-based care structures that would allow telehealth to be a part of that, and then let the doctor decide whether they want to use telehealth or an in-person visit, whichever is most important or applicable in that situation. That saves a lot of money.

*Mr. Buchanan. Yes, and let me just say in closing, Mr. Chairman, this is a real opportunity -- I think we all sense that -- to make a big difference this subcommittee, and I look forward to working with you and seeing if we can't, all of us working together, get something -- a great product moving forward. Thank you, and I yield back.

*Chairman Doggett. Great. Thank you very much.

Mr. Kind?

*Mr. Kind. Well, thank you, Mr. Chairman. And Mr. Chairman, much appreciation to all the witnesses and their testimony today. They have all done a terrific job. And just to pick up on what Mr. White was -- I couldn't agree with him more, that there is a real opportunity to

improve upon value-based care, even with telehealth services out there.

But, Mr. Chairman, as you know, I represent a large rural Wisconsin district, and telehealth has been a lifeline for services for my constituents. And I feel -- and I think most members do feel -- that there is no going back at this point. We have to find a path forward to amplify the telehealth, the convenience, and improve upon the quality of care.

And Dr. Mehrotra, let me start with you. You did draw a point of distinction between audio-only versus video, and I think concern about a diminishment in quality of care with audio only. Let me tease that out with you a little bit more. What more, specifically, are you worried about with just audio telehealth?

Because you are recommending a one or two-year extension to get -- buy time for broadband expansion. And again, that is something that we absolutely have to do, but I am a little less optimistic that we are going to be able to close that digital divide in one or two years. We are going to have to maintain some flexibility with audio, going forward.

*Dr. Mehrotra. You know, I -- first I thank you for the -- very much for the question. I think you raise a really critical point.

And one thing we will -- I will highlight is that, while we -- in the pandemic we have been tracking the use of telemedicine in the Medicare population, well, there -- if there is a very clear discrepancy or disparity, it is between urban and rural areas, where rural Medicare beneficiaries are much less likely to use telemedicine.

I also -- it is also quite striking to see that because, before the pandemic, rural communities were using telemedicine at a much, much higher rate, and it was very expansive. There was very rapid expansion in rural communities. So it is a little unfortunate that there has been a flip there.

The one thing I would emphasize is, beyond having -- one of the reasons that it was able to grow in rural communities is because rural beneficiaries were able to go to their doctor's

office, where there was broadband, and that was able to facilitate those visits. And so that is one thing I do think we should consider, as we think about the future of telemedicine policy, is do we create these telemedicine hubs within rural communities so that patients can go there, and have both the video equipment, the broadband, as well as other ancillary equipment such as digital stethoscopes, digital otoscopes, et cetera, so that they can really receive the highest-quality care that they can receive that they wouldn't be able to get from a phone call.

*Mr. Kind. Yes, that is an excellent recommendation, one that we certainly want to follow up with you and MedPAC on.

Dr. Kim, let me shift to you. Obviously, our congregate care facilities, from long-term nursing homes to care facilities to juvenile detention centers, prisons, jails, they were hit particularly hard during the pandemic. Now, moving forward, is there going to be a key role for telehealth services in those congregate care settings, as well?

*Dr. Kim. I think that is an unqualified yes. The institutions and the facilities that you referenced have always been on the leading edge of telehealth sort of exploration and development of services. There is a lower bar, given the infrastructure support that those facilities have.

To sort of key off of your prior question and Dr. Mehrotra's response, what we can learn from our past I referenced in this idea of creative, collaborative innovations. There is perhaps an equal, if not greater, amount of energy and attention being brought to the educational domain, with regard to how the pandemic sort of hit us all from left field, and there was a significant disparity in children being able to access their classes. Pooling all of those resources together to create, as Dr. Mehrotra suggested, a hub in rural areas, working with middle and last-mile partners towards creating more, again, creative, and inventive, collaborative processes that support our fellow Americans everywhere, I think, is the path forward.

We have a finite amount of resource. I believe that we can do better with what we have

in improving the care of everyone.

*Mr. Kind. And we have kind of an example of that within the VA system already, those hubs being established for telehealth that I have noticed.

But Mr. White, with the remaining time, you said there was no cost explosion during the pandemic. Good. But is there a concern that we need to share == that when people figure it out, when they get comfortable with telehealth, that we are going to see a huge increase in utilization, maybe fraud, that it is not going to lead to quality outcomes?

*Mr. White. Yes, I think we should always be concerned about bad actors, particularly in the Medicare program. I think we have seen discreet examples of fraud, both telehealth and telemarketing-type fraud, since the pandemic began. And -- but I do think that, you know, we can use tools to stop that.

And, you know, the AI and machine-learning-type tools are really good at pulling data from a lot of different sources, spotting this stuff, detecting it, and stopping it before it happens. My understanding is the HHS inspector general is already deploying these tools. I think Congress needs to direct the HHS IG to specifically do it in telehealth. Because, again, getting this benefit in place permanently, you know, is important. And if you are concerned about fraud or over-utilization, give them the tools to be able to spot it and stop it. And then, if you need to make a program change in the future, after you get some additional data, do that. But don't do something temporary. Go permanent.

*Mr. Kind. Right. Thank you. Thank you, Mr. Chairman.

*Chairman Doggett. Thank you.

Mr. Smith?

*Mr. Smith of Nebraska. Thank you, Mr. Chairman, thank you to all of our witnesses and colleagues for gathering today. It is certainly, I think, timely that we have this discussion. I think we can take away from COVID these expanded telehealth flexibilities that I think can

really help the American people. Hearing from patients and providers how important it is that we offer flexibility with new technologies is absolutely vital.

I have been working on this issue because I represent one of the most rural districts in the country, and we know that increasing telehealth increases access and options in -- not just in rural areas, but urban areas, too. Certainly, there are challenges across the population spectrum.

You know, I think it is important to note I have been working on removing distant site and original site restrictions for safety net providers like rural health clinics and federally qualified health clinics. And I believe that this can dramatically expand access to primary care in rural and, really, all underserved areas. And we have seen this happen in real time, as these clinics have taken advantage of new flexibilities to connect with their patients.

Obviously, we still have challenges. There are still gaps in cell phone coverage -- rural and urban, I might add -- that -- you know, that access to communication is -- it is not, I think, what we want it to be, and what it needs to be, but certainly we can't let some of those shortcomings stand in the way of moving forward on telehealth.

Let's talk about audio-only visits for a bit here. I know that this has raised some concern, you know, that a simple telephone call -- that invites some fraud, perhaps. Just like with any medicine, you know, the initial communication can be very important, and the quicker it takes place, the more timely that is. Obviously, that is important, and can prevent more complications from taking place.

So Mr. White, I was wondering, can you speak to perhaps any large-scale fraud that might take place, or that has taken place with audio-only communication?

I get there is a time and a place for all of this, but can you speak to any large-scale fraud from audio only?

*Mr. White. Yes, I think that one of the things that the inspector general has raised is that there, you know, there are some unscrupulous individuals who are using telephone calls to

order DME and other products that -- you know, or to use schemes in order to bill for those products and services.

And, you know, I kind of liken it more to a telemarketing fraud or a scam. And, you know, here -- you know, we see this a lot in stolen iPhones, or unlocking iPhones or other types of mobile devices. And, you know, one company, for example, H2O AI, has done a whole program with AT&T, where they have they have reduced fraud by 80 percent through applied machine learning and, you know, saved about $1 billion a year. IBM does a similar program with other telecommunications firms.

I mean, this is stuff that we know about in the market, in the commercial market, that happens on a daily basis, that companies are really good and sophisticated about stopping in its tracks, and that is why I am saying, like, this needs to be a major focus. As we expand telehealth, recognizing that that is where employers want to go, that is where consumers want to go, Medicare beneficiaries want to go, we need to have this as part of -- a tool in the toolbox for the inspector general.

But the challenge, I think, is, unfortunately, is that we are confusing, I think, telehealth and over-utilization and potential fraud issues in telehealth with telemarketing, or, you know, scams like that.

On the audio side, Congressman, I think that, you know, there is a concern that, you know, because you don't have the face-to-face interaction or the video interaction, that it is easier to do, because you just kind of pick up the phone, you call, you say, "Hi, Congressman Smith, how are you doing today?"

And you say, "Great," and it is like, great, I have just billed for an E&M code. And what MedPAC has said is that you can multiply that on a scale that, you know, has potential to defraud the program. Great. But you can also scale and apply AI and machine learning to stop those kinds of schemes.

*Mr. Smith of Nebraska. Now, there has been some concern about Medicare Advantage plans and risk scores as it relates to this. Do you think we can get to the place where we have what we need in place, so that Medicare Advantage beneficiaries will have all the access and options that they need?

