TESTIMONY OF

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"Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency"

I would like to begin by expressing my gratitude to the members of this Subcommittee for this opportunity to discuss the current and future state of telehealth in the United States.

Telehealth took off during the early stages of the pandemic, thanks to essential flexibilities such as the removal of geographic restrictions and coverage for audio-only telehealth. In MedPAC's survey, 90 percent reported satisfaction with their telehealth visits.

Currently, telehealth accounts for 10% of office visits, a rate that has been stable since July 2021 and is anticipated to remain so until December 31, 2024. However, I am concerned about a potential decline in telehealth usage after that date, which could occur either rapidly or gradually. Preventing both the *fast and slow death* of telehealth depends on the actions of Congress and CMS.

The fast death of telehealth could happen if the originating site and geographic restrictions are reinstated. If that were to occur, there's no doubt that we could revert to the pre-pandemic levels of telehealth usage, where fewer than 1% of healthcare providers and patients were utilizing telehealth services.

The slow death of telehealth may occur when patients and providers become increasingly frustrated by regulations and unexpected bills and ultimately stop using telehealth. Four key factors could contribute to this slow decline if left unaddressed:

1. **Lack of coverage alignment among payers** - Medicare sets the standard that many commercial payers follow. If Medicare continues to view expanded telehealth coverage as 'temporary,' commercial payers will reduce or eliminate their coverage for telehealth services. This is already underway, and we are witnessing the development of a fragmented telehealth payment system that creates confusion for both patients and providers. Imagine being a patient and not knowing whether your insurance will cover a video visit, a phone call, or neither. The path of least resistance for both patients and providers would be to schedule the next follow-up as an in-person visit, even if a video visit was clinically appropriate.
2. **Loss of audio-only coverage** – My personal research, along with that of others, has shown that there is an obvious digital divide. Recently, I experienced this myself in my clinic when I attempted to conduct a video visit with a patient from rural Michigan who was experiencing connectivity issues. After about 5 minutes of troubleshooting, I resorted to picking up the phone and conveyed the exact same

information about surgical options for his enlarged prostate over the phone. Such scenarios are quite common, particularly for Medicare beneficiaries residing in rural and underserved communities. If audio-only visits become ineligible for billing in the future, healthcare providers will not offer them and, as a result, Medicare beneficiaries will lose this option for remote care.

3. **Loss of payment parity** - The prevailing narrative suggests that the practice expenses related to telehealth visits are lower than those for in-person visits, thereby supporting the argument for payers to reduce reimbursement rates for telehealth visits. While on the surface this narrative is convincing, the reality is that unless your practice is entirely virtual, it's unlikely that your practice expenses have decreased. In a practice where only 1 out of 10 office visits is virtual, healthcare providers still incur the same costs for maintaining a physical office, equipment, and salaries of staff, such as clerks and nurses, who schedule visits, collect records, and provide care between visits. Practically speaking, these expenses don't decrease by 10% just because 10% of your visits are virtual.
4. **Implementation of guardrails that lack clinical evidence** - While we all recognize the importance of preventing fraud and abuse, implementing guardrails like mandating periodic in-person visits for patients receiving telehealth services only creates barriers to healthcare access. In 2022, the Office of Inspector General evaluated 742,000 telehealth providers and found that only 0.2% displayed potentially fraudulent or abusive billing patterns. There isn’t a need to impose in-person guardrails on the 99.8% of healthcare providers who use telehealth without exhibiting any patterns of fraud and abuse.

Actions of Congress and CMS in these 4 key areas can help prevent the slow death of telehealth after December 31, 2024.

I understand that there is appropriate concern both within this Committee and beyond that the permanent expansion of telehealth will result in excessive healthcare utilization and spending. Based on my research and my experience overseeing telehealth at the University of Michigan, I can confidently state that this is unlikely.

In my written testimony, you will find data that sheds light on what researchers have learned over the last three years. While no single study or report can definitively capture the entire impact of telehealth on costs, quality, and access, I believe most researchers would at least agree on these three points:

1. Telehealth expansion has not led to runaway healthcare spending or utilization.
2. Telehealth does not compromise quality of care for patients.
3. Telehealth improves access to care.

In the end, making telehealth expansion permanent is about ensuring that Medicare beneficiaries have choices in their care, whether it’s in-person, via video, or through a phone call. I applaud this Committee for its extensive efforts in making telehealth coverage permanent.

Summary of studies on the impact of telehealth on cost, quality, and access

Utilization and costs

- From July 2021 through December 2022, the proportion of telehealth-based evaluation and management visits among Medicare FFS beneficiaries has consistently hovered around 11%. (Figure 1, Ellimoottil 2023)
- From March 2020 through December 2022, the combined total number of monthly in-person and telehealth office visits has not exceeded 2019 levels at any point. (Figure 1, Ellimoottil 2023)
- There were greater rates of same-specialty in-person follow-up in the 90 days after in-person office visits than after telehealth visits. (Gerhart 2023)
- The availability of telehealth has not led to additional primary care visits; instead, telehealth is serving as a substitute for specific in-person encounters, resulting in no overall increase in primary care utilization. (Dixit 2022)
- Patients who had visits for acute respiratory infections were more likely to seek follow-up care within seven days after telemedicine visits (10%) compared to after in-person visits (6%). (Li 2021)
- Adjusted 30-day episode costs were lower for Medicare patients who had initial telehealth visits compared to in-person visits. These patients exhibited higher rates of 30-day return visits but lower rates of imaging and laboratory testing. Results are preliminary. (Ellimoottil 2023)
- Total cost of care per beneficiary increased in 2021 compared with 2019 across all regions evaluated but increased more in high-telehealth intensity regions. Conclusion: "Greater telehealth use was associated with slightly increased costs to the Medicare program." (MedPAC 2023)

