**Next Steps in Telehealth Payment and Regulatory Policy**

Statement by
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Thank you, Chairman Cardin, Ranking Member Daines, and distinguished members of the subcommittee; I am honored to have been invited to testify before you on a topic of such critical importance to Americans and their health.

My name is Dr. Ateev Mehrotra. I am a physician at the Beth Israel Deaconess Medical Center and a Professor at Harvard Medical School. My research focuses on the impact of telehealth. Specifically, how does telehealth impact quality, spending, and people's ability to access care, particularly in rural communities? I have studied a wide range of clinical applications of telehealth, including stroke, mental illness, substance use disorders, contraception, and acute respiratory illness. I do this research because I hope telehealth can help address the common complaint I hear as a physician and what I am sure you hear from your constituents: that people across this nation often have difficulty accessing timely care.

**INTRODUCTION**

The rapid adoption of telehealth early in the pandemic was dizzying, with telehealth visits accounting for 42% of Medicare outpatient visits in April-May 2020.[1] Clinical changes that I would have expected to take a decade occurred within weeks. Most federal pandemic-era telehealth policies have remained temporary and have been extended numerous times by Congress. Implicit or explicit in the legislation authorizing these extensions is that more research is needed to dictate permanent regulations. As I describe below, some of that evidence is starting to emerge.

Some contemplated whether the unprecedented rates of telehealth use during the COVID-19 pandemic were the beginning of a new normal — one with telehealth as a core component of how patients receive care. The result has been more of a modest change in most clinical areas than a paradigm shift.[2] The number of telehealth visits per month in the United States continues to fall since its peak in April 2020 and today represents roughly 5% of all outpatient visits in Medicare.

In surveys and interviews, patients and physicians have greatly valued the availability of telehealth and want it to remain an option in the future.[3] However, both patients and physicians have questioned the quality of care in a telehealth visit, specifically due to the inability to conduct a full physical exam and key tests (e.g., electrocardiograms).[4] Many patients prefer in-person visits.[5]

My testimony will focus on the future of payment policy and regulations for telehealth. I began by describing three key principles that I believe should drive telehealth policy, and then I specifically discuss the following six issues related to payment and regulation:

1. Permanent expansion of telehealth coverage for all Medicare beneficiaries
2. Whether telehealth visits should be paid at the same rate as in-person visits
3. Role of audio-only telehealth visits
4. In-person visit requirements
5. Physician licensure in the context of out-of-state telehealth visits
6. Telehealth payment models

**KEY PRINCIPLES OF TELEHEALTH POLICY**

The first principle is that policymakers should formulate their telehealth policy decisions through the lens of *value*. In the case of telehealth, value is the dollars per improvement in care outcomes and access. Improvements in access could decrease travel time, disruption to lives, and the need for childcare. Under the value framework, the questions are: What are the high-value applications of telehealth? And how can policies encourage higher-value applications of telehealth and discourage lower-value applications of telehealth?

Value is dictated by the condition treated (for example, common cold vs. stroke) and the patient receiving care. Consider two patients with depression who can participate in a telehealth visit. One lives in rural Alaska with no access to local clinicians and substantial transportation barriers. Telehealth could be the only way he can access care and improve his condition. The second patient lives in Anchorage, her depression is well controlled, she sees her psychiatrist every month, and she is on the right medications. There is minimal value in an additional telehealth visit every two weeks for her depression.

Many of the policies that have been considered or implemented (for example, targeted expansions of telehealth by condition and limitations on which patients can receive telehealth) try to prioritize higher value applications of telehealth while continuing to restrict applications with uncertain value. For example, implicit in Congress's expansion of telehealth for rural communities is that rural residents have more difficulty accessing care. Implicit in the expansion of telehealth for mental illness treatment is that mental illness is undertreated in the United States. The hope is that targeted expansions result in substantial quality improvements at a reasonable cost.

It is important to acknowledge that all such policies are inherently crude. There are patients in rural communities who are getting all the care they need without telehealth, and there are plenty of patients in urban areas who are not getting the care they need. Fundamentally, using billing rules and regulations in the fee-for-service system to determine when one form of telehealth is allowed and another is not allowed is a daunting task — clinicians and patients will quickly point out circumstances where the payment rules do not make sense. The growth of telehealth has accelerated the need to shift to other forms of payment.[6] This is a topic I touch upon below.