*Mr. White. Yes, this is a critical change. The -- you know, low-income people, the people who sign up for Medicare Advantage right now, are going to face some higher costs if we don't fix this, any risk adjustment for audio only. And that is going to be higher premiums, higher cost sharing, fewer benefits. We need to get audio-only on the MA side. They do it in Obamacare, in ACA. We need to just, you know, do the same thing in both programs. So that is a critical change. We need to do that.

*Chairman Doggett. Thank you very much. Thank you, Mr. Smith.

And Mr. Blumenauer?

*Mr. Blumenauer. Thank you. Thank you, Mr. Chairman. This has been a fascinating discussion, and I appreciate your work on this. I appreciate the leadership of Mr. Thompson.

The impact on my constituents since the start of the COVID pandemic has been significant and positive. Now we must figure out how we have the advantages of telehealth in a post COVID-19 health care system. I think we have learned a lot about it during the pandemic. However, this has been a once-in-a-century experience. We have much more to learn about how patients and providers will utilize these technologies in our new normal.

I do a lot of work with neuroscience, and I have heard from families and individuals with ALS about their experiences during the pandemic. Telehealth has been a lifeline for many of these families. It can take hours of effort and caregiving support for a person with progressive ALS to be able to attend a live medical appointment. To add to the challenge, transportation to ALS specialty care centers can be very challenging, particularly if it is a center located a long distance away.

In Oregon it is not unusual for people to travel over 100 miles from rural areas to go to a specialty care site in Portland. Additionally, Oregonians, particularly those with ALS, do not have equal access to broadband, communication technology, and the means to travel such a distance.

I championed the Patient Choice and Quality Care Act, which would create a demonstration project to allow providers to leverage telehealth to provide quality, coordinated care for Medicare beneficiaries with a serious illness. This model focuses on providing high-value care, rather than just paying for volume.

Dr. Mehrotra, in your testimony you suggested a strategy of moving to full or partial capitation and bundled patient -- payments. Should CMS commit to proactively targeting certain patient populations, like those with ALS patients, for expanded telehealth access after the COVID crisis has gone?

In a payment -- how could a capitated model account for equity, racial, along economic or geographic lines?

*Dr. Mehrotra. Well, I think it is a really critical point you emphasize, and this is kind of echoing what Mr. White also emphasized, which is we want a system, ideally, for patients, where they can contact their provider, and the provider can contact them back, and have a full continuum, from text messages to phone calls to video visits to in-person visits. And we don't want to create a bureaucracy and an administrative paperwork which really limits our ability to choose between them.

We are having already a situation where patients aren't sure what is going to get charged for and what they are not going to get charged for, and I think that is a really critical issue. And so, to the degree we use alternative payment models, where we provide a single sum of money per month or per year to a provider, and -- to care for their patients, and give them that flexibility, I think it is going to be a much better system for both Americans and their providers.

In that light, I think that you raised a really important question for select populations such as those, unfortunately, suffering from ALS. Could they particularly benefit from such a program? And I think they would, because it would allow them, again, that flexibility. You know how difficult it is for them to go see their providers. And having that flexibility would be very important. That would come from one of those alternative payment models.

*Mr. Blumenauer. Thank you. I yield back.

*Chairman Doggett. Thank you very much. Let me check on who is next, and I believe that is Mr. Reed.

*Mr. Reed. Thank you, Mr. Chairman --

*Chairman Doggett. Thank you.

*Mr. Reed. -- I appreciate this hearing. And this is an exciting area that I think we can work together in order to really bend the cost curve when it comes to our health care costs in America. And I am excited by the testimony and the input that we have received and, in particular, the testimony that is focusing on those morbidities in America's health care that seem to be the drivers of most of our health care dollars that are being positively impacted by telemedicine and the treatment opportunities that are there, both rural and urban, in the settings.

And so one of the things I wanted to maybe start with Mr. White in regards to is diabetes care in America. Now, you know, that has been a passion of mine. We have talked about it numerous times over the years, and both type 1 and type 2, and that is uncontrolled diabetes, in particular. I think it is estimated to be about $330 billion on the American health care system of a cost.

And one of the things that I wanted to delve into is -- telemedicine, obviously, provides you an opportunity to talk to a provider, have an exchange with a provider, see how you are doing. But the diagnostic services of an A1C test, that requires a blood draw, that requires some additional medical services that telemedicine right now may be not capable of doing. But I am

hearing of exciting technology that is coming down the pipeline like my wife just underwent. She was at her doctor's, and the doctor performed a handheld scan of her neck arteries to see if they were blocked for potential stroke implications.

I know of an individual who underwent a neurological exam by a telehealth provider that was in Florida, while they were in an emergency room here, in New York.

And so how do we best drive up -- and I know we are concerned about over-utilization. I am concerned about a little bit of under-utilization by -- especially by the diabetic population. How do we drive up and incentivize efficient utilization that rewards that diabetic patient, in particular? Let's start there, with that morbidity, to reward that staying on top of the A1C number.

How do we dovetail the diagnostic service with the examination that a telehealth conversation and consult will provide?

How do we make sure that those services are dovetailed together, and that we are rewarding that efficient utilization?

And then how do we maximize that next generation of telemedicine that will dovetail those together, that we don't block it with antiquated policies here, especially on the Medicare and Medicaid front?

*Mr. White. Great question, Congressman, and I think that, you know, you know better than anyone, because of your experience and your leadership as co-chair of the Diabetes Caucus, that, you know, more than a quarter of the over-65 population has diabetes, either type 1 or type 2.

And I think, you know, one of the things that -- well, first, kind of the -- the least impactful to the most impactful, the least is we -- Congress authorized remote authorization of dialysis care, which is important, because you don't want people to get hung up in the, you know, the paperwork in going to get this -- the care that they need. And so that is, you know,

something that I think needs to be, you know, just standard operating procedure. Right?

The second thing is we need to move to value-based care, right, to have that kind of be a part of, you know, the incentives and the equations in play.

But I think, you know, one of the bills that I think you and others -- Congresswoman DeGette and others -- have introduced -- the, you know, the Prevent Diabetes Act, which would really leverage virtual care in the diabetes prevention program and start to do things like remote weight monitoring. You know, scales have bluetooth now. They can automatically send the read into your EHR. Virtual assistants and coaches can be leveraged so that you don't have to do the in-person care to do the weight reduction that you need on the type 2 side. I mean, this is just commonsense stuff. We should be doing this, anyway. That can have a dramatic impact on costs.

But the third point, and kind of the most forward-thinking, is we are starting to get really good technology around remote labs and bedside diagnostics. So if you think about people in -- who are homebound, or SNFs, or, you know, maybe in rural areas that can't go in to get those blood draws, these are going to be lifelines that, literally, will save -- it will save lives, it will save a lot of money, too, because you are not going in for that office visit every time. We are getting really good at this stuff. And I think that needs to be integrated into the Medicare program almost automatically.

We shouldn't be having this conversation about Congress needs to pass a law to get these diagnostics into circulation –

*Mr. Reed. Mr. Chair, with my limited time, Mr. Chair, I would love to work with you on that type of diagnostic care for our populations that need it most. I appreciate that, and I yield back.

*Chairman Doggett. Thank you very much.

Mr. Higgins?

*Mr. Higgins. Thank you, Mr. Chairman.

Telehealth was in place before COVID, and then accelerated during COVID, and it was a rigorous demonstration of the value of telehealth, in terms of access, cost, and good outcomes. The United States health care system spent $3.8 trillion last year, or $11,600 per person. Of that, the United States federal government spent 34 -- over 34 percent of that, $1.3 trillion in Medicare, Medicaid, the Veterans Administration, and tax treatment. It is a lot of money, but that funding responsibility on the part of the federal government provides us with a lot of leverage, and leverage to drive down costs and drive-up quality.

So I think that we -- you know, everybody seems to agree that telehealth has been, in its accelerated mode, has been a really, really positive thing in all of the measures that we value health care delivery on. But as Ms. Hernandez-Cancio had talked about earlier, we need to even the playing field so that everybody can benefit from this.

So, Ms. Hernandez-Cancio, could you speak to the issue of more investments in broadband to help close the disparities around telehealth use?

And it seems to me, if we can do that, then, you know, the movement, an aggressive movement toward more use of telehealth, could be very helpful.

The other thing I was looking at, too, which was interesting, is I was just kind of curious as to what percentage of the health care is provided by nurses versus doctors. And I don't have a United States statistic, but there is a world statistic that said -- from the Global Health Organization -- almost 90 percent of health care services are delivered by nurses. So a better utilization of the health care personnel that we have, in combination of telehealth, could perhaps, you know, be a real game changer, an inflection point in health care delivery in the United States.

So, Ms. Hernandez-Cancio?

