

Testimony of Elizabeth Mitchell

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**Hearing of the Committee on Energy and Commerce
Health Subcommittee**

**THE FUTURE OF TELEHEALTH:
HOW COVID-19 IS CHANGING THE DELIVERY OF VIRTUAL CARE**

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Chairwoman Eshoo, Congressman Guthrie, and members of the Subcommittee on Health: Thank you for the opportunity to address the subcommittee today on this critical issue. I am Elizabeth Mitchell, President and CEO of the Purchaser Business Group on Health (PBGH). PBGH is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend \$100 billion annually purchasing health care services for more than 15 million Americans and their families. Our members work with us to identify needed system reforms to achieve and pay for optimal quality and outcomes and affordable care.

As you know, the novel coronavirus (COVID-19) pandemic has challenged the country's public health, health care payment and delivery systems more than any other event in living memory. Among the numerous challenges, millions of people have been unable to receive needed medical care from their usual medical providers due to travel restrictions, office closures and concerns about viral spread. The result has been a significant decline in needed care including childhood vaccinations, mental and behavioral health care, and deferred care for chronic conditions.¹

COVID-19 As Catalyst for Telehealth – Opportunities and Concerns

The U.S. health care system needs urgent reforms in care delivery including more effective use of technology. But simply adding a new service or technology to an already dysfunctional system without consideration for quality outcomes, patient experience and total cost is not the right approach. My testimony today will focus on ways policymakers can harness the promise of telehealth and its rapid adoption during the pandemic -- and if managed properly -- to help millions of people in the United States access high quality, affordable health care. By making care more accessible, telehealth can function as a highly useful tool in providing care to underserved areas and populations and in expanding care in under-resourced sectors, such as behavioral health.

Academic studies suggest telehealth is popular with many patients and is often preferred compared to in-person care.² Many physicians and other providers are finding that telehealth suits their needs as well.³ **Recently completed research by PBGH found that among 1,500 patients in California covered by commercial HMO and Medicare Advantage insurance plans, no difference was reported in satisfaction between virtual and in-person care.** In addition, 87% of respondents reported that they would recommend telehealth and 73% wish to continue its use. Telehealth adoption is an overdue improvement to enhance access and patient experience.

But rapid adoption of telehealth has the potential to be a double-edged sword: without proper oversight by policymakers and purchasers, greater use of telehealth could lead to increased fragmentation, duplicative and unnecessary spending,

higher rates of fraud and ultimately higher overall costs and worse outcomes for patients. This is why your hearing today is so timely and critically important. Congress has an opportunity to get this right the first time, rather than having to go back and fix unintended consequences later. In our view, this is not unlike the early days of electronic health records (EHRs) that had the potential to greatly improve care coordination and patient safety and outcomes. Very significant federal and private investment went into electronic data sharing and tools but ten years later we find ourselves with a massive industry that does not effectively share data, does not prioritize quality and safety, adds to the burden of physicians and care teams and has become entrenched in business interests that do not always align with patient needs or public interest. We hope to avoid that same fate for telehealth by setting clear standards and objectives for its use and adoption.

From the purchaser perspective, I offer the following principles for expanded use of telehealth in the years ahead. My testimony dives deeper into each of these principles and offers specific policy recommendations:

- ***Clinically appropriate and high quality:*** Expanded use of telehealth services must be clinically appropriate and provide high-quality care, with outcomes commensurate with or better than in-person care.
- ***Cost effective:*** Telehealth should be cost effective for purchasers and patients and its use should reduce the total cost of care by reducing low-value care.
- ***Coordinated:*** Telehealth should enhance care coordination, rather than duplicate services and add to an already fragmented system.
- ***Meets Patients where they Are:*** State licensure requirements should not be a barrier to access to care.
- ***Equitable:*** Expanded use of telehealth should reduce disparities in health care, not exacerbate existing inequities.
- ***Used in population-focused, total-cost-of-care models:*** Finally, telehealth is most effective when deployed in a payment model where providers are accountable for quality, patient experience, equity and the total cost of care.

