Testimony before the

Senate Health, Education, Labor and Pensions Committee

June 17, 2020

Karen S. Rheuban MD
Professor of Pediatrics
Senior Associate Dean for Continuing Medical Education and External Affairs
Director, University of Virginia Center for Telehealth
UVA Health
Charlottesville, Virginia, USA 22908

Chairman Alexander, Ranking Member Murray, Senator Kaine and members of the Senate Health, Education, Labor and Pensions Committee, thank you for the opportunity to provide testimony regarding "Telehealth – Lessons from the COVID-19 Pandemic".

I am the co-founder and Director of the Center for Telehealth at the University of Virginia (UVA Health), past President of the American Telemedicine Association, Board chair of the Virginia Telehealth Network, and chair of the Telehealth subcommittee of the Virginia Department of Health/Virginia Hospital and Healthcare Association COVID-19 response Working Group.

It is from these related perspectives that I offer testimony regarding the critically important role of telehealth during the COVID-19 pandemic, the rapid expansion facilitated both by necessity and policy change, the related impact on patient care, and enduring policy changes that we believe will enable cost-effective, sustainable care delivery models.

Before doing so, Mr. Chairman, I'd like to note that in September, 2000, I testified before the House Energy and Commerce Subcommittee on Health and Environment on a related

subject, "Telehealth: A Cutting Edge Tool for the 21st Century".[1] Admittedly, telehealth was a relatively new concept at the time. However, with thousands of peer reviewed studies over the past 20 years that have proven its benefits, and a global pandemic that has clearly demonstrated its full potential, it is time to make full use of telehealth in the delivery of health care services.

UVA Health

UVA Health is an academic medical center located in Charlottesville, VA and is comprised of the UVA Medical Center, the UVA School of Medicine, the UVA School of Nursing, and University Physicians Group, our practice plan. UVA Health includes a 612 bed state-supported academic medical center, an additional 84 beds in our recently completed new bed tower (which currently houses our COVID-19 patients), a 70 bed Emergency Department, designated as a Level 1 Trauma Center and a 50 bed long term acute care hospital. UVA is one of two safety net hospitals in the Commonwealth. In 2014, we were designated as one of two special pathogen hospitals in Virginia by the Virginia Department of Health and by the CDC to care for patients with suspected Ebola virus, other hemorrhagic fevers, novel respiratory viruses and high risk pathogens such as COVID-19.

The University of Virginia Center for Telehealth

The UVA telemedicine program was formally established in 1996 as an effort to improve access to high quality care for all Virginians, regardless of geographic location. Since the establishment of our telemedicine program, we have developed collaborations that connect UVA providers with patients located in more than 150 healthcare facilities across the Commonwealth

[1] Hearing before the Subcommittee on Health and Environment, Committee on Commerce, US House of Representatives, One hundred sixth Congress September 7, 2000, Serial No 106-144, US Government Printing Service

using high definition video-teleconferencing, store and forward technologies, remote patient monitoring and mobile health tools. We connect with hospitals, clinics, federally qualified health centers, free clinics, community service boards, health departments, medical practices, dialysis facilities, correctional facilities, PACE programs, rural schools, skilled nursing and long-term care facilities, and under certain circumstances, the home. Our telemedicine program has reduced the burden of travel for Virginians by more than 21 million miles, saved many lives and fostered innovative models of care delivery and workforce development. In 2012, we launched a care coordination and remote patient monitoring program for patients at home that has significantly reduced hospital readmissions by more than 40% regardless of payer. UVA telemedicine offers services in more than 60 different clinical subspecialties, spanning the continuum from prenatal services, to emergency and acute care consultations and follow up visits, to chronic disease management and palliative care. Prior to COVID-19, we facilitated more than 100,000 telemedicine related patient services using high definition video-teleconferencing, monitored more than 11,000 patients at home, screened more than 18,000 patients with diabetes for retinopathy, the number one cause of blindness in working adults, and through our electronic medical record, EPIC, facilitated more than 12,000 e-consults between providers. In 2014, with our designation as a special pathogen hospital for Ebola and other hemorrhagic fevers, we established a virtual model to facilitate care provided to our patients in isolation. The model, our Isolation Communication Management System (ISOCOMs) was developed to provide remote treatment, guidance and supervision for UVA's Special Pathogens Unit and a biocontainment room in UVA's Emergency Department.[2] UVA Health is also the

[2] Gossen, Allison, Beth Mehring, Brian S. Gunnell, Karen S. Rheuban, David C. Cattell-Gordon, Kyle B. Enfield, and Costi D. Sifri. "The Isolation Communication Management System. A Telemedicine Platform to Care for Patients in a Biocontainment Unit." *Annals of the American Thoracic Society* 17, no. 6 (2020): 673-678.

home of the Health Resources & Services Administration (HRSA) funded Mid Atlantic Telehealth Resource Center, through which we provide technical assistance to providers and systems across 9 states including the District of Columbia (www.matrc.org).