*Ms. Hernandez-Cancio. Thank you very much for that question. And, you know,

absolutely, we are very clear, and we saw that there was already a reference to this, on how much families were struggling in just getting their kids to be able to be in school remotely. So there is a much broader issue around broadband infrastructure that we are not experts on at all at the national partnership.

But that clearly is, you know, as Dr. Kim was saying, clearly, really essential, not just for better health, but also for better education, and for economic justice, as well as health justice, right?

I think it is important to understand that it is not just whether there is a broadband, you know, in the county where you live, as the FCC tends to report it, right? You may have broadband, but you might not actually be able -- it might not be reliable, or it might be beyond your financial reach, or it might be that you have four people in your family, and only one at a time, you know, can be on the Internet, or you might not have the hardware that you need, and it is too expensive for you to be able to really take advantage of those opportunities.

So it is really important for us to understand that, yes, there is a major infrastructure problem that needs to be resolved, and then there is also the affordability and access problem that is on top of those infrastructure problems that really needs to be addressed.

And the other thing that is really essential to consider is that, you know, I -- we are very positive about the incredible, incredible potential that telehealth has, particularly around what it does for, you know, caregivers, right, the women who are taking care of their kids' health and their parents' health, and being able to support, especially, Medicare populations by being an advocate, connected on -- you know, connected through telehealth to their parents', you know, appointment. You know, that need is going to continue, right?

So it is very important that we be thinking about all these -- all of these options. But at the same time, there is a lot of data that we don't know. And fundamental to that is having the data disaggregated by race, ethnicity, and gender, and disability, and language access, because

there may be some -- you know, we may be seeing, across the board, a lot of benefit, but we don't know where there might be particular populations, particular geographies where there still may be a lot of challenges that we -- not to not expand telehealth, but to make sure that we are building opportunity structures so that everyone can have a -- take advantage of it.

*Mr. Higgins. Got it. Thank you.

I yield back, Mr. Chairman.

*Chairman Doggett. Thank you.

Mr. Kelly?

*Mr. Kelly. Thank you, Chairman, and thanks -- all our panelists, thank you, it has been very interesting. I got to tell you, I think almost all the questions that I was going to ask have been answered, and all of you have done a great job on it.

Joel, I just wanted to get with you on a couple of things. Now, I -- what I have never been able to understand is why, when we look at any type of a government program, there is so much fraud, there is so much abuse. And I think, if you just kind of look to the private sector, you would find out, because they can't tolerate losing money and still staying in business -- the government has no problem running deficits; private business does -- why don't -- why we can't just bring some of those same things into government that we see in the private sector.

But having said all that, one of the big problems is, you know, I am from an area where it is a big rural area, but also a lot of seniors, both in rural areas and in our towns. And some of them don't seem to have the skill set that you may need to have to handle the telehealth programs. So do you think -- and any of you can tell me -- do you think any of the providers have risen to the challenge, and been able to help their patients get to the point where they feel comfortable using telehealth?

I know David and I talked an awful lot about it, because he is on this idea about the disruption, of everything that has taken place, and how we take the old standards, and we look at

them, and say there is no reason for them to still be in operation, there is a better way to do it, and it is coming very quickly. Anybody that can help me on some of that, because one of the things I do face in our district is people who just aren't ready for that type of technology.

*Mr. White. It is a great question, Congressman. I think that the answer is simply yes. There are bright, shining islands of excellence out there, and then there are kind of the rest of the pack, and it is -- some of what we see in the telehealth applications are clunky, or can be clunky. The user interface isn't great. You know, so I think that is one challenge.

And part of that, we need to realize that the federal government has some standards around user interface on electronic health records, and a lot of times the telehealth application is built into the EHR.

But the other two areas, I think, are literacy, which gets to, you know, digital literacy, like, can I use the app, do I know how to -- and we see this in school, we see it in jobs. But most importantly, we see it in health, where the stakes are really high.

And then the third issue is broadband.

So it is broadband, literacy, and user interface are, really, the three challenges. And there is probably others, but in my -- from my perspective, those are the three big ones.

*Mr. Kelly. Yes, so let's talk just a tiny bit about broadband, because I think you really hit on something there.

Usually, the private sector, if there was an opportunity to run a business profitably, they would get into it. When it comes to broadband, some of the places that are unserved is because there is just no reason to go there. There is not enough market for the private sector to get into. And that is one of the areas, I think, when we talk about where the government's role is really critical, it is going into those underserved areas that there is no market to support, from a private position, but we could do an awful lot with broadband getting into those areas.

Listen, I think a lot of us on this call today represent areas -- and I know Mr. Kind was

on, he is from -- his area in Wisconsin is a lot like my area in Pennsylvania, a lot of rural, a lot of ag people. But they just -- they don't have the services available, or it is intermittent. That is what I would like to see. So if we were going to do something this Congress, we should be looking at can we put more money into broadband, making sure that everybody across the board has access to it.

Then the second part is the literacy part, which you just hit on. How do we get that segment of the population that is not comfortable using the telemedicine, any -- whatever you want to refer to it -- that they would be able to do things that are more comfortable for them. So I think that is a huge challenge. It is a learning experience, I think, and a comfortable -- you have to reach a comfort level.

But again, I am going to tell -- my friend, Mr. Schweikert, is going to have a chance to talk. He has always been talking about this. Now we have been in Congress together for 10 years. If there is one person that understands what the future looks like, and what the upside is for every single American -- I know we talk about disparity. Education is the answer to everything we are facing today. We have to get people educated, so they can use all of these things at a comfort level that actually benefits us all. Then the whole country wins.

So I am going to yield back. Mr. Chairman, thank you. Great, great hearing today. And to our panelists, thank you for what you are doing. We need to stay in touch with you. Thank you.

*Chairman Doggett. Thank you, Mr. Kelly. And I am going to move to two Democrats and then one Republican, as I move to Ms. Sewell.

And just reminding the members and the witnesses, we are only to the halfway point, in terms of the number of members who have questions. And so please do try to get your question and your answer in within the five-minute period, so we can complete at a reasonable time, and with respect to our witnesses, as well.

Ms. Sewell, would you please proceed?

*Ms. Sewell. Yes, thank you so much, Mr. Chairman. Hopefully, you can hear me.

*Chairman Doggett. Yes.

*Ms. Sewell. So I first want to thank you for holding this hearing today on telehealth. Telemedicine is going to be critically important, and we know that. This pandemic has laid bare the need and the ability of us to work together on a bipartisan basis in order to improve access, but also to maintain quality when it comes to telehealth.

As the -- as one of the co-chairs of the Rural and Underserved Communities Task Force, I am pleased that myself and our Republican colleagues have really identified telehealth as an area where we can work together on trying to decide on best practices, but also understanding the importance of making sure that some of the gains that we have had because of this pandemic are not lost, and that the flexibility within telemedicine maintain itself.

I also am very struck by what Dr. Mehrotra said regarding the creation, or possible creation, of two tiers of services: for those who have access to quality infrastructure, broadband, getting those videos; and those that don't only being audio.

So, Dr. Mehrotra, can you talk a little bit about what we in Congress can do to make sure that we don't create a two-tiered system, and at the same time still be able to provide high-volume -- high-value-added services with telemedicine?

*Dr. Mehrotra. Thank you for emphasizing this really critical issue.

And also, building on that point, as well as Representative Kelly's question previously, it does take a lot of hand-holding to try to provide -- I mean, I think we have create this dichotomy, but our older adults, they may be leery of doing this, but we have had success in community health centers who devote the resources and time to work with our older -- our seniors and say, "When you come into the clinic, bring that device, and we will walk you through that first visit."

And so a lot of that is about working with, one on one, with our seniors to teach them

how to do this. They are -- they can do it, and then it will take time, and then they will become more accustomed. And I think that is a really important point. And that is one of the reasons why I have advocated for this short-term expansion, so that we have that time to work with our seniors to do so.

*Ms. Sewell. But as Congressman Kind said, it may take more than one to two years. I represent very rural African-American communities in the black belt of Alabama. I grew up there, and I saw my constituents very grateful to have the option of having telehealth being covered. But the access was mostly in the urban areas, and the digital divide is really real.

My question is to you, Ms. Hernandez. You talk a lot about the equity, both racial equity and income equity, disparity. Can you talk a little bit more about that?

I want to thank you, also, for your testimony, honing in on the need or the availability of having telemedicine when it comes to maternal health. I have had several rural hospitals close, and many of the ones that are barely hanging on have done away with their OB/GYN services.

Can you talk a little bit about equity, when it comes to maternal health, and what we can do to ensure that that – that equity -- that we create that equity and parity when it comes to that?