The second principle is that we should try to *avoid one-size-fits-all telehealth policies* — just as there can be no single coverage policy for all prescription drugs. In the same way different drugs yield different outcomes, telehealth's benefits will vary across clinical conditions, different forms of telehealth, and different providers. For example, telehealth for treating stroke could save lives, while telehealth visits for the common cold have little clinical benefit.

There are many different forms of telehealth. While much of the focus of debate on telehealth policy is on video visits, the pandemic has led to a surge in other forms of telehealth that have received less attention, such as asynchronous visits (eVisits), consultations between clinicians (eConsults), remote patient monitoring, and simple messages from patients asking for advice. Across over 300 health systems that use the Epic electronic health record, there has been a 57%

increase during the pandemic in the number of messages patients submit daily via patient portals asking for medical advice.[7] While I largely focus on video visits, I will touch upon payment policy for other forms of telehealth.

Another critical distinction in telehealth policy is the type of provider. While telehealth-only providers may improve access for Americans and have introduced many innovative models of care, they also raise new issues. They have lower overhead costs than "brick and mortar" providers because they do not have to pay for office space and equipment. Also, due to the pressures of venture capital funding, they have been pressured to grow as rapidly as possible. This pressure to grow rapidly may have been one driver of a recent scandal where a direct-to-consumer telehealth company was accused of overprescribing stimulant medications.[8] It is unclear whether telehealth-only providers should be regulated and reimbursed differently.

The third principle is that we want to *limit the administrative burden*. Administrative burden frustrates patients and clinicians and drives up spending. Already, clinicians sometimes struggle to correctly bill and document for telehealth visits.[9]

**IMPACT OF TELEHEALTH ON SPENDING, QUALITY, AND ACCESS**

Concern that telehealth will drive up healthcare costs is a key impediment to its permanent expansion. Consistent with others, including the Congressional Budget Office, [10] I have expressed concern that greater telehealth use will increase spending. The concern is that in some circumstances, telehealth is *too convenient* and may encourage greater use of care such that telehealth visits may largely be additive to the healthcare system. In other words, telehealth's ability to make care convenient and more accessible — the key to its enormous potential to improve the health of many patients — may also be its Achilles' heel.

After several years, evidence is beginning to emerge on the impact of greater use of telehealth. In our work, we took advantage of variations in uptake across large health systems to understand the impact of telehealth use. For various reasons, including the type of electronic health record, health system leadership, and local policy, some health systems adopted telehealth to a greater degree than others. We compared patients receiving care at health systems that used more telehealth during the COVID-19 pandemic to those that relied more on in-person services. The difference in telehealth use in 2020 was substantial –patients assigned to the highest telemedicine adoption health systems received 27% of their visits via telemedicine compared to 10% in the lowest telemedicine adoption. Though telemedicine use fell through December 2022, patients at high telemedicine health systems continued to receive more telemedicine through the end of 2022.

In 2021-2, we found a relative increase of 2.2% in visits per patient per year between patients in the highest and lowest telehealth use health systems. Most of these visits (83%) substituted for in-person visits. The relative increase in visits was larger among lower-income, non-white patients. Patients receiving care from higher telehealth health systems also had small improvements in chronic disease medication adherence and decreased ED visits. However, these changes accompanied a $248 (1.6%) increase in healthcare spending per capita.

Our results showing increases in visits, small increases in spending, and modest improvements in quality are qualitatively consistent with other recent work. An analysis for the Medicare Payment Advisory Commission found that geographic areas with higher telehealth uptake through 2021 had a 3% relative increase in total clinical encounters and a spending increase of $165 per capita.[11] A 2021 study in Ontario found that greater physician telehealth uptake was associated with small decreases in ED visits.[12] Another analysis focused on telehealth for mental illness found that greater telehealth use was associated with more total visits (in-person plus telehealth) without substantial improvement in quality metrics.[13] Our results are also consistent with Congressional Budget Office modeling that telehealth expansions for mental illness will increase spending because of projected increases in total visits.[14]