Our telemedicine programs and partnerships are dependent on reliable broadband communications services and in the majority of cases, we rely heavily on the Federal Communication Commission (FCC)'s Rural Health Care Program for connectivity between facilities. In 2019, UVA Health underwent a multi-stakeholder strategic planning process to further expand our telehealth program.

UVA's telehealth response to COVID-19

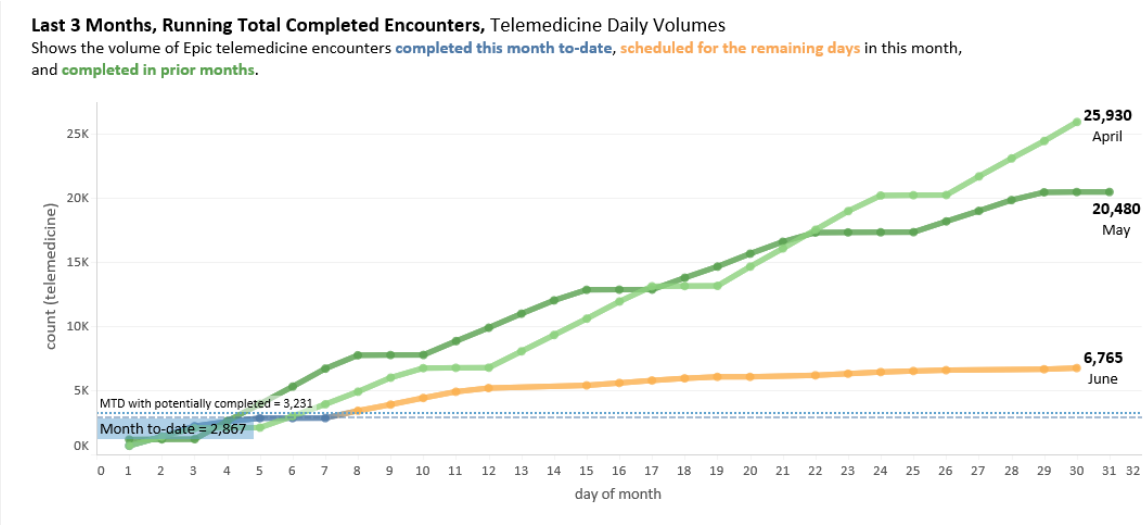
Much like other healthcare systems, UVA's telehealth response to COVID-19 has been a multipronged effort designed to reduce patient and provider exposure, maintain patient access, ensure continuity of care for our patients, and where appropriate, conserve personal protective equipment (PPE). Fortunately, our 2019 multi-stakeholder strategic planning process enabled us to rapidly scale our telehealth program to address pandemic related needs. We initiated these actions prior to the (critically important) announcement of the Medicare Interim Final Rule, passage of the CARES Act and other enabling federal and state waivers and executive orders.

These efforts have included:

- Configuring more than 100 isolation rooms in the Medical Center (including the Emergency Department and our newly established COVID clinics) with our iSOCOMs "virtual PPE" designed to reduce provider exposure, improve communications between our hospitalized COVID-19 patients and COVID suspected patients with our physicians, nurses and patient families and conserve PPE. Imagine the value of communicating face-to-face with patients

and their families (albeit via video) without cumbersome PPE such as isolation gowns/suits, face-shields, goggles and masks.