*Ms. Hernandez-Cancio. So thank you so much for that question. As you know, the National Partnership has been working for many years on issues of maternal mortality and morbidity, and it is a high priority for us. And there are a lot of very interesting and exciting potential benefits in the space of maternal health when it comes to telehealth, especially for those who can't access, otherwise, the kind of specialty care that is really needed.

And I think it is also important to underscore the fact that we know that part of the challenge with maternal health is that you cannot educate your way out of it, right? You cannot -- you know, it doesn't matter if you have a Ph.D. and you are a Black woman, you are still going to have higher risks and worse outcomes than a White woman with only a high school education, right?

And there is a lot of research around cultural congruency as being one of the antidotes to that. So being able to -- for example, whether it is in maternal health or in mental health, to be able to access a culturally competent, congruent provider that may not be, you know, driving distance from your home, can make a huge, huge difference. Enabling, with the technologies that are available, better and closer monitoring, whether it is because you are pregnant, or whether it is because you have diabetes, because let's be clear, you know, there are huge diabetes inequities when it comes to Black and Latino and even some Asian, Pacific Islander populations, and Native American -- and some Native American populations, as well.

All of these things have huge potential, but then we really need to make sure that we are doing more, so that people can get the access to telehealth, if that is what they want, because the other part of the equation that is missing is patient choice, right?

As someone –

*Ms. Sewell. Basically –

*Ms. Hernandez-Cancio. As someone who has tried to explain to her mother-in-law multiple times how to take pictures of her grandchild online -- she lives in San Juan, Puerto Rico -- there are some people who are never going to -- it doesn't matter what you do, they are never going to be, you know, comfortable --

*Ms. Sewell. Yes --

*Ms. Hernandez-Cancio. -- with health care --

*Ms. Sewell. I know I am running out of time. I just want to say, Mr. Chairman, I think that several of our panelists have talked about the need for uniform -- making best practices and standards when we talk about telehealth. But I think that what we have to also do is make sure that people are culturally competent, and we have training on that for everyone who wants to do this telehealth.

And I think that, when we think about racial equity, what we need to make sure is that

people are not unconsciously putting their own biases and affecting their ability to provide health care to everyone.

So I want to thank our panelists. I want to thank you again for bringing this up, as the chairman, Chairman Neal, has tasked myself and some others on racial -- on the racial equity initiative. It is going to be critically important that we help to figure out ways that we can standardize care, but more importantly, really make sure all health providers are attuned to the specific needs and cultural competencies that are required when dealing with health care outcomes. Thank you all.

*Chairman Doggett. Thank you.

Ms. Chu?

*Ms. Chu. Yes. Thank you, Mr. Chairman, for holding this important hearing today. I have heard from so many health care professionals about the incredible work that they have done via telehealth this past year. And I think it is clear that we can't go back to where we were at the beginning of the pandemic.

So, Dr. Kim, thank you for your testimony as a mental health provider. I am one of only two psychologists in Congress. And, as such, I am especially interested in the impact that telehealth can have on expanding access to mental health services.

We know that the isolation and increased stress of the pandemic has only increased the need for mental health services. And a survey of the American Psychological Association members showed that psychologists are seeing a greater prevalence of anxiety and depressive orders, so much more than before COVID-19.

So, Dr. Kim, can you discuss why behavioral health services are particularly well-suited to telehealth, given the historic disparities in access to behavioral and mental health services by communities of color and low-income Americans?

Could telehealth be one possible solution to access issues in this area of health care?

And can audio-only services be beneficial in this space?

*Dr. Kim. Thank you, Representative Chu. So it comes as a surprise to no one that behavioral health has a long history of progress and success with telehealth, in large part because, predicated on a therapeutic relationship, I do not actually have to touch my patients in order to forge that bond and rapport.

And as a result, my reach in caring for patients is, literally, unlimited. And I have had years and years of success, as I mentioned, taking care of prison kids, military folks, disaster victims, and the list goes on, from the comfort of my home. And it has been quite a learning experience, all the way back when I started using those way-too-overpriced H.323 set top boxes that I continue to use with some of my prison engagements.

And so behavioral health is tailor-made for telehealth, and it serves as an interesting template for my peers in other domains to say, "Examine your therapeutic relationship, see how you can leverage those relationships, and use whatever tool is available to you in order to be the right doc with the right information at the right time."

To your question about telephone, I think that this is an important conversation because, even before the pandemic, the telephone is an important tool in the toolkit for all physicians, perhaps all people. And, as has been mentioned before, technology continues to grow in some extraordinarily innovative ways. And I myself use text-based solutions, audio-based solutions, and audio-video-based solutions.

The underlying sort of star that I navigate by is that, in order for me to establish a therapeutic relationship, I need more than one mode of communication. So that is not to say that I don't use the telephone.

In fact, I have a very dramatic story about how I was presenting in Boston when I got word that a patient of mine in a prison was suicidal. And this was years ago. And on the phone I was able to talk him down, avoid an ED visit, and see him the next day, when I flew back,

through a video chat. So untethered, it is difficult to comment on an audio-only solution. As part of a toolkit, for the right doctor with the right information, I think it can be a lifesaver.

*Ms. Chu. So, Dr. Kim, what are the guardrails you think are necessary for telehealth services, when it comes to mental and behavioral health care?

What populations have you found are the hardest to reach through mental and behavioral telehealth?

*Dr. Kim. I am still looking. I have had wonderful success caring for pretty much every vulnerable population that I can find, with the exception of language barriers. I am only fluent, as a physician, in English, but I have utilized a translation service in accessing that particular population.

But where I think that the virtue of telehealth lies is the fact that I can convey the message that I am your doc, and I am not going anywhere. And for many people struggling with mental illness who feel alone, who feel helpless, who feel disconnected from our broader community and tribe, that is everything. And it keys into all of the goals that have been mentioned so far in testimony, whether it is cultural competence, health equity, social determinants of health, adverse childhood experiences. I see it as being all lumped into the same pool that, if I can forge that relationship, I can be of service to you.

*Ms. Chu. Thank you. I yield back.

*Chairman Doggett. Thank you.

Mr. Jason Smith?

*Mr. Smith of Missouri. Thank you, Mr. Chairman. I first want to start off by thanking you for holding --

[Audio malfunction.]

*Mr. Smith of Missouri. -- and the health care of rural and low-income Americans.

If we were to look for a silver lining in the COVID-19 pandemic --

[Audio malfunction.]

*Chairman Doggett. We are getting you kind of in and out, Jason.

[Pause.]

*Chairman Doggett. I think, Jason, I am going to pass and come back to you. We need a little better connection. So let me go to Mr. Evans, please.

*Mr. Evans. Yes, Mr. Chairman, thank you.

*Chairman Doggett. Thank you.

Jason, we will come back to you, we just can't hear you.

Go ahead, Dwight.

*Mr. Evans. Thank you very much, Mr. Chairman. Mr. Chairman, the question I would like to ask the panel is, what do you think you have seen that is the most important lesson to take away from this year, and what improvements do you think are most needed, especially when it comes to reaching and helping underserved communities?

I would like to start out with Ms. Ellen Kelsay.

*Ms. Kelsay. Yes, thank you. Thank you for the great question.

The most important lesson is just how quickly we can mobilize to access and reach people in a very different way, very quickly. You know, this pandemic was thrust upon us pretty much overnight, and the entire health care system and the patient community adapted very quickly to accept and embrace virtual health, including those populations who, historically, have been under-resourced and marginalized, who also, unfortunately, have the greater prevalence of chronic disease burden.

And so I think that is an important issue around health equity, and the spotlight that has shown on it across all of us in the industry, and that we are talking about today, is one of the greatest silver linings coming out of this past year.

And I think, again, to all the points that we have been discussing so far this afternoon,

telehealth and virtual care yields so much promise, in particular, in that community, and others, as well, not only from a primary care perspective, but a chronic disease burden, managing conditions, as well as mental and behavioral health needs, as well. Thank you.

*Mr. Evans. Ms. Hernandez, would you like to respond?

*Ms. Hernandez-Cancio. Yes, sorry, I was unmuting myself. Thank you so much for that question.

I think the most important thing that we think that we have learned, in addition to the fact that there are too many people in this country who are essential workers that are being treated almost as expendable workers, and that those -- and the over-representation of communities of color in that population has not just been tragic, it has been heartbreaking, and unfair.

And so I think that the inequities, not just in health care and health, but overall in our economy, and in people's rights that were underscored and highlighted with this pandemic, hopefully will unleash a lot more attention to addressing kind of the infrastructure issues that drive these inequities. It is not just whether or not and how you get health care that really, really matters. And there is so much -- so many structural issues that we need to address when it comes to health care.

And telehealth is just a tool, but for the tool to work you need to have, like, the connection -- well, if it is a power tool, let's say, you need to have the connection to electricity. And we have too many communities that are not able to make those connections for health, for education, for remote-work jobs. And we need to do better, fundamentally, for those communities.