Clinically Appropriate and High Quality

There is relatively little academic research regarding the clinical appropriateness of telehealth as an alternative to traditional in-person care. **Certain services, such as behavioral health care, may be best delivered via telehealth for many populations.**⁴ Yet, with current technology and regulations, many treatments and services cannot be reasonably provided outside of an in-person setting.⁵ Further, certain patients may be better suited to telehealth than others. Those with poor

cognitive function, for instance, may face challenges receiving care through telehealth.⁶

There is limited research on differential quality outcomes between in-person and telehealth-based care.⁷ **In addition to clinical outcomes, one critical area of quality is patient experience, where PBGH research shows promising results for telehealth. For 20 years, PBGH has led the largest statewide patient experience program, collecting data from over 40,000 patients each year, and producing performance ratings for roughly 180 provider organizations in California.** Included in our research are questions regarding patient experience with telehealth. Among the high-level results:

- Patients are roughly equally satisfied with virtual and in-person care.
- Overall, telehealth is popular: 87% of respondents say they recommend telehealth, and 73% want to continue using telehealth in the future.
- Video visits are favored over audio-only by most patients.
- The audio-visual / audio experience does not appear to negatively impact provider communication, which is rated highly among patients.

Despite these promising findings, PBGH research has been, to date, limited to commercial populations in the state of California. Further research on patient experience and clinical outcomes should be conducted nationwide with more diverse populations, including Medicaid beneficiaries, racial and ethnic minorities and those with limited English proficiency. **PBGH will have preliminary results from a survey with a sample of patients with Medi-Cal coverage in spring 2021 and seeks to expand this measurement nationwide.**

PBGH recommends that policymakers:

- *Develop clinical guidelines for which treatments and services can be appropriately provided through telehealth.*
- *Require measurement of patient experience and outcomes through telehealth*
- *Invest in nationwide research on the differential impacts of telehealth versus in-person care on quality outcomes and patient experience.*
- *Avoid mandates or other permanent policy changes regarding telehealth coverage requirements for specific services until there is clear evidence on clinical appropriateness.*

Cost-Effective

Telehealth can provide a cost-effective health care solution for many patients. By reducing overhead costs and enabling health care providers to efficiently treat more patients, **several studies have concluded that broader availability of telehealth could bring significant cost savings to the health care system.**⁸ One of our member companies, eBay, has calculated that if they were to enable appropriate adoption of telehealth among its U.S.-based employees, the company could reduce its self-insured medical and pharmacy costs by roughly 8% annually without sacrificing quality and improving the patient experience.

Yet despite the inherent efficiency of telehealth as an alternative to in-person care, some stakeholders have urged policymakers to mandate that telehealth services be compensated at the same rate as in-person care, including circumstances in which care is provided via telephone rather than video link. **While so called “payment parity” may be useful in certain circumstances – for instance, during the COVID-19 pandemic, when patients had no choice but to use telehealth for needed care – we believe that parity should neither be the goal, nor the yardstick by which policymakers measure telehealth payment. Payment parity within a flawed payment system should not be the goal. Payment parity assumes several facts with which we disagree.**

- First, payment parity assumes similar input cost basis. Medicare, for instance, pays physicians according to Relative Value Units (RVUs). RVUs are derived, in part, from an assessment of the time and intensity it takes for a physician to provide a certain service, and the “practice expense” – overhead costs – of operating as a health care provider.⁹ Evidence suggests that the overhead costs of telehealth can be lower than in-person care, and that physicians are able to provide service to more patients in less time than traditional in-person care.¹⁰
- Second, as noted above, there remains limited evidence regarding the quality of health care outcomes for telehealth versus in-person care for many sets of services. Measurement of care and more federal research funding is needed.
- Finally, pay parity could disadvantage in-person providers of similar services who lack the resources to aggressively pursue telehealth but are subject to higher overhead costs. And more importantly, we must avoid the potential for telehealth to exacerbate health disparities among rural communities or lower income communities without needed technology or broadband to benefit.