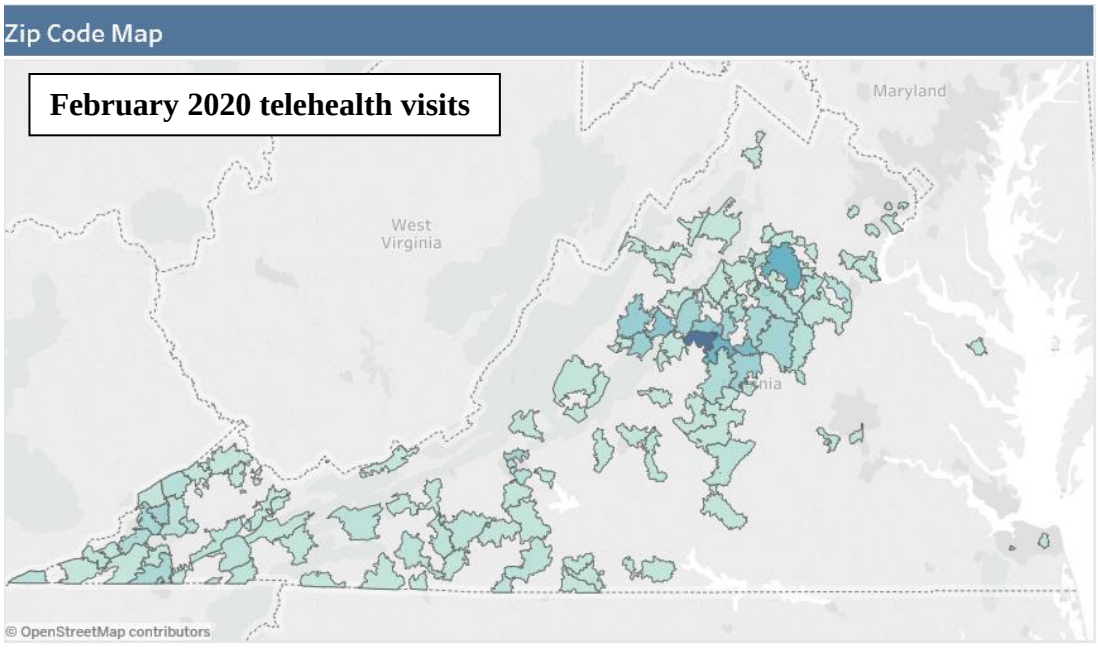
- The establishment of processes that enabled our providers to convert more than 45,000 in-clinic patient appointments to virtual patient visits beginning in mid-March.