*Mr. Evans. Thank you.

I yield back the balance of my time, Mr. Chair.

*Chairman Doggett. Thank you. Let's see, I am going to go on to Mr. Schneider. But if the staff will advise me if -- as soon as Mr. Smith is back in range, and we have got a good

connection, I want to work him back into the regular order.

Mr. Schneider?

*Mr. Schneider. Thank you, Mr. Chairman. I want to thank you for calling this hearing today and, as always, thank our witnesses for sharing your perspectives and insights on how we can sensibly and successfully advance telehealth for our country.

The COVID-19 pandemic has been an unmitigated disaster, between the loss of life and economic downturn. It has been difficult to find bright spots over the last year. However, crises often provide the opportunity to advance in new or unexpected ways, and I think telehealth is certainly one of these ways.

I have said repeatedly that our economy will not be the same, post-COVID. Our health industry will not and should not be the same, either. In the same way that more people will telework in the future, our health system should allow more individuals to receive care in the comfort of their own home, as well. In the span of just the past year, we have seen a greater expansion of telehealth than we may have seen in 20 years without the pressures placed upon our society by the pandemic. This provides both an opportunity and a challenge.

Congress's job, moving forward, should be to find ways to responsibly shepherd this growth, not stand in its way. Telehealth is not a replacement for in-person visits, but should be complementary to them, and can open new avenues of care for previously underserved populations.

And importantly, patients want these services covered. Convenience and patient satisfaction matter.

In my own sense, I come here -- I had a visit with my skin doctor today to -- she had to remove a benign growth. But the follow-up to make sure everything is okay, we talked about -- we can certainly do with telehealth. There is that complementary aspect to it. It will work out better for me, it will work out better for my doctor.

Our goal is that, with telehealth, we can try to identify improvements in our health care system, areas for efficiency, for effectiveness, for better outcomes. But one of the things I think is important is understanding how we will identify and measure these improvements. So, Dr. Kim, if I could ask you, at least to start, what do you see as some of the key criteria we should be using in evaluating the progress that we can make on telehealth?

And what metrics should we be using in evaluating those criteria?

*Dr. Kim. That is an excellent question, Representative. And largely, I am going to echo some of the comments that have already been stated by the other panelists. But it ultimately boils down to are we conducting a high-value intervention?

And so, bringing back the example of concerns that were raised with over-utilization or fraud when, say, we look at the data and see two identical -- "identical" -- encounters, one tele and one in person, you very articulately described how a skilled clinician can pivot between the two services. So perhaps an initial attempt was try to telehealth by the right doctor and said, "No, no, no, we have to bring you in in order to do X, Y, and Z," and that was followed by a conventional encounter.

It could be that the patient accessed, again, an untethered doctor through one of their member benefits, through their payor, who said, "I can't do anything for you, you need to reach out to your primary care doctor," or your psychiatrist, or what have you, at -- which they subsequently do, and have "an identical encounter."

And so, in an effort to truly demonstrate value, whether it is lowering costs, empowering practicing active physicians in doing what we can to support them to skill up in telehealth, to be able to meaningfully and efficiently and effectively use that, you know, as a provider, I have X number of visits every single day. I am not in any way incentivized to pack in as many telehealth encounters -- I can see X number of people.

And so, if I am able to increase my efficiency, increase my reach, increase my timeliness

with people with whom I have a therapeutic relationship, I think I will have a much larger impact than being overrun with crisis after crisis after crisis of people coming in who has run out of their meds for two weeks, who -- you know, I could go on and on about the -- sort of the scenarios that physicians like me, you know, are challenged with every day.

One of the common things that I will close with is -- that I say to my patients at the end of each encounter, is I say, "I am going to see you in X number of weeks, or X number of months, but remember, you can always message me, and I will do my best to see you in that moment." If you drop your pills down the toilet, if you, you know, have a blowout with your mother-in-law, I can work with you in that moment, and avoid an escalation and increase in intensity of challenges, and ultimately, I believe, avoid ED visits, hospitalizations, you know, increased medication burden, although proving a negative is exceedingly difficult, and I reserve that for the academics who have teams of statisticians.

*Mr. Schneider. And that will be -- absolutely, our challenge is demonstrating. But thank you.

And the other piece -- we are out of time, so I will just mention this, and then yield back -- is you talked about medications. But I would imagine, with check-ins and follow-ups, we can improve compliance with taking medicines in some cases that, hopefully, will improve outcomes, as well. And with that I yield back my time.

*Chairman Doggett. Thank you very much. I am going now to Mr. Schweikert, unless I hear Mr. Smith is back in, and thank him again for his leadership on the Telehealth Caucus.

And then, after Mr. Schweikert, we will go -- some members -- we will have the order down to Mr. Gomez, Mr. Horsford, and Dr. Wenstrup.

Please proceed, Mr. Schweikert.

*Mr. Schweikert. Thank you, Chairman Doggett, and also a particular thank you to Mr. Thompson for tolerating my fixation on what is telemedicine.

I would like to ask for just a quick unanimous consent. I have -- I am blessed to have Mayo Clinic here, in Arizona, in my district, who is doing some really neat work on, in many ways, what is telehealth. It is data, it is interventions, it is even a project they are doing on telestroke, and that is actually part of my point. So first I would like to be able to submit those for the record.

*Chairman Doggett. Without objection.

[The information follows:]

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

*Chairman Doggett. I am glad you have someone there in Arizona to talk data with you.

*Mr. Schweikert. Oh, yes. And apparently, I am really annoying to them, also. We are what we are.

And you know my fixation -- and this is for everyone on this hearing -- I truly appreciate it, but I also don't think we are being sort of forward-leaning enough. And that is, what is telemedicine? Is it an intervention with someone who is having a personal crisis? Of course it is.

But is it also someone like myself, who has hypertension, who is experimenting with a data device on his wrist, and just sent a week's worth of data to my physician without speaking to her -- I just sent it to her, and got a little text message saying, "Looks okay."

It turns out it was data coming off my body multiple times a day for a week. And, as Tom Reed actually mentioned, you know, we don't do a particularly great job using technology to help our brothers and sisters with chronic conditions, even though chronic conditions are the majority of health care.

I want to do a couple quick -- in my over-caffeinated pace here -- I believe we are actually about to have a miracle in broadband. As you all saw yesterday, FCC license -- permitted the new low-orbit broadband satellites. Every inch of North America is about to have broadband. With 5G, our urban areas will have access to, functionally, what is broadband.

We already know that those on the lower-income quartiles actually have a higher -- smartphones than other populations, because that is their access to the Internet. And as 5G comes out, much of that broadband access problem -- we are at the cusp, it is about to be solved by technology.

And a respect for the working poor, for those that sell their labor, a visit to a doctor is expensive. It is not the -- it is not only the cost, but it is also the fact that they lost that much time of selling their labor. And I think we need to be much, much more respectful for that.

So we are sort of back to what is telemedicine. And I want to argue telemedicine are things like this -- and I am sorry, but you know me and charts -- something that -- where I can do home diagnostics by blowing into something, and it functionally -- and this exists today, there is a number of these that are here today.

How many of us would immediately evangelize for home COVID tests for rural, for poor communities, for those that don't feel they have access? The ability to have instant home COVID tests, is this telemedicine? I would actually argue it is. It is taking care of people, whether it be voice, whether it be video, whether it be data.

And so, Mr. Chairman, particularly -- one of these days, even if it is not a formal hearing, could I beg of you, could we bring together a group of the health futurists, the health data experts who actually are talking about how this technology is about to, basically, eliminate much of the health outcome barriers, racial barriers, access barriers, and potentially crash much of the price of health care by using technology?

And yes, there are a lot of incumbent businesses, organizations, guilds that are very uncomfortable with this conversation, but it is here. And if it is about access, and it is about making people healthy, we need to look at where, actually, we are going, what is actually already here.

And Mr. White, just because I have now rambled for most of our time, if I were to ask you what -- if we didn't have some of our rules and regulations that are barriers to adoptions of the next generation of technology, what could telemedicine look like over the next few years?

I mean, give me something that is sort of techno-Utopian. Where are we going?

*Mr. White. Well, I think we need to eliminate the molehill before getting to the mountain, but we need to get to the mountain because the costs that are going to swamp us are massive. And I think it is, as you described, it is data-enabled, technology-assisted, consumer-driven care, right?

And so it is -- you know, we have talked about kind of this remote monitoring for asthmatics who, you know, maybe are taking Albuterol inhaled by habit every morning, or whenever they need it, but may not be needing to do that inhaled dose every day. And so you have got --

*Mr. Schweikert. And as you know, that is my personal story.

*Mr. White. And you have got this wasted medicine, wasted time. Maybe you have got people who are being over-medicated, they are not as active, they are not as -- et cetera.

