TELEHEALTH: LESSONS FROM THE COVID–19 PANDEMIC

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING TELEHEALTH, FOCUSING ON LESSONS LEARNED FROM
THE COVID-19 PANDEMIC

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JUNE 17, 2020

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TELEHEALTH: LESSONS FROM THE COVID–19 PANDEMIC

Wednesday, June 17, 2020

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Burr, Collins, Cassidy, Roberts, Murkowski, Scott, Romney, Braun, Loeffler, Casey, Baldwin, Kaine, Hassan, Smith, Jones, and Rosen.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. Good morning. The Committee on Health, Education, Labor, and Pensions will please come to order.

First, a few administrative matters, which we are getting used to. We thank the attending physician and the Sergeant at Arms, all of whom have consulted with us. Individuals in the hearing room are seated 6 feet apart. There is no room, as a result, for the public to attend, but there is a press pool relaying all of our information. And anyone who wants can watch it online at our website, *www.help.senate.gov*.

Witnesses are participating by videoconference, and so are most Senators. Senators in the room may remove their mask when we talk because we are 6 feet apart.

We are grateful to the Rules Committee and our staffs, Architect of the Capitol, Chung Shek, and Evan Griffis for all their hard work, too, to make this hearing possible.

Senator Smith and I will each have an opening statement, and then we will turn to our witnesses, who we thank for being with us today. We would ask you to summarize your comments in 5 minutes, and that will leave Senators more opportunity to ask you questions. I will ask Senators in order of seniority, alternating between Republicans and Democrats, during the question period.

Senator Kaine and I were just talking about this ought to be a very interesting hearing. Here is an example. I just spoke recently with Tim Adams, who is the CEO of Ascension Saint Thomas Health, which has nine hospitals in Middle Tennessee and employs over 800 physicians. He told me that in February, before COVID–19, there were about 60,000 visits between patients and physicians each month in that hospital system. Almost all of those visits were

done in person. Only about 50 of the 60,000 were done remotely through telehealth through the internet.

But, during the last 2 months, Ascension Saint Thomas conducted more than 30,000 telehealth visits, or about 45 percent of all of its visits, because of changes in Government policy and the inability of many patients to see doctors in person during the COVID–19 Pandemic. Tim Adams expects that number to level off at about 15 to 20 percent of its visits going forward.

The largest hospital in San Francisco told me a few weeks ago that 5 percent of its visits in February were conducted through telehealth, and the hospital considered that to be a very high percentage. Then, in March, telehealth visits made up more than half of all the visits in that hospital. So, from 5 percent to more than half.

Because of COVID–19, our healthcare sector and Government have been forced to cram 10 years' worth of telehealth experience into just 3 months. As dark as this pandemic has been, it creates an opportunity to learn from and act upon these 3 months of intensive telehealth experiences, specifically what permanent changes need to be made in Federal and state policies.

In 2016, there were almost 884 million visits nationwide between doctors and patients according to the Centers for Disease Control and Prevention. If, as Tim Adams expects, 15 to 20 percent of those become remote due to telehealth expansion during COVID–19, that would produce a massive change in our healthcare delivery system. Our job should be to ensure that change is done with the goals of better outcomes and better patient experiences, and at a lower cost.

Part of this explosion in remote meetings between patients and physicians has been made possible by temporary changes in Federal and state policies. The private sector, too, has made important changes. One purpose of this hearing is to find out which of these temporary changes in Federal policy should be maintained, modified, or reversed; and, also, to find out if there are additional Federal policies that would help patients and healthcare providers take advantage of delivering medical services using telehealth.

Of the 31 Federal policy changes, the three most important seem to me to be, one, physicians now can be reimbursed for telehealth appointments wherever the patient is located, including in the patient's home. That change was to the so-called Originating Site Rule, which previously required the patient live in a rural area and use telehealth at a doctor's office or clinic.

Number two, Medicare and Medicaid began to reimburse providers for nearly twice as many types of telehealth services during COVID–19, including emergency department visits, initial nursing facility visits, discharges from those facilities, and therapy services.

Three, doctors are allowed during COVID–19 to conduct appointments using common video apps on your phone, like Apple Facetime or phone texting apps, or even on a landline call, which required relaxing Federal privacy and security rules from the Health Insurance Portability and Accountability Act, or HIPAA.

Many states made changes, as well—most importantly, making it easier for doctors to continue to see their patients who may have traveled out of state during the pandemic. For example, a college student from Memphis, who attends college in North Carolina, has

a doctor she sees in Chapel Hill was able to go home to Tennessee during the pandemic and continue to see her Chapel Hill doctor via Facetime. Or, a patient in Iowa has been able to start seeing a new psychiatrist in Nashville.

The private sector has reacted to these changes, as well. One of our witnesses today is from Blue Cross Blue Shield of Tennessee, which has already begun to make permanent adjustments to its telehealth coverage policies based on some of the temporary Federal changes in Medicare.

Now, looking forward, of the three major Federal changes, my instinct is that the Originating Site Rule change and the expansion of covered telehealth services change should be made permanent. One purpose of this hearing is to hear from experts and discuss whether there may be unintended consequences, positive or negative, if Congress were to do that.