Instead of focusing on payment parity, we urge policymakers to consider telehealth payment adequacy and efficiency in the context of value-based payment. A successful telehealth payment system should be focused on improving access to

needed care while maintaining quality and reducing the **total cost of care**, rather than simply matching current payment levels.

Several studies have found that even if telehealth services are cost-effective, they can increase duplication of care, ultimately costing purchasers and patients even more than standard in-person care in the long run.¹¹

Further, the Department of Health and Human Services' Office of Inspector General has found that **expanded telehealth flexibility created to respond to COVID-19 has led to a dramatic increase in telehealth-related fraud** in Medicare.¹² The cost of telehealth-related fraud can be significant. In September 2020, the Department of Justice charged more than 85 people in an alleged telehealth fraud schemes that cost purchasers \$4.5 billion.¹³

PBGH recommends that policymakers:

- *Refrain from making permanent any payment parity requirements for Medicare, and other payers. Instead, policymakers should focus on a telehealth value-based payment system that ensures improved access to care, maintains quality and reduces the **total cost of care**.*
- *Develop and implement mechanisms to minimize telehealth-related fraud.*
- *Study the extent to which telehealth services increase duplication of care, adjusting payment rates accordingly.*
- *Given that a large percentage of people are covered by high-deductible health plans (HDHP's) we recommend making the CARES Act provisions permanent and allow pre-deductible treatment of telehealth services for HDHP's.*

Coordinated

Poor care coordination is a leading cause of poor health care outcomes and leads to billions of dollars in unnecessary, wasteful spending.¹⁴ Employers and purchasers strongly support efforts to enhance care coordination and integration as an essential factor in improving quality and reducing the costs of care. While telehealth can be integrated into a patient's regular source of care, the rise of independent "point-solution" telehealth providers raises several concerns for purchasers. More telehealth vendors are being acquired by health plans and leveraged as competitive plan-specific products, which may inhibit data-sharing and coordination.

Unless those point-solution providers are required to coordinate care with a patient's regular care provider or are paid as part of a population-focused total cost-of-care model, **we believe the proliferation of independent telehealth providers is likely to increase care fragmentation**, raising costs for purchasers and patients and resulting in poorer health care outcomes.

PBGH recommends that policymakers:

- *Require independent telehealth physicians and providers to directly provide all care information to their patients' primary care physician or medical home, or to an interoperable electronic medical record that the patient and his or her physician can readily and freely access.*
- *Provide purchasers the flexibility to require coordination of care between freestanding telehealth providers and primary care physicians in contracting negotiations.*

Available Across State Lines

Many researchers have identified state medical and nursing licensure requirements as significant barriers to broader use of telehealth.¹⁵ Such requirements substantially limit the ability of patients to find appropriate telehealth providers, particularly in lower-population states and for some sub-specialties.¹⁶ **By limiting competition to providers within states, these licensure requirements drive up health care prices without improvement in quality.**¹⁷

The same barriers are present for mental health care as well. For example, about one-fifth (19%) of metropolitan counties lack even a single psychologist, compared with almost half (47%) of non-metropolitan counties. And whereas about two-fifths (42%) of metropolitan counties lack even a single psychiatric nurse practitioner, this proportion nearly doubled to 81% in non-metropolitan counties.¹⁸

Recognizing these barriers to access, most states have taken steps to waive or reduce state licensure requirements during the COVID-19 pandemic.¹⁹ Researchers and policymakers have identified several changes that could ease barriers and improve cross-state access to telehealth. Among the policies under consideration are:

- ***Interstate compacts:*** Some states have engaged with neighboring states to offer licensing reciprocity or make it easier for physicians and other health care providers to hold licenses in multiple states. Such compacts exist for physicians, nurses, psychologists, emergency medical services personnel and others.²⁰
- ***Changing "site-of-service":*** Under current federal law, the practice of medicine occurs at the location of the patient, not the health care provider. Hence, a health care provider must be *licensed in the state where the patient is located* to be allowed to provide and bill for services. Federal legislation has been introduced in previous Congresses to reverse

this distinction, establishing the *location of the provider* as the site-of-services. Thus, a provider licensed and physically located in one state would be able to provide services to patients located in any other state based on their own location.