So, like, that data can actually drive a situation where you can, like you said, crash prices, crash costs, and actually make people feel better, and have a better outcome. But it is the data that is critical, and the data is currently owned and stored up in some silos. We need to democratize it and get it out to be useful to individuals.

*Mr. Schweikert. Thank you, Mr. White. We are over time.

Mr. Doggett, thank you for your patience with me.

*Chairman Doggett. Thank you very much, Mr. Schweikert.

I understand that Mr. Smith is continuing to have some technical difficulties in getting into our hearing. So without objection, his questions and witnesses' written responses will be included as a part of our final record.

[The information follows:]

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

*Chairman Doggett. And now, Mr. Gomez, if you would, ask your questions.

*Mr. Gomez. Thank you so much, Mr. Chairman, for having this important hearing. Given what we know about our health care system, and all that we have learned because of the past year, it is more important than ever, as a committee, we are intentional about addressing equity in our work. And with that in mind, I am going to focus my questions on telehealth, but also on the question of equity.

Telehealth has existed for many years, but the pandemic has just accelerated it to a pace that we haven't really been able to do the kind of analysis necessary to find out -- to ask the hard questions about equity. And a lot of people want to just say, hey, this is the, as a witness put forward, the panacea that will solve all access issues. But we know that equity is connected to socioeconomic status, immigration, place of residence, sexual orientation, and gender identity, and racial and ethnic backgrounds.

Telehealth is a promising access method to access health care, but this is -- that is only if we take into consideration and recognize the impact on -- social factors have on access and address the underlying broadband and resource inequities.

The digital divide in this country is real. A recent Pew report found that 34 percent of African-Americans and 39 percent of Latino communities don't have a wired connection. And census data reports that Native Americans are at least -- are the least-connected population, with 33 percent lacking in broadband subscription, and 47 percent of those living on tribal lands have no access at all.

And if you look at a couple of things this past year, the census -- first time it went online -- we had lower response rates, partly because of that, partly because of the pandemic. And you can almost do a map overlay of the areas that had the least connectivity.

And then, when you look at when -- the vaccine rollout, you know, going online and trying to use an email to get your appointment, you saw that disparity exacerbated amongst the

African-American and Latino communities, even though they are disproportionately impacted.

So, Ms. Hernandez-Cancio, can you tell me more about the digital divide, and how it plays into health inequities, and what -- and the role it played during the vaccine rollout?

*Ms. Hernandez-Cancio. Yes, thank you so much, Congressman Gomez, for that question.

I think one of the important things -- you know, we have talked a lot about the digital divide, and I think it is really important to understand that that is just one of the many structures that is -- that has been disadvantaging communities of color in this country, you know, for generations.

And we saw, even here in D.C., some real challenges with trying to get vaccines in the arms of people of color, even though D.C. is a majority, you know, people of color. We saw that it was the more well-off, Whiter parts of the city that were actually able to get online really quickly and have the facility to be able to get their appointments.

In fact, we know that there was a provider here in D.C. -- Bread for the -- now I am going to blank out -- Bread for the World? No, Bread for the City, that tried to -- because of their population was mostly Latino and African-American, they were trying to create their own portal for them, and they found out that it was White people from, you know, many neighborhoods over that were the ones that were using the portal, and they realized that is not the way to get to our community, and they shifted to door-to-door, using community health workers and people that the community already knew and trusted, to get them there.

I think that the other thing that is really important for us to remember is that a lot of these -- when it comes to figuring out what the evidence says, and especially when we are thinking of very, very high-tech ways to use technology, but whether it is to detect fraud, or to find out, you know, medication utilization, or all of those nifty gadgets that all of us really like, we have to remember that there is plenty of information about racial biases in AI, racial biases in machine

learning, that there is -- that, even when it comes to health care evidence, the National Academy of Medicine themselves say that, at most, 50 percent of our -- of health care is based on evidence, and the other 50 percent is based on practice and judgment. And that 50 percent that is based on evidence was generated based on the experience of mostly White men.

And so it is really important that we are being very judicious and looking at disaggregated data to know how we are doing, and if we are actually reducing inequities or making them worse.

*Mr. Gomez. My time has run out, but that is an interesting point regarding data, and how do we get the more -- the specific data when it came to the use of telehealth over the past, especially during the pandemic, and how do we take steps to make sure that telehealth doesn't necessarily replace in-person visits but complements it.

So thank you so much, Mr. Chairman, for holding this hearing. I yield back.

*Chairman Doggett. Thank you.

Mr. Horsford?

*Mr. Horsford. Well, thank you very much, Chairman Doggett. And to my colleagues and to the witnesses today, I really feel that this has been a productive hearing, and that there is agreement that telehealth has made it possible for countless people to get health services during this public health emergency. It has allowed those who have had to relocate the opportunity to continue services with trusted providers, which has been vital during these unprecedented times.

And one of the services that has had some of the most positive results are mental health services. Being able to access mental health services is especially important for those battling with heightened anxiety and depression due to the pandemic, and the loss of loved ones, and the impacts on our communities. One local Nevada mental health service practitioner shared with me that being able to see children and teachers before they go off to school in the mornings has enabled his clients to go into their day a bit less anxious, and with freshly practiced coping

techniques.

Telehealth has also helped people feel safe and comfortable in their own space, and this is something that is extremely important for those who need it.

Of course, a key part for being able to access services via telehealth is broadband, as people have indicated today. The challenge with broadband access has acutely been the lack of cross-connection, broadband data transmission. This has not only hindered our telehealth services and efforts, but also the day-to-day clinical operations, and most certainly has had a negative effect on the community, as well. I will share one example.

The Amargosa Health Center in my district, which is located in a rural part of my district, has struggled over the years with its inability to obtain an adequate broadband connection. While there has been fiber laid along Highway 395, the cost of pulling wire from that highway to the clinic is cost prohibitive. So I would love to see fiber options for the Amargosa clinic to facilitate telehealth and direct-to-consumer virtual care.

Now, I want to just raise one last point around language barriers. With more than 350 languages spoken in the U.S., and 20 percent of the U.S. population who are limited English proficient, already disenfranchised, and finding themselves disproportionately impacted by the transition to telehealth, it is immensely important for patients to receive the care that they need in their primary language.

So, Ms. Hernandez, how can telehealth better integrate language translation to make it more equitable and accessible?

*Ms. Hernandez-Cancio. Thank you, Congressman, for that question. I do believe that the fact that telehealth is one of -- that is one of the tools that will make it, in some ways, easier to be able to get the kind of language access that people need in two ways.

Number one, and especially in areas like mental health, right, where you can't have a translator translating the entire thing in a way that would be as effective, to be able to have

mental health providers who are bicultural and bilingual extend their reach is incredibly powerful and important. We need to make sure that we are not overextending them, right, we need to continue to try to diversify the workforce. But that is one way, directly, that we can address some of those language barriers.

The other thing is that, you know, you can -- three-way communication is something, you know, here we are, I don't know, like, you know, 20-something of us on one video call, right? Being able to have three-way communication with a culturally competent translator that may not be able to show up to your home, or show up to the doctor's office, or show up to the hospital is going to be also a real game-changer for these communities that are struggling with language access.

And the thing is that, even if you are fluent in English, you may just be much more comfortable and able to communicate your health care needs if you can do it in your primary language. So that is a plus, all around.

*Mr. Horsford. Great. Well, I know we are coming to a close. I want to again thank our witnesses. This has been very informative. We have got a lot of work to do, but this is an area where there is a lot of agreement, so let's get it done.

Thank you, Mr. Chairman, and I yield back.

*Chairman Doggett. Thank you.

Mr. Larson?

Oh, I am sorry, I believe I skipped Dr. Wenstrup, a member of our subcommittee.

Doctor, please proceed.

*Mr. Wenstrup. Thank you, Mr. Chairman. Thank you all for being here today. I am glad we are having this great, robust conversation to discuss telehealth.

You know, as a physician, this means a lot to me. You know, we have opportunities to provide more care, less expensive care, in many cases, increased access to care, and have better

outcomes. It is all good. So I am excited about the opportunities.

And, you know, we faced this pandemic. My constituents range from urban to rural, so the rural and underserved health care task force was formed, and I am very glad to be a part of that. I thank Chairman Neal for putting that together in a bipartisan fashion. And telehealth is one of our top priorities on that task force. And -- but we have embraced things from rare diseases to behavioral health and areas that people have really struggled to get the care that they need, depending upon their circumstances. In many cases, the rural circumstance has the same barriers to care that the underserved areas in the urban areas have.