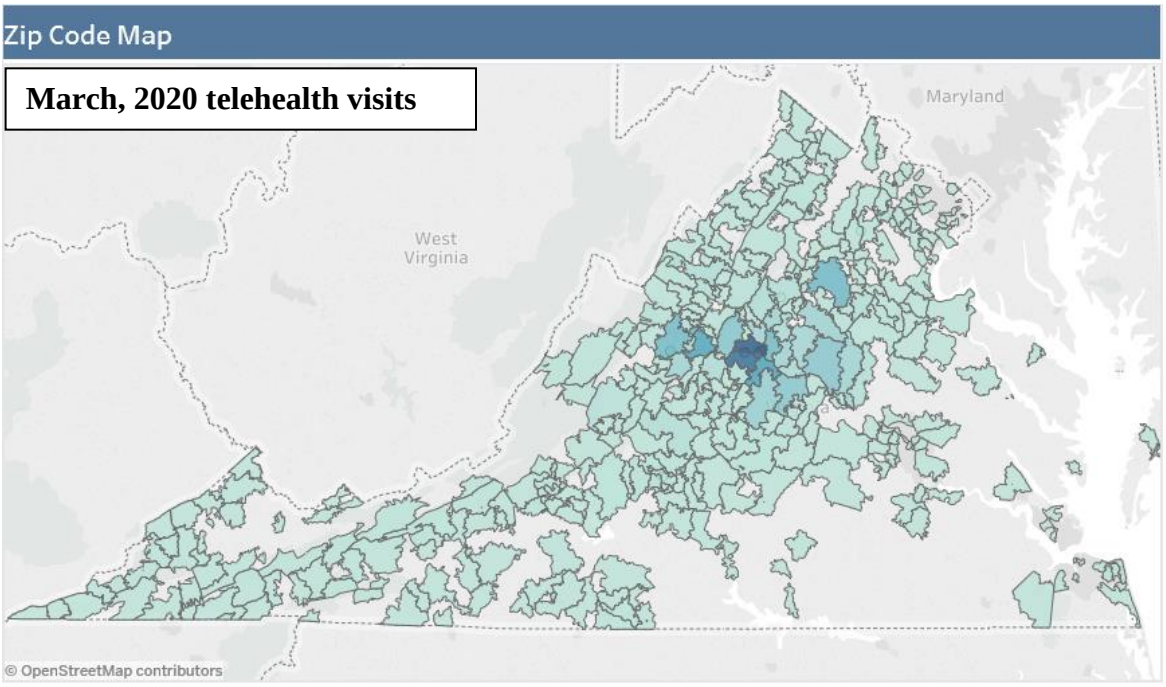


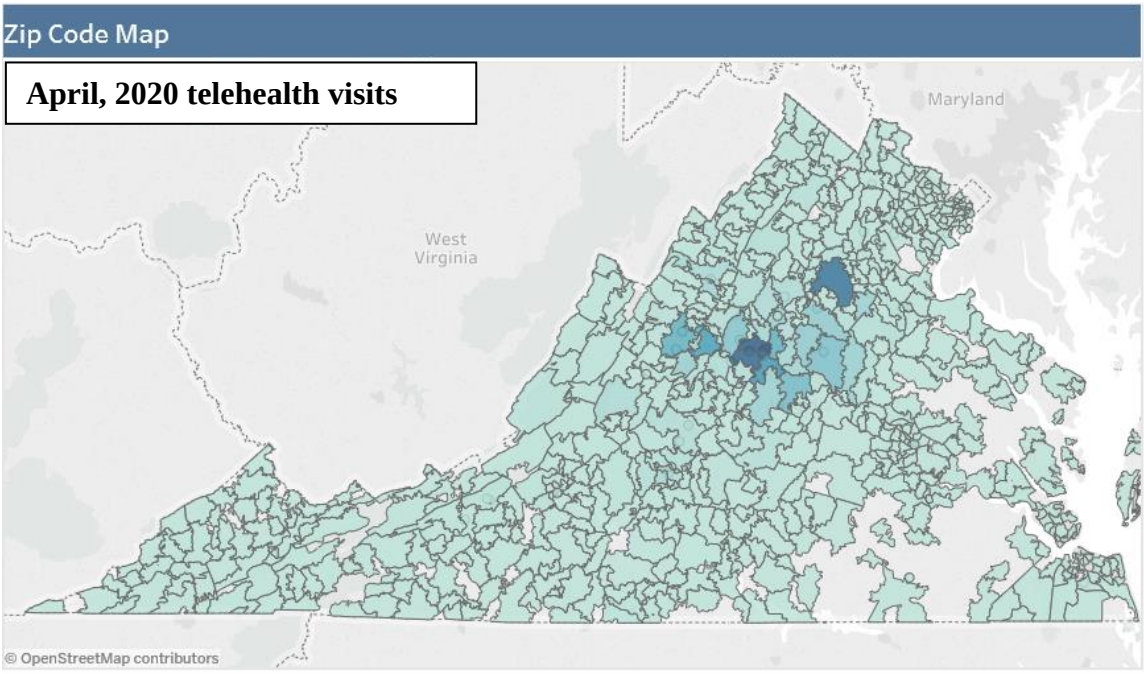
- The launch of an innovative approach to the rapid deployment of telehealth tools to support the management of at-risk patients in congregate care settings experiencing high COVID-19 outbreak rates, such as skilled nursing (SNF) and long-term care (LTC) facilities. This model enabled rapid diagnosis, virtual rounding, escalation of care if needed, and post-acute management after hospitalization. In one LTC facility, in which more than 90% of residents and all but one healthcare provider developed COVID-19, we deployed technology, executed a contract and began monitoring and treating patients in less than 24 hours. This could not have been possible but for the Office of the Inspector General notice of enforcement discretion on Stark and Anti-Kickback statutes during the public health emergency.
- The establishment of a new virtual Urgent Care service in the Emergency Department
- The expansion of provider to provider eConsults in outpatient and inpatient settings