Though we observe an increase in outpatient visit utilization, the increases that we and others have documented are relatively small. Several factors may explain this. Clinicians may have limited capacity to provide additional visits. Alternatively, there may have been limited demand from patients. As noted above, patients have worried that the quality of telehealth visits is lower than in-person visits.[15]

It is important to acknowledge the limitations of these studies. We use data through 2022, when there were still ongoing waves of COVID-19 illness, which may have impacted healthcare-seeking behavior. One must be cautious in extrapolating results from the care patterns during the pandemic to those we will observe after the pandemic. The effects of telehealth on quality and spending could change as technology improves, health systems optimize telehealth services or patient demand changes. The results may not translate to virtual-only companies, and these broad-based evaluations do not capture the quality outcomes specific to a clinical area. Therefore, moving forward, it will be important to continue monitoring telehealth's impact on quality and spending in different clinical areas.

*Policy recommendation*

Acknowledging these limitations, I recommend that Congress permanently eliminate site-location requirements and allow video visits for all conditions at any site to any Medicare beneficiary in the United States. My recommendation tries to balance the principles I described above. While telehealth does not reduce healthcare spending, the increase in spending is modest, and the research has highlighted that greater telehealth can result in small improvements in access and quality. Perhaps most importantly, patients and clinicians want telehealth to remain an option, and policymakers will find it difficult to "take away" telehealth. Limiting telehealth expansions to some conditions or patients adds administrative burden (for example, navigating different modifier codes). Finally, almost four years after the pandemic's start, it is reasonable to signal to clinicians that telehealth payments are here to stay so they can make investments in telehealth with more certainty.

I would also permanently allow Federally Qualified Health Centers and Rural Health Clinics clinicians to provide telehealth visits beyond mental health visits as "distant" clinicians, enabling them to provide telemedicine care to patients in their homes. These clinics often treat patient populations with greater difficulties accessing care; therefore, their telehealth visits will likely be of higher value.

Invariably, areas will emerge where we observe overuse or low-value telehealth use. But those areas could be addressed on a case-by-case basis by Medicare. For example, Medicare could address concerns of fraud or overuse by requiring in-person visits if a physician wants to order specific high-cost tests.

Given the rapid pace of change in telehealth, I believe it is critical to give Medicare as much flexibility as possible in adapting telehealth policy. As noted above, I am both excited and concerned about the emergence of virtual-only companies. To better track the care they provide, Medicare should be able to require clinicians to report if they have any corporate affiliations and Medicare should have the ability to exclude specific companies they believe provide low-value care.

**PAYMENT PARITY**

Payments for office visits in the Medicare system are based on the time a physician or other clinician takes to provide care and the overhead to support the space, staff, and equipment necessary to provide that visit. For a common office visit (CPT 99213), the payment is roughly half for physician time and half for these practice expenses. While it does require some overhead, telehealth visits do not require the same practice expenses as in-person visits. Physicians also believe that telehealth visits cost less than in-person visits.[16]

*Policy recommendation*

I recommend that telehealth visits be paid less than in-person visits. Some clinicians have objected. They argue that their practice expenses have remained the same because they provide both in-person and telehealth visits and therefore must maintain the same staff and resources. This argument does not convince me. I do not think Medicare should cross-subsidize in-person visits with telehealth visits because it will create distortions in the market. Paying the same amount for telehealth visits will give virtual-only companies a competitive advantage. It will also incentivize brick-and-mortar clinicians to give up their practice. We find that roughly 5% of mental health specialists have given up their physical office and gone "virtual only."

The correct difference in payment between a telehealth visit and an in-person visit is unclear. Currently, Medicare reimburses for a telehealth visit ~25% less than an in-person visit.[17] While this is a reasonable starting place, this difference may need to be adjusted as Medicare receives more data on the practice expenses necessary to provide telehealth visits.