It is also important to examine the other 28 temporary changes in Federal policy. The question of whether to extend the HIPAA privacy waivers should be considered carefully. There are privacy and security concerns about the use of personal medical information by technology platform companies, as well as concerns about criminals hacking into those platforms. When HIPAA notification requirements are waived, a person might not even know that their personal information has been assessed by hackers. Additionally, several of these technology platforms have said they want to adjust their platform to conform to the HIPAA rules.

Another lesson from these 3 months is that telehealth or teleworking or telelearning is not always the answer, especially for those in rural areas or low-income, urban areas who do not have access to broadband.

Still another lesson is that personal relationships matter. Personal relationships involved in healthcare, education, and the workplace cannot always be replaced by remote technology. Children have learned that—learned about all they want to learn over the internet in the last few months. Patients like to see their doctors, and workplaces benefit from employees actually talking and working with one another in person. There are some limits on remote learning, healthcare, and working.

There are obvious benefits to allowing healthcare providers to serve patients across state lines during a public health crisis. As a former Governor, I am reluctant to override state decisions, but it may be possible to encourage further participation in interstate compacts or reciprocity agreements.

Last week, I released a white paper on steps that Congress should take before the end of the year in order to get ready for the next pandemic. One of those recommendations was to make sure that patients do not lose the benefits they have gained from using telehealth during this pandemic. Even with an event as significant as COVID–19, memories fade. Attention moves quickly to the next crisis, so important—it is important for Congress to act this year on those things that we believe are important for the next pandemic, which we know will surely come.

Because of this 10 years of telehealth experience crammed into 3 months, patients, doctors, nurses, therapists, and caregivers can

write some new rules of the road, and we should do so while the experiences are still fresh on everyone's minds.

Senator Smith.

OPENING STATEMENT OF SENATOR SMITH

Senator SMITH. Thank you, Mr. Chairman, and thank you so much for convening this hearing, and thanks to all of our witnesses for being here with us today.

We are more than 3 months into the economic and public health crisis created by the coronavirus pandemic, and more than 2 months through the passage of the CARES Act, which provided urgent and much-needed emergency support to families and our healthcare system.

While the COVID epidemic has affected everyone in one way or another, we have also seen that it is not the great equalizer. In fact, it hits hardest those who are already struggling without a safe place to call home, because they do not have access to healthcare, because of low wages or chronic poverty, and because of the generational impacts on Black and Brown and indigenous people for the systemic racism that limits their freedom, their opportunities, their health, and even takes their lives.

Following the murder of my constituent, Mr. George Floyd, Minnesotans and people across this Country have been rising up to demand that we address the systemic inequities in every part of our community. Congress must step up to this challenge and fulfill America's full promise of racial and economic justice, and how we respond in this moment will tell the story of our values.

Today, we have the opportunity to consider how we can deploy telehealth to expand access to healthcare for everyone, and to also address the systemic inequities that result in the worst healthcare outcomes for communities of color, or rural communities, and for poor families.

As we grapple with the COVID pandemic, changes to Federal telehealth rules and expansion of telehealth coverage have been a lifeline for many Americans. Telehealth has helped to support continuity of care during the pandemic by helping patients get the care that they need without exposing themselves or their providers to the risks of the COVID–19 virus.

Federal changes to telehealth regulations have made it possible for patients and providers to receive and deliver healthcare from their own homes, and it has also allowed for more services to be provided via telehealth, including emergency department services, home health visits, speech-language pathology, physical and occupational therapy, and behavioral health services. This has helped Americans continue to get the care that they need during the pandemic.

One of many examples of this is Hennepin Healthcare, a Level I trauma center and acute care hospital in my hometown of Minneapolis, which serves some of the most diverse and in-need communities in Minnesota. They have found that increased audio-only telehealth—telephone services are reducing the disparities that are driven by the digital divide.

Telehealth has also provided important financial support to hospitals and clinics that have been buffeted by dramatic losses of rev-

enue and increased costs during the pandemic. These hospitals have delayed non-emergency procedures. And, as they have followed stay-at-home orders in hopes of flattening the curve, this has resulted in, for many of them, a traumatic financial challenge. But, new regulatory flexibility has allowed healthcare providers to bill Medicare and Medicaid for more telehealth services at the same rate as if they were provided in person. This has helped these centers to recoup some of the financial losses that they have faced.

But, the move to telehealth has also revealed some significant weaknesses in our system. While telehealth has been a lifeline to some, the lack of technology, of digital literacy, and access to high-speed internet is a digital divide that exacerbates health disparities for people of color, rural communities, and poor communities.

According to the Census Bureau, nearly 37 percent of Black American households, and 31 percent of Hispanic American households, have no broadband or computer access in their homes. In 2018, the FCC estimated that 35 percent of Americans living on tribal lands lacked access to broadband services. So, the disparities in access to technology reflect the underlying inequity that exists throughout our society in urban and in rural areas.