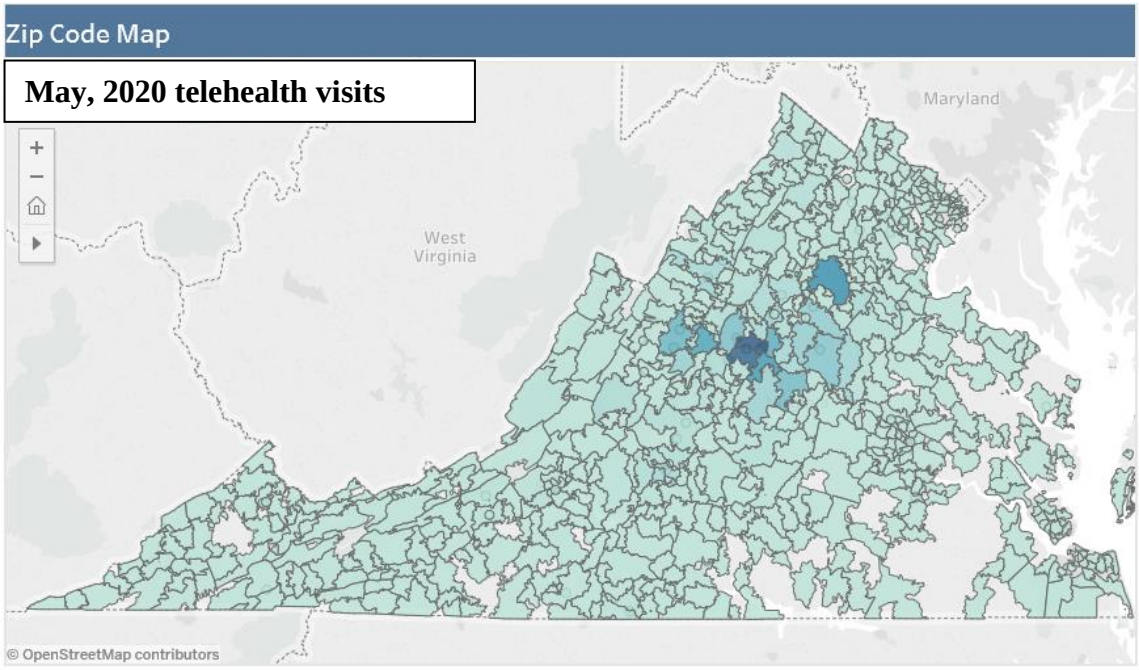
- The expansion of our remote patient monitoring program to vulnerable patients and quarantined patients with COVID-19, that allows us to monitor vital signs at home, including through video based virtual rounds by UVA Health advanced practice nurses. Several patients required escalation of care that otherwise might have been delayed had it not been for the video enabled monitoring service.
- The establishment of a COVID-19 Project ECHO (Extension for Community Health Outcomes) educational series for practitioners, including training on the use of PPE, COVID-19 testing, treatment and the use of telehealth.
- The rapid scaling of other telehealth training for all levels of providers, students and support staff with a broad range of resources, to include through our Mid-Atlantic Telehealth Resource Center, and through our UVA accredited, online training program, Telehealth Village. (telehealthvillage.com)

Maps below demonstrate the expansion of UVA telehealth services by patient home zip code beginning in February, 2020 prior to our March COVID-19 expansion of virtual visits




Zip Code Map
March, 2020 telehealth visits
Maryland
West
Virginia
© OpenStreetMap contributors


Zip Code Map
April, 2020 telehealth visits
Maryland
West
Virginia
© OpenStreetMap contributors



Key: Telehealth patient visits by zip code
Heat maps color coded as % of total visits

- **5-6%**
- **4-5%**
- **3-4%**
- **.1-3%**

Patient satisfaction:

Our experience and that of others is that patients have overwhelmingly embraced virtual visits and remote patient monitoring tools. Press Ganey recently released patient satisfaction data with virtual visits, in which they reported 96.3% of respondents were likely to recommend a video visit with their provider. [3] Not surprisingly, considering the race to deploy virtual visits, technology scores were somewhat lower (in the 70-80% range).

[3] Press Ganey Special Report: The Rapid Transition to Telemedicine:Insights and Early Trends, May, 2020

UVA Health patient satisfaction results are equally favorable as reported by Press Ganey. We received more than 1900 survey responses for our telehealth service from April to June 12, 2020 and

- 97.5% were likely to recommend their care provider
- 90.1% were likely to recommend our video visit service
- 83.4% were willing to have future telemedicine visits after the COVID quarantine is over

Whether because of convenience, concern for contracting COVID-19, reduced clinic appointment availability or a combination of the above factors, patient satisfaction data are clear that consumers wish to continue to engage with their providers where THEY are, and not necessarily always in bricks and mortar healthcare facilities. To quote a patient who had a recent UVA virtual visit, "Thank you for the valuable service of a video appointment. It was enormously helpful and easy to receive medical services using this modern technology, from scheduling the video conference to picking up the medicine at the pharmacy and experiencing closure by receiving the directive for me to go back to work! It was so comforting and satisfying to have time with Dr. *(redacted)* during this medical emergency during COVID-19, eliminating a crisis in my life. Again, thank you for the excellent medical service."