We have seen a lot of people change their practices, advance through technology, and we need to signal to those people that there is going to be stable reimbursement for the services that they have invested in, so that they can continue to provide it, and be there for the patients. So I am glad we are doing this in so many ways. We have come up with a lot of bipartisan ideas and opportunities, like telehealth in the emergency room, and behavioral health, telehealth. These are all good things.

But as we are looking ahead, you know, we are looking at things like -- and I have seen it within our practice -- remote patient monitoring. This is in orthopedics. All of this in an attempt to get better outcomes. And so the question comes up, well, what is this really going to look like? How do we ensure appropriately that in-person care is part of the care plan, as well?

You know, I mean, I treat a lot of fractures. I treat a lot of infections. You know, telehealth is great for a lot of things, pre-op, post-op, and things like that, but at the same time you have got to be able to palpate that patient, to touch them. And a lot of times, with infections, you know, it is -- you walk in the room, and you know what they got based on the smell. That doesn't come through telehealth.

The other thing I can also tell in person is when people are not telling me the truth about whether they are still smoking or not.

But, you know, we do have these opportunities to increase where -- we are looking always for opportunities to increase access to needed care, and to have a faster response time so we can have better outcomes or, in some cases, even prevention. And actually, when we do that, the cost of health care goes down.

But there is also the importance, I find as a practitioner, in the need to be the one who -- and I think Dr. Kim will understand this, that there is times where you need to be the one holding someone's hand and putting a pat on the back. And these are powerful tools that are all part of caring for people.

So I do like looking for alternative payment models that work, that incentivize health.

You know, we often look at life span. We don't necessarily look at health span. And, you know, I think we can focus on preventive care, and keeping patients healthier, longer. And telehealth can play a part of this, there is no doubt about it.

And so I believe telehealth can be used as one of the tools in the toolbox to keep patients healthier, longer, and address health disparities that exist in areas for a lot of different reasons. This can fulfill a lot of needs.

But I guess I want to ask Mr. White, and finish with this, that, you know, what would be the consequences if we don't signal that there will be enough -- a very stable reimbursement for telehealth services, especially when it comes to the underserved areas and the rural areas?

*Mr. White. Thank you, Congressman. I think, you know, fewer people will invest in it, and fewer people will think that it is real if it is not permanent, and so they won't adopt it as a longer-term strategy. I think that would be unfortunate.

You mentioned, you know, mental health. You know, according to HRSA, we have got about 7,000 additional mental health providers needed, just to meet the current needs of the population. And that is not going to happen unless we have telehealth in the mix as a permanent strategy. So, you know, this -- you know, it is a critical thing that we need to do.

But you are right, I mean also, you can't -- this needs to be a supplement, not, you know, not something that supplants the in-person care, because, you know, there are some services that are just -- you know, require in person, you know, whether it is orthopedics, or chemotherapy, or whatever.

So, you know, anyway, I think that is an important point you make.

*Mr. Wenstrup. Yes, thank you. I have one more quick thing on licensing. You know, if you are a practitioner, and you are actually practicing in your state, it doesn't matter where the patient happens to be. They are, essentially, in your office.

But at the same time, you know, I live right along the border of Kentucky. I treated patients from Kentucky, I gave them a prescription, they could get it filled in Kentucky. I have always taken calls also from patients, even if I am out of state. And, you know, for a lot of those calls, for many, many years, we don't charge for that. And I think that there is components of that that we need to keep. It is just part of the care you are giving the patient, whether it is post-op questions, things like that. Not everything needs to be billed. Maybe some practitioners wouldn't like me saying that, but I still think that is part of being a physician.

So thank you all very much. I appreciate it and yield back.

*Chairman Doggett. Thank you, Doctor. I have down Mr. Larson, Mr. Kildee, and Mr. Panetta.

Mr. Larson?

*Mr. Larson. Well, thank you, Chairman Doggett, for the opportunity to join today's subcommittee hearing on telehealth.

As chairman of the Ways and Means Subcommittee on Social Security, we are very interested in this topic. As part of the application for Social Security disability benefits, people must provide medical evidence to document their problems. During the pandemic this has included evidence from telehealth visits. So it is very helpful for those of us working on Social

Security to learn more about telehealth, and I appreciate the hearing.

Additionally, I am very concerned about recent changes that the Social Security Administration -- people who are applying for Social Security disability benefits. Last December, the previous Administration finalized a rule that allowed Social Security to put unqualified staff attorneys in charge of disability hearings, instead of independent, administrative law judges.

These hearings are vital to people with severe disabilities who are appealing a denial of their application for Social Security disabilities, especially our veterans. The hearing is an important step for many applicants because it is the first time they are able to present their case in person before a judge. It is essential that these new hearings be impartial and fair.

The Social Security Administration has, for many years, used administrative law judges to hold these hearings. These judges are independent. They are protected from interference by – leaders, who are pressured to decide cases. Using these independent judges is a vital part of making sure that the hearings are impartial and fair.

A rule adopted by the previous Administration would allow Social Security staff attorneys to hold these appeals hearings, rather than independent judges. That is why it is so unfair. These staff attorneys are regular employees of the agency, and they are not protected from agency interference. This would compromise due process and could limit people's access to their earned Social Security benefits.

Along with Chairman Davis of the Worker and Family Support Subcommittee, we have introduced the House Joint Resolution 38 to overturn this harmful rule. Our bill has been cosponsored by a majority of our colleagues on the Committee on Ways and Means, and I thank them. Our bill has been endorsed by many national organizations, including AFL-CIO, Paralyzed Veterans of America, the Strengthen Social Security Coalition, and others. I would like to enter into the record the whole list of organizations.

Thank you, Mr. Chairman, and with that I yield back.

*Chairman Doggett. Thank you, Mr. Larson.

Let's see, Mr. Kildee?

*Mr. Kildee. Thank you, Chairman Doggett, for recognizing me, and for allowing me to sit in on this hearing. I am not a member of the subcommittee, and I appreciate your gracious willingness to allow me to sit in because of my interest.

I, like many, believe that telehealth has the potential to provide access to health care services for people who might not otherwise have that access. It is not just a modality for the same care, it is an opportunity to overcome barriers for people who otherwise may not get care at all. And I think it is important to keep it in that particular context.

But increasing access to care is something that a lot of us have been focusing on. In fact, we just heard from Representative Wenstrup. He and I are working together on H.R. 2228, the Rural Behavioral Health Access Act. During this pandemic, as we have heard, we expanded payment for telehealth services because people couldn't go safely to their doctor in person. And that changed the way we conduct medicine, and our legislation builds on that.

Our bill expands access to behavioral therapy through telehealth in rural and underserved areas. It would also allow some greater flexibility for audio-only care when there is limited access to broadband or technology, which, of course, we have been discussing during this hearing.

The bill would do this through our critical access hospitals, which is a designation for many rural hospitals that fill an important void, delivering health services in the rural areas. And while I do represent a couple of urban areas, I have a lot of rural area in my district. And one area is served by Ascencion Standish, which is in my district.

So I would like to follow up. Ms. Hernandez-Cancio, you mentioned in your testimony, very effectively, that creating more opportunities for telehealth should not be a substitute for

building the much-needed capacity for high-quality, in-person care, particularly in underserved, rural, and other low-income communities. And I completely agree with that. But my question, I guess I would like you to address, is how we can do both. How can telehealth, with adequate reimbursement, expand patient access to care, while also being a way to ensure more financial stability for providers in these rural and underserved areas like critical access hospitals, or community health centers? Could you address that?

*Ms. Hernandez-Cancio. Yes, thank you so much, Congressman, for that question.

So we definitely need to ensure that there are guardrails in the deployment of continued and, you know, permanent telehealth services, so that we are measuring utilization, so that we are measuring quality, so that we are measuring outcomes in those contexts. And that way we can, as I said in my testimony, course correct.

And I think it is also important to point out that, you know, there is a lot of conversation about, you know, we need to reduce utilization. Where that may be true for a lot of folks, but there are a lot of populations where the problem is the opposite, right? It is not sufficient utilization to be able to take care of their health in a way that is not only better for them and their families, but also saves money in the long run, right?

At the same time, we cannot let that become a crutch, so -- in a way that then we are not investing in addressing the issues of the provider shortages, the incentives for providers to work in rural areas. There are so many different things that, even in Medicare, can be done around, like, GME, more GME in rural areas, and more program -- you know, just really promoting the next generation of clinicians, and not just doctors, but clinicians, generally. That includes nurses, and midwives, and pharmacists. And even how do we promote more non-clinical care that can extend and support the work of the clinicians?

So the danger is saying, "Don't worry about it, they are going to get their telehealth." It needs to be the choice of the patient and not, you know, what the -- what bureaucrats in

Washington want, or even, like, what the doctor's office says.

Like, I do not want to see a world where, if I want an appointment, they are like, "Well, we are not going to be able to see you for three months, but someone can call you in three days," because --

*Mr. Kildee. Right.