**AUDIO-ONLY TELEHEALTH VISITS**

Another area of debate is the role of audio-only visits. Though it is unclear exactly what fraction of telehealth visits are audio-only,[18] it is clear that they are quite common. Audio-only visits may be particularly important for disadvantaged communities and safety-net clinics.[19] In a study on digital access, we found the proportion of patients with access to the necessary technology for a video visit was lower among those with a high school education or less, were Black or Hispanic, received Medicaid, or had a disability.[20] Many policymakers have mandated coverage of audio-only visits to ensure all people have access to telehealth. For example, Arkansas, Florida, Kentucky, Vermont, and Washington have all passed legislation ensuring access to audio-only care for all residents or those with Medicaid.[21] However, there are also concerns from physicians and policymakers that audio-only care may lead to inferior care. Though there is limited data on the quality of audio-only telehealth visits, in a survey of clinicians who treat substance use disorder, 70% perceived that their patients received higher-quality care via video than audio-only visits.[22]

One assumption is that clinicians turn to audio-only visits due to patient preference. However, growing evidence shows clinicians also turn to audio-only visits due to provider preference. Many clinicians do not offer video visits to all their patients and they are less likely to be offered to historically marginalized groups.[23] There is substantial variation in video telemedicine use among Federally Qualified Health Centers. This difference appears to be driven by their information technology platforms and what investments were made in helping patients address barriers to obtaining video visits.[24]

*Policy recommendation*

I recommend that Medicare pay for audio-only telehealth visits for a time-limited period, such as two years. Given the lower practice expenses, I believe an audio-only visit should be paid less than a video visit. While I recognize telephone calls may increase access for disadvantaged populations, I am concerned about a future with a two-tiered system where the poor and disadvantaged receive phone calls, and the wealthy have video visits. Though a phone call may be sufficient in many cases, I worry that on average phone calls may not lead to the same level of care. I also recommend Medicare require physicians providing an audio-only visit to attest that they offered the patient a video visit and that their clinic provides resources to patients who face barriers to video visits. I hope limiting payment for a short period and requiring this attestation will spur the necessary investments in support at clinics so that all Americans can receive a video visit. It will also create an opportunity for more research on what impact audio-only visits have on quality, spending, and access.

## IN-PERSON VISITS BEFORE A TELEMENTAL HEALTH VISIT

At the end of 2020, Congress permanently expanded coverage of telemental health in Medicare but required that an individual have an in-person visit within six months before the first telemental health visit. Many mental health clinicians expressed concerns that there was no evidence of clinical benefit for this requirement, and it would create an unnecessary barrier to care. In December 2022, Congress passed legislation delaying the in-person requirement until January 2025.

To better understand what impact this rule may have on care in the future, we examined the care of Medicare fee-for-service beneficiaries. Of the more than 800,000 first telemental health visits in 2022, only 19% were preceded by an in-person visit with that clinician. Our results highlight that such a new requirement would require a substantial change in current practice. It could also imply that clinicians do not perceive in-person visits within six months as clinically necessary.

*Policy recommendation*

I believe that Congress should remove the requirement for in-person visits requirements before mental health visits. While removing this requirement will likely increase spending on mental health, requiring in-person visits will decrease the ability of telehealth to expand access to mental health services for patients who live far from any mental health clinician and, therefore cannot have in-person care.

## PHYSICIAN LICENSURE AND THE ROLE OF EXCEPTIONS

The COVID-19 pandemic prompted federal and state governments to relax licensure requirements temporarily to facilitate out-of-state physicians' care. During the early-pandemic period (through mid-2021), there was substantial use of out-of-state telehealth.[25] Among all Medicare beneficiaries with a telemedicine visit, 5% had an out-of-state telemedicine visit. In most cases, this was a continuation of an established relationship. Out-of-state telemedicine use was greatest for some conditions, such as cancer, among people who lived near a state border and in more rural states such as Montana and South Dakota. Most of these temporary regulations have now expired.

This return to pre-pandemic policy is not limited to video visits. Follow-up phone calls are also victims of this return to pre-pandemic licensure practice. Some lawyers have interpreted that a follow-up phone call constitutes the "practice of medicine" and must be limited to patients in a state where the physician is licensed. For example, the governing code in Texas defines practicing medicine as the "diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method" and notes that any "person who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state…that would affect the diagnosis or treatment of the patient, is considered to be engaged in the practice of medicine."[26] Texas is not unique; similar definitions and rules exist in other states. Such rules can create issues for a patient seeking clinical advice from a physician in their home state while traveling to another state.