Committee members know well, telemedicine is not a new specialty, a new procedure or a new clinical service…simply defined, it is the use of technology designed to enable the provision of healthcare services at a distance. 21st century telemedicine services can be provided live, via high-definition interactive videoconferencing supported, as appropriate, by peripheral devices and remote examination tools; asynchronously, using store and forward technologies, or through the use of remote patient monitoring tools with biometric monitoring

devices such as oximeters, blood pressure cuffs , electronic scales, and in many cases, with video capabilities.

Telemedicine has been demonstrated to effectively mitigate the significant challenges of workforce shortages, geographic disparities in access to care, while improving patient triage and timely access to care by the right provider when needed. Telemedicine tools foster patient engagement and self-management as appropriate. [4]

Elements that contribute to the success of any telemedicine program include the establishment of consistent workflows, training of practitioners and staff, technology acquisition, broadband connectivity, tracking of clinical and process quality metrics, workforce capacity, and careful analyses of outcomes, including return on investment. These must be considered in the context of organizational mission and programmatic alignment with that mission.

Significant barriers to the broader integration of telemedicine services into everyday healthcare remain. More than 16 different federal agencies report engagement in telehealth, be it through research and other grant funded opportunities, through the establishment of broadband communications networks, clinical service delivery, and even device development and regulation. However, despite of our multi-billion dollar federal investment in telemedicine and broadband expansion, those good faith efforts remain stifled by 20th century federal and state barriers to widespread adoption and a lack of alignment across the payers.

Reimbursement

Medicare:

Payment coverage restrictions remain a major impediment to the broader adoption of telehealth by providers. Congress, in 1997, through the Balanced Budget Act, and later in

[4] K Rheuban, EA Krupinski , Understanding Telehealth, 2017 McGraw Hill.

2000, though the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act, authorized the Centers for Medicare and Medicaid Services (CMS) to reimburse for telemedicine services provided to rural Medicare beneficiaries across a range of CPT codes and services. However, those Medicare telehealth provisions, as established in the Section 1834 (m) of the Social Security Act limit eligible patient originating sites to rural, eligible types of originating sites, and types of providers eligible to furnish those services (not all Medicare providers). The statute allows the Secretary to establish a process by which additional telehealth services may be added; indeed, CMS has expanded coverage in the 2018, 2019 and 2020 Physician Fee Schedules. The Bipartisan Budget Act of 2018 expanded services and requires Medicare Advantage plans to cover "additional telehealth benefits" beyond those covered under Medicare fee-for-service beginning in 2020.

However, prior to COVID-19 public health emergency, Medicare reimbursement of telehealth services provided to fee-for-service beneficiaries remained limited due to the 1834 (m) restrictions of the Social Security Act. The 21st Century Cures Act directed CMS to provide an update on telehealth services provided to Medicare beneficiaries.[5] Claims data analyses demonstrated that between 2014- 2016, only 0.25% of the more than 35 million Medicare beneficiaries in the fee-for-service program utilized a telehealth service. That report suggested that the most significant statutory restrictions to the utilization of telehealth included 1) the requirement that the patient originating site be rural and 2) the home is not an eligible originating site.

During the public health emergency of the COVID-19 pandemic, provisions of the CONNECT for Health Act were included in the Coronavirus Preparedness and Response

[5] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf

Supplemental Appropriations Act and the Coronavirus Aid Relief and Economic Security Act giving the Secretary of Health and Human Services authority to waive telehealth requirements under Section 1834(m) of the Social Security Act, and allowing Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to provide distant site telehealth services. CMS issued regulatory waivers and Interim Final Rules in March and April, 2020 related to the provision of Medicare telehealth services.

Importantly, these COVID-19 public health emergency waivers eliminated geographic restrictions, allowed the home as an eligible originating site, expanded eligible distant site providers, enabled federally qualified health centers and rural health clinics to serve as both an eligible originating and distant site, expanded covered CPT codes, and allowed hospitals to charge a (limited) facility fee along with other important changes. The facility fee payment, however, was not at parity with that of in-person visits. Economic incentives need to be in place to enable providers to recover costs associated with telemedicine technology acquisition, deployment, and operational costs such as investments in HIPAA compliant platforms, electronic medical record integration, hardware (dual monitors, webcams and headsets), staffing to support patient scheduling and registration, and facility broadband services.