*Ms. Hernandez-Cancio. -- exactly the things that we want to make sure do not happen.

*Mr. Kildee. Yes, I mean, that brings up the issue of how we track quality.

And I wonder if, Dr. Kim, if you might address issues about how you think Congress ought to be measuring the quality of the delivery of these sorts of health care, particularly because of your expertise in behavioral health through telemedicine.

*Dr. Kim. I think, to speak to -- to start, your original question looked at the particularly vulnerable population in rural areas. And having had a considerable amount of experience reaching out to the -- those communities, my general approach is to keep them well.

And so you rightly point out that it is one of the reasons why I recommend payment parity as the economic engine to allow more of my peer group to figure out that, rather than 20 different people chasing the same nickel in an urban center, we can now spread out -- at least, certainly, in behavioral health rather easily -- and care for more people in a more meaningful way, including the under-represented in rural areas.

With the stability of that economic engine, the result will likely be reduced ED visits and reduced hospitalizations. As you lower costs, that, in and of itself being a quality metric, we would have to sort of dig down deep, just to sort of make sure that the data that we are looking at is the right data.

Again, there is -- telehealth is a big tent. You know, it was mentioned previously that it includes devices and AI and tech. It will include pure telehealth services, and it will include the skills exhibited by your physician, or your nurse practitioner, or your PA and/or nurse, or other

clinician. So having a clearer view and parsing out how the data sort of -- what the data represents will be the first step.

I am fairly optimistic that, for those of my peer group that, essentially, does their job, that we will be able to largely demonstrate the quadruple aim of value-based care.

*Mr. Kildee. Great. Thank you, all. Thank you, Mr. Chairman.

*Chairman Doggett. Mr. Panetta?

*Mr. Panetta. Thank you, Mr. Chairman. Thank you for allowing me to sit in on this very important hearing. We have heard a lot of good information today. So I also want to thank all of the witnesses, as well as my members, my fellow colleagues on the Ways and Means Committee, who are a part of the subcommittee, even some of those who are not, who asked some very invaluable questions, and we got some very invaluable information. So thank you very much.

Look, I think what we have heard today, and what we all know, it is that telehealth is -- it is not a one-stop solution when it comes to fixing the inequities of health care. But clearly, this technology, when it comes to delivering health care, has many, many advantages, from cost savings, to convenience, to care to those with mobility issues. It can bring specialists into communities that have a hard time obtaining those services. It can bring mental health experts into our homes when some people don't want to leave our homes, or don't want to have the stigma of going to other offices, and so forth.

So clearly, clearly there is a lot of value to this. Unfortunately, the pandemic highlighted, as we know, many inequities in health care and, of course, in our society. And one was the lack of capital that many communities, many people have, to invest in this type of technology. And I do believe that that is where Congress can help. Congress can help with these types of investments in broadband, in our digital infrastructure, and knowing that there is an absolutely excellent return rate on that type of investment.

Now, I am a cosponsor of the Telehealth Modernization Act, which would eliminate a number of outdated restrictions on Medicare coverage for telehealth services, including by removing geographic and originating site restrictions, and ensuring that federally qualified health centers and rural health clinics can continue to serve as distant sites after the public health emergency ends.

Mr. White, if you could, do you support those types of policy proposals as a means of -- as means of expanding access to care?

*Mr. White. I do, on a permanent basis.

*Mr. Panetta. Got it. And beyond something like the Telehealth Modernization Act, what else do you think is necessary to improve access to telehealth services, especially in diverse districts like mine, here on the central coast of California?

*Mr. White. Yes, I think we really need to invest in broadband. I think that we have heard from a number of the panelists today that that is a critical gap. The digital divide is real.

I would encourage you know -- I think the Biden plan is one way to go. I think, for this committee, you can look at tax incentives and other things to incentivize the development of broadband and deployment. I think we need to help workers with out-of-pocket costs through HSAs, the companies' plans.

*Mr. Panetta. Great. Thank you, thank you.

Mr. Hernandez-Cancio – Ms. Hernandez-Cancio, I am going to give you the last word, okay, because I am the last witness, so I think. But I just want to talk to you about a couple of things. What would you cite as some of the most significant barriers to telehealth access?

And what roles do you see telehealth and other virtual health technologies playing within our broader goal, within our broader goal of combating health disparities?

Hit it out of the park.

*Ms. Hernandez-Cancio. Thank you so much for that, for that question and for this

opportunity.

Well, I think it just -- I just need to reiterate what we already know, which is that there is enormous promise in telehealth in so many different ways, in many of the ways that have been described at great extent during this afternoon. But we need to make sure that we are being very, very careful about centering and designing for equity, right?

Like, we can anticipate -- we already have had a great conversation today about all of the pain points that we know different communities are facing. It is not just whether there is broadband, it is, "Is it affordable?" It is, "Am I comfortable with the technology?" It is that I just simply do not feel like I am going to get the best care remotely, and I want to see and touch my doctor. There are literacy issues. They are language issues. So it is not going to be -- I don't want us to end up actually being surprised when we see the data, and saying, like, "Oh, some people were left behind." We know that. They are the same communities that are continuously left behind.

So it is really important that, as we are looking for standards and measurements, that they are patient-centered, really focused on not just like, "Did I get my A1C," but, "Did the doctor treat me with disrespect? Was the entire thing a mansplaining exercise that turned me off?"

There are so many -- so we need to have the right measurement, and we need to make sure that the measurement that we are tracking is by race, and ethnicity, and all those subgroups, so that we can very, very quickly say, "Oops, we" -- not only can we design for this in advance to try to mitigate it, but if we are still not -- if we are still not hitting it, then how do we continuously improve?

Because we all deserve to be healthy in this country, and we can do that if we decide to center those that most often get left behind.

*Mr. Panetta. Outstanding, thank you.

And thank you, Mr. Chairman. I yield back.

*Chairman Doggett. Thank you very much. That is a very good place for us to conclude the hearing.

I appreciate very much the involvement of all of our members, including the members who joined the subcommittee this afternoon, like Mr. Panetta, for the contribution.

I think that our witnesses have provided a great deal of insight on this.

I also want to thank, from my personal staff, Sarah Laven Jones and Afton Cissell, who played such an important role in talking with each of these witnesses and assisting me, as well as with many other people who offered statements and insight into the challenges we face with health care.

With regard to our witnesses, understand that, as will be the case with Mr. Smith, who had the communication problem, that all of our members have two weeks to submit written questions to be answered later in writing. We will welcome your further input, anything else you would like to have in the record. Those questions, your answers all become a part of our record.

And with that, the committee stands adjourned. Thank you so much.

[Whereupon, at 4:41 p.m., the subcommittee was adjourned.]

Submissions for the Record follow:

Advocate Aurora Health

Alliance for Connected Care

American Academy of Audiology

American Academy of Family Physicians

American Academy of Neurology

American Association for the Study of Liver Diseases

American Association of Respiratory Care

American Chiropractic Association

American College of Gastroenterology

American College of Obstetricians and Gynecologists

American Hospital Association

American Medical Association

American Medical Group Association

American Occupational Therapy Association

American Pharmacists Association

American Physical Therapy Association

American Psychiatric Association

American Speech-Language-Hearing Association

American Telemedicine Association

American Urological Association

America's Health Insurance Plans

Association for Clinical Oncology

Austin Regional Clinic

Better Medicare Alliance

Center for Telehealth & e-Health Law

Children's National Hospital

Children's Health

CommUnityCare

Cromford Health

DialCare

ERISA Industry Committee

GlobalMed

Greenbrook TMS NeuroHealth

Health Equity Inc.

Johns Hopkins University

Laurel Health Advisors

Medical Group Management Association

Mental Health Liason Group

Multiple Sclerosis Association of America

National Association of ACOs

National Association of Health Underwriters

National Center for Primary Care

National Multiple Sclerosis Society

National Organization for Rare Disorders

Northwell Health

Ochsner Health

Partnership For Employer Sponsored Coverage

Premier Inc.

Prevent Blindness

Priva Medical Group North Texas

Priva Medical Group Florida

Priva Medical Group Gulf Coast

Providence Telehealth

Psychiatric Medical Care

Salus Telehealth Inc.

SOC Telemed

Spina Bifida Association

Stanford Health Care

SWORD Health

Teladoc Health

The Center for Fiscal Equity

UW Health Madison

UW Health Seattle

Questions for the Record follow:

Questions for the Record from Rep. Kind

Questions for the Record from Rep. Nunes

Questions for the Record from Rep. Smith

Sinsi Hernández-Cancio Response to Questions for the Record

Ellen Kelsay Response to Questions for the Record

Ateev Mehrotra Response to Questions for the Record

Joel White Response to Questions for the Record