These geographic limitations of telehealth visits have created substantial frustration. Patients wonder why driving across a state border results in better care. For many video telehealth visits, patients sit in cars or coffee shops on smartphones, searching for good WiFi and sharing tips about the best parking lots just across the state border.[27] And many patients simply stopped following up with their out-of-state physicians.[28]

Unfortunately, reforms such as the Interstate Medical Licensure Compact, a process for making it easier for physicians to get a full license in multiple states, or the use of special telehealth licenses have had limited benefits. Expanding the use of licensure exceptions would be more helpful.[29] Many states have already incorporated exceptions to their licensure requirements. For example, Arizona allows a physician licensed in another state to provide telehealth to a patient in

Arizona "[t]o provide after-care specifically related to a medical procedure that was delivered to a person in another state." Other key groups, such as the American Medical Association, support the need for greater use of exceptions for out-of-state telemedicine follow-up care. The Federation of State Medical Boards (FSMB) believes there is a need for exceptions that "permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located. These exceptions to licensure are only permissible for established medical problems or ongoing workups and care plans."[30]

Using these exceptions is relatively simple for a physician. A physician only needs to be aware of the limitations of exceptions and that one cannot initiate a physician-patient relationship using an exception. From a patient perspective, such exceptions would allow most patients to use telehealth when needed. A student who is away for college can still see their psychiatrist in their home state. Patients traveling for work can keep in touch with their primary care physician regardless of where they are.

*Policy recommendation*

I recommend Congress pass legislation implementing a narrow exception to state licensure allowing any physician to provide telehealth across state lines if they have an established prior relationship with that patient and are licensed in good standing in their home state. The advantage of federal legislation is that it creates a clear set of rules nationwide. While many states have implemented similar exceptions, the language is not always consistent, and physicians have to carefully track the specific rules in the state where their patient is currently located. Creating this type of narrow exceptions for licensure is consistent with prior federal licensure legislation, such as the Sports Medicine Licensure Clarity Act[31] and the VA MISSION Act.[32]

## PAYING FOR OTHER FORMS OF TELEHEALTH

As noted above, telehealth is not limited to video and audio-only visits. We are seeing rapid growth in other telehealth applications, such as remote patient monitoring.[33] In some cases, Medicare is paying for such care using monthly bundled payments instead of fee-for-service payments. The bundled payments include payments for data transfer costs and all communication between clinicians and patients in the month.

Similar payment innovation is needed for other forms of telehealth, such as portal messages.[34] The number of portal messages has surged during the pandemic, and clinicians, particularly primary care physicians, are frustrated because they spend substantial time at night answering these messages largely without reimbursement.[35] The fee-for-service system is poorly suited for frequent but short interactions, such as short phone calls or portal messages. When the units become smaller and smaller (e.g., it may take a clinician only 2 minutes to respond to a portal message), the estimated $20 of administrative costs required to submit a bill for a single patient encounter may not be worth it.

*Policy recommendation*

I encourage giving Medicare as much flexibility in creating payment models that use partial capitation or bundled payments to pay for telehealth applications such as portal messages. Such alternative payment models give clinicians the flexibility to use the full range of telemedicine tools (portal messages, video visits, eVisits, phone calls, eConsults, telemonitoring) best suited for an individual patient and clinical scenario and avoid the administrative burden of billing for each encounter.

## SUMMARY OF POLICY RECOMMENDATIONS

To summarize, my policy recommendations are:

- Permanently eliminate site-location requirements and allow for video visits for all conditions for all Medicare beneficiaries.
- Pay for telehealth visits at a lower rate than in-person visits, avoiding telehealth parity.
- Pay for audio-only telehealth visits for only a time-limited period and require attestation from the clinician that they offered the patient a video visit.
- Remove in-person visit requirements before mental health visits.
- Introduce selective exceptions to state licensure that allow patients to get care from any clinician with whom they have an established relationship.
- Encourage innovation in payment models for telehealth that use bundled payments of partial capitation.

I acknowledge that the coverage decisions and payment choices I recommend are not perfect. They will deter some effective forms of telehealth and may add some administrative burden. Also, telehealth use is rapidly changing, and policy must adapt accordingly. However, I believe they represent the best way to encourage high-value applications of telehealth and encourage a necessary transformation of our healthcare system.

Again, I thank Chairman Cardin, Ranking Member Daines, and members of the subcommittee for allowing me to appear before you today to discuss this critical topic in health care.

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