Notably, during the public health emergency, recognizing that audio and video based services may not be feasible or available to all Medicare beneficiaries, CMS activated evaluation and management codes for reimbursement for telephone calls. The Federal Communications Commission and the states have found that geographic limitations in broadband deployment and sociodemographic factors create a healthcare digital divide. The activation of evaluation and management codes for telephone-based services has enabled improved access to care, particularly within the context of the primary and specialty medical home.

This exponentially scaled coverage expansion during the COVID-19 public health emergency will further enable HHS to study the cost effectiveness, clinical outcomes and any incidents of fraud or abuse related to telemedicine services covered by federal payment programs.

To build on the important actions taken during the COVID-19 public health emergency, to prepare us for any future public health emergency and to ensure that providers and patients do not lose access to telehealth supported care when the COVID-19 emergency concludes, Congress must act to advance telehealth payment reform particularly through Medicare and Medicaid, and encourage alignment by the commercial plans.

Recommendations: The simplest and most important step would be for Congress to give the Secretary the authority to make permanent the telehealth changes made during the public health emergency. This would

1. **Remove outdated restrictions that require patients to be located in a specific geographic location in order to receive telehealth services,**
2. **Permanently make the home and other sites eligible places for patients to receive telehealth care**
3. **Continue to cover telephone evaluation and management services when provided in the context of the patient's primary or specialty medical home and/or existing doctor-patient relationship**
4. **Waive restrictions in order to allow HHS to determine the providers appropriate to practice telehealth for different services**

5. **Permanently allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to provide telehealth both as originating and distant site providers**
6. **Give the Secretary of HHS automatic waiver authority during future public health emergencies**
7. **Ensure payment at parity for comparable in-person services, and**
8. **In addition, we and others also recommend payment of facility fees comparable with in-person facility fees.**

Medicaid:

Fifty state Medicaid programs plus the District of Columbia provide some form of reimbursement for the delivery of telehealth facilitated care to Medicaid beneficiaries. Medicaid innovations adopted by many states in addition to video-based telemedicine consults and follow up visits include coverage for remote monitoring, home telehealth and store forward services.

Prior to COVID-19, Virginia Medicaid covered facility based telemedicine services without geographic restrictions, some store forward services (screening for diabetic retinopathy and limited remote monitoring services to include continuous glucose monitoring). Following the declaration of the public health emergency, Virginia, like other states expanded Medicaid telehealth coverage to the home, activated telephone evaluation and management codes, eConsults and remote monitoring codes for COVID-19 patients or patients under investigation.

Recommendation: To drive adoption and ensure access to care, particularly for vulnerable patients, state Medicaid programs should continue to have the flexibility to expand telehealth services and at a minimum, align with the Medicare telehealth provisions.

***Private payers**:*

Forty-two states plus the District of Columbia require private insurers to cover telehealth services, although not all at parity with in-person services. Many of the ERISA plans have chosen to cover telehealth services. Post public health emergency, most commercial plans expanded coverage for telehealth services aligned with Medicare, with variable sunset dates for elimination of coverage.

Recommendations: Commercial plans should be encouraged to have flexibility to expand but at a minimum, align with the Medicare telehealth provisions.

Other relevant policies

Licensure:

During the COVID-19 public health emergency, through the waiver process, Medicare allowed for reimbursement for services provided to patients in states where the practitioner is not licensed, so long as that individual practitioner holds a valid license in another state, and is enrolled in the Medicare program. By executive order, many states have implemented similar waivers of licensure during the COVD-19 public health emergency. For example, Virginia Governor Ralph Northam (M.D.) issued several executive orders in the public health emergency that have enabled practitioners licensed in other states to provide care to patients in the Commonwealth either for purposes of continuity of care where a doctor-patient relationship exists, or when contracted by healthcare entities in the Commonwealth and those contracted providers licensure information is reported to the relevant board overseen by the Virginia Department of Health Professions.

Many states currently participate in the Federation of State Medical Board's Interstate Licensure Compact which enables expedited licensure. Other states have created their own

models of expedited licensure, reciprocity or licensure by endorsement. The value of state licensure (or regional compacts) is that 1) state (or regional) public health information can be disseminated quickly to licensees by state public health entities, or by the boards themselves, and 2) patients can be assured that potential adverse actions by licensees can be appropriately investigated. As we learned, in the face of large numbers of practitioners experiencing cancellation of in-person clinics and procedures, as the uptake and use of telemedicine has grown, the existing workforce within a state often can be sufficient to meet the needs of its patients.