Quality

- Hospitalization rates for conditions such as congestive heart failure and dehydration were lower in the second half of 2021. However, the rate of decrease in areas associated with high telehealth use was slower. Emergency department visit rates were not found to be associated with a region's telehealth use. Conclusion: "Greater telehealth use was associated with little change in quality." (MedPAC 2023)
- Practices that have high levels of telehealth use had marginally higher overall hospital or emergency room visit rates than low telehealth practices. (Li 2022)
- AHRQ review of 165 studies reporting outcomes concludes: "Across a variety of conditions, telehealth produced similar clinical outcomes as compared with in-person care; differences in clinical outcomes, when seen, were generally small and not clinically meaningful when comparing in-person with telehealth care." (Hatef 2023)
- Beneficiaries were generally satisfied with the visits. Forty percent of telehealth users expressed their interest in continuing to use telehealth even after the pandemic ends. (MedPAC 2023)

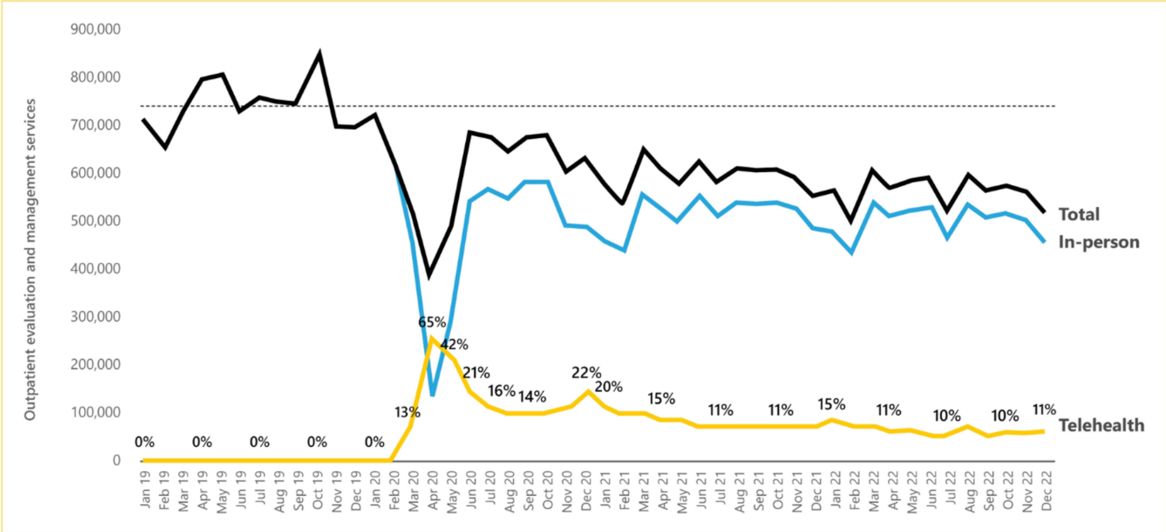
Access

- Total clinician encounters per beneficiary were lower in the second half of 2021 than in the second half of 2019, though the decline was slower, on average, among high-telehealth-intensity regions compared with low telehealth-intensity regions. Conclusion: Greater telehealth use was associated with "slightly improved access to care for some beneficiaries" (MedPAC 2023)

- Patients who are older, are African-American, require an interpreter, use Medicaid, and live in areas with low broadband access are less likely to use video visits as compared to phone. (Chen 2022)
- Patients who had at least one telehealth visit for opioid use disorder were more likely to remain engaged in treatment for at least 90 days, compared to in-person treatment. Staying in treatment is key to reducing the risk for relapse and overdose. Among those who had at least one telehealth visit, those who were older (45–65+ years old), male, Black, or had housing instability were more likely to have only audio-only visits rather than video visits. (Frost 2022)
- Interviews with behavioral health providers revealed that they felt better equipped to meet their clients' diverse needs after receiving the flexibility to offer telehealth services when appropriate. Telehealth helped mitigate frequently-cited barriers to accessing behavioral health care, such as the lack of transportation, missed work, and the need to arrange childcare. (Beck 2021)
- Increase in overall and telehealth addiction treatment utilization after telehealth policies changed during the COVID-19 pandemic. There was no evidence that disparities were exacerbated. (Palzes 2023)
- Compared to patients with in-person visits, a higher percentage of patients with telemedicine visits gave higher satisfaction ratings for access (62.5% vs. 75.8%, respectively) and care provider concern (84.2% vs. 90.7%, respectively). Telemedicine visits consistently outperformed in-person visits over time in terms of access and care provider concern. (Patel 2023)

<u>Summary</u>
This list is not comprehensive; it simply represents a sample of the thousands of studies and reports conducted on telehealth since 2020. The impact of telehealth on costs, quality, and access depends on the condition, measure, and telehealth modality. The studies listed here specifically focus on video visits and do not cover other modalities, such as remote patient monitoring and telestroke. However, in general: 1) Telehealth expansion has not resulted in runaway healthcare spending or utilization. 2) Telehealth does not compromise the quality of care. 3) Telehealth improves access to care.

Figure 1: National Trends in In-Person and Telehealth Evaluation and Management Visits Among Medicare Fee-for-Service Beneficiaries, 2019-2022



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