- ***Creation of a national medical license:*** The most radical change suggested, and one that has received more attention due to COVID-19, is to do away with state medical licensure altogether, at least for telehealth services. Instead, the federal government would license medical professionals, who could then practice anywhere in the country.²¹

To make telehealth services more affordable and accessible for patients across the country, PBGH recommends that policymakers:

- *Accelerate state-level solutions by mandating interstate compacts for telehealth services for both physical and mental health providers.*
- *Closely consider and then enact federal solutions, which may include changing site-of-service rules or establish a national framework for telehealth provider licensure for physical and mental health providers.*
- *While policymakers consider longer-term solutions, Congress should enact the TREAT Act or other legislation to ease licensing restrictions during the pandemic.*

Equitable

In recent years, policymakers have begun to focus on not only improving access to and quality of health care across the system but also to tackling persistent inequities in care particularly affecting racial and ethnic minorities and underserved areas and populations. **Telehealth provides a golden opportunity to accelerate the path toward health equity by making care less expensive and more accessible for many people experiencing disparities.**²² For years, telehealth has been found to be particularly useful for people in underserved rural areas, where physical barriers to access are greatest.²³ Research suggests that health disparities may be reduced when people from marginalized groups receive care from people who look like them or share some key identities and experiences.²⁴ In conjunction with changes to state licensure requirements, telehealth can significantly expand the number of diverse physicians and other providers who can provide culturally competent, compassionate care.

Like a double-edged sword, however, telehealth has the capacity to aggravate or even further entrench disparities. Profit-motivated health care providers and intermediaries will naturally direct their energy and resources toward serving profitable commercial populations, and low-income patients may lack access to necessary technologies to receive telehealth services in their own homes.²⁵ In

addition, the most vulnerable populations may also be the least comfortable with receiving care through telehealth, including low-income seniors and young children.²⁶ Finally, health care providers that serve low-income populations may lack the financial resources to effectively pivot to telehealth for their patient population. **To better understand these potential challenges, PBGH is working to expand its patient experience research to include Medicaid beneficiaries, with ability to stratify findings by race, ethnicity, education, income and primary language.**

PBGH recommends policymakers:

- *Proactively investigate and seek to mitigate disparities in access to telehealth.*
- *Invest in broadband infrastructure to improve access in rural areas.*
- *Provide financial support to build telehealth capacity for health care providers that disproportionately care for low-income populations, including community health centers and independent primary care practices in underserved areas.*

Population-Focused, Total-Cost-of-Care Models

The rapid adoption of telehealth catalyzed by the COVID-19 pandemic provides a golden opportunity to improve access to affordable, high-quality health care, but it comes with significant potential risks, including care fragmentation, duplication, and susceptibility to fraud. **Like other health care delivery innovations, telehealth is best implemented in a payment system in which providers are held accountable for clinical outcomes, patient experience, equity and, critically, the total cost of care.** In these environments, telehealth's benefits – greater efficiency and enhanced access – can be magnified, and its risks can be minimized. By aligning incentives between providers, purchasers and patients, telehealth can be used when clinically appropriate and cost-effective and avoided when not.

To that end, PBGH recommends policymakers:

- *Rapidly accelerate movement away from fee-for-service payment models in Medicare, Medicaid and other public payers, driving volume toward population-focused models accounting for total-cost-of-care, clinical quality and patient experience in upside and downside risk sharing arrangements.*
- *Drive multi-payer alignment across Medicare and commercial payers through multi-payer programs to ensure minimal burden and waste for providers and patients.*

Conclusion

As I hope my testimony makes clear, PBGH firmly believes that Congress has a golden opportunity to establish a durable framework for sustainable, high-quality telehealth – ideally, by making telehealth a centerpiece of payment models focused on quality, equity and the total cost of care. If you miss this opportunity, I fear that telehealth will become just another profit silo that the health care industry and its private equity investors use to continue to drive up costs while ignoring quality and patient experience.

I appreciate the opportunity to provide the perspective of employers and health care purchasers in this critical debate and I look forward to your questions.

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