Recommendation: In a public health emergency, states themselves should determine models for licensure that best suit the needs of their citizens.

HIPAA Privacy and Security:

During the public health emergency, the Office of Civil Rights (OCR) issued a waiver of enforcement discretion against health care providers who in good faith utilized non HIPAA compliant applications to connect with their patients. States may have additional HIPAA privacy and security laws, and as such the federal waiver does not eliminate risk for providers, who may still be subject to state enforcement action.

Recommendation: Although OCR waiver of enforcement action helped to enable providers to rapidly adopt telemedicine, as a matter of policy, with the increasing availability of free and/or low cost HIPAA compliant solutions, and to ensure protection of personal health information, non HIPAA compliant solutions should only be used in good faith in an emergency. As such, telehealth providers should work now to execute business associate agreements and ensure that whenever possible, telehealth services are delivered via HIPAA-compliant electronic communication systems.

Prescribing:

Complicating efforts to combat our nation's tragic opioid epidemic, (which has not disappeared during the COVID pandemic), is our nationwide shortage of mental health professionals such as psychiatrists and addiction specialists. Telemedicine provides access to those providers who otherwise would not be available in-person. However, the prescribing of controlled substances over telemedicine is currently limited to very few scenarios. The Drug Enforcement Agency (DEA) has yet to act on a requirement by Congress in the SUPPORT Act to address this more permanently with a special registration process for telemedicine providers. The DEA recognized this during the pandemic and has increased flexibilities for DEA-registered prescribers to see patients over telemedicine.

Recommendation: The DEA must act to finalize the rule needed to implement the Special Registration process and ensure continued access to telemedicine for needed services such as medication-assisted treatment.

Training of the workforce

Prior to the public health emergency, training in telehealth has not been consistently applied across health professions curricula in undergraduate, graduate and continuing medical and nursing education. In 2019, the Association of American Medical Colleges convened a working group to develop competencies for purpose of training. The American Medical Association and other health professional organizations have provided extensive training, as have the HRSA funded telehealth resource centers. Our Mid-Atlantic telehealth resource center, much like the other resource centers, has experienced a greater than 1000-fold increase in requests for technical assistance and guidance. We have launched an accredited training portal, Telehealth Village. In addition, the significant expansion of Project ECHO (Extension for

Community Health Outcomes) training has enabled virtual case conferences and training related to a broad range of COVID-19 related topics, along with other critically important training for practitioners.

Recommendation: Telehealth Resource Centers and Project ECHO should receive expanded support to further enable practitioners to deploy telehealth capabilities and to expand training for health professionals.

Broadband access:

The Federal Communications Commission, as a provision of the Telecommunications Act of 1996, established the Rural Health Care Program. This program has provided support for critical broadband infrastructure to healthcare facilities. The FCC and many of the states themselves track broadband availability including to the census tract level. The FCC's Connect2Health Task Force mapped both broadband availability and health status indicators, and their findings suggest that a lack of broadband is indeed a health equity issue. The FCC recently voted to establish two additional programs, the ($200 million) COVID-19 Telehealth Program funded by the CARES Act, and the ($100 million) Connected Care Pilot Program, designed to enable healthcare providers and systems to deploy broadband to the homes of their patients. Other federal programs have also supported broadband expansion particularly in rural and underserved areas.

Recommendation: Congress should ensure robust funding to expand broadband infrastructure across the nation to ensure that all patients have access to telehealth services, both during and after the public health emergency.

Conclusion:

In summary, to build on the important actions taken nationwide during the COVID-19 public health emergency, to prepare us for any future public health emergency and to ensure that patients do not lose access to telehealth supported care when the COVID-19 emergency concludes, Congress must act to advance telehealth payment reform particularly through Medicare and Medicaid, and encourage alignment by the commercial plans. **The simplest and most important step would be for Congress to give the Secretary the authority to make permanent the telehealth changes made during the public health emergency.** Congress must also further invest in broadband expansion to reduce disparities, increase funding for the HRSA funded telehealth resource centers, encourage the DEA to establish the Special Registration Process for prescribing of controlled substances by telemedicine providers, expand training of the healthcare workforce in telehealth, and support innovative models of virtual continuing health professional education such as Project ECHO.

Thank you.