This moment presents us with a unique opportunity, I think, to learn from the past 3 months, to assess how telehealth has worked, and to make the changes we need to make to close these disparities and to improve telehealth delivery.

I hope to learn from our witnesses today the following: First, how do we close the digital divide to improve health equity?

Second, how do we protect patients while we expand telehealth, particularly patients' privacy?

Third, what temporary flexibilities that we have adopted during the pandemic should we make permanent, and what changes and investments do we also still need to make?

Mr. Chairman, it is my hope that we will use today's hearing to learn about what is working, to figure out what more needs to be done, and figure out how we can build a telehealth delivery system that is accessible to all Americans.

Thank you.

The CHAIRMAN. Thank you, Senator Smith, and thank you—Senator Murray has asked Senator Smith to serve today as the Ranking Democratic Member of the Committee, and I appreciate her doing that.

Each witness will have up to 5 minutes now. We welcome our witnesses. We have some terrific witnesses today. Senator Kaine will introduce our first witness, and then I will introduce the other three, and then I will call on all four.

Senator KAINE. Thank you, Mr. Chairman. I am glad we are having this important hearing today, and I am happy to introduce from the University of Virginia our first witness, Dr. Karen Rheuban. I am happy to introduce her. She is an expert in this field with many, many years of expertise and will be sharing that with us.

Dr. Rheuban is a pediatric cardiologist, a professor of pediatrics, and a leader in the field of telehealth. She is the co-founder and director of the University of Virginia Center for Telehealth and has made such an impact on our Commonwealth that the Center was

actually renamed in her honor in 2016 as a result of her significant contributions to the field.

The Center at UVA serves as a hub for 155 site telemedicine—155 sites of telemedicine throughout Virginia. It is funded in part by Federal grants, and it has supported more than 180,000 patient visits, e-consults, remote patient monitoring, and thousands of hours of health professional and patient education. And, I have had the experience to be in some of the telehealth visits at a remote medical clinic that is offered every year in the coal fields of Wise County, Virginia that is well-supported by UVA telehealth.

Dr. Rheuban's leadership on telehealth has been instrumental in addressing the COVID crisis. She chairs the Virginia Department of Health and the Virginia Healthcare and Hospital Association's COVID–19 response telehealth working group.

I look forward to hearing from Dr. Rheuban and our other witnesses about how we can use telehealth to continue to increase access to healthcare, strengthen the workforce, and also improve health outcomes.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kaine.

Our second witness is Dr. Joe Kvedar. He is a dermatologist and professor of dermatology at Harvard Medical School, the vice president of Connected Health at Partners Healthcare, where he is focused on leveraging information technology to improve healthcare delivery. As of today, Dr. Kvedar is the president of the American Telemedicine Association.

The third witness is Dr. Sanjeev Arora. He is director and founder of Project ECHO, which is a renowned video technology tool that links doctors and medically underserved in rural areas with specialists in another location to enhance medical knowledge and improve patient outcomes. Our bipartisan Lower Healthcare Costs legislation, which was approved by this Committee last year 20 to 3, includes a provision to expand Project ECHO and build upon its successes. Dr. Arora is a Distinguished and Regents' Professor of Medicines in the Department of Internal Medicine at the University of New Mexico Health Sciences Center.

Finally, our fourth—our next witness is Dr. Andrea Willis, who joins us from Chattanooga, Tennessee. Dr. Willis is a pediatrician by training, and currently serves as senior vice president and chief medical officer of BlueCross BlueShield of Tennessee. She was recently recognized by Modern Healthcare as one of the Country's top 25 minority executives in healthcare, and one of the 50 most influential clinical executives world—nationwide. Dr. Willis is a fellow in the American Academy of Pediatrics and a member of the Tennessee Medical Association.

Welcome, again, to all of our witnesses.

Dr. Rheuban, let us begin with you.

STATEMENT OF KAREN S. RHEUBAN, M.D., PROFESSOR OF PE-DIATRICS, SENIOR ASSOCIATE DEAN OF CONTINUING MEDICAL EDUCATION, AND DIRECTOR, UNIVERSITY OF VIRGINIA KAREN S. RHEUBAN CENTER FOR TELEHEALTH, CHARLOTTESVILLE, VA

Dr. RHEUBAN. Can you hear me?

The CHAIRMAN. Yes, we can.

Dr. RHEUBAN. Wonderful. Thank you.

Chairman Alexander, Senator Smith, Senator Kaine, thank you for the kind introduction. And distinguished Committee Members, thank you for this opportunity to testify today.

As we have heard, telehealth tools play a critically important role during the COVID–19 public health emergency. By necessity, and thanks to recent regulatory and statutory changes related to the pandemic, patients and their providers have turned to digital health platforms, devices, and services to provide and receive care in place and to avoid unnecessary exposure to the novel coronavirus.

Prior to COVID–19, the UVA Center for Telehealth's efforts included video-based, interactive consults and follow-up visits with patients located at more than 150 partner healthcare facilities across Virginia.

We also support a remote patient monitoring program for vulnerable adults, high-risk pregnant women, and medically complex children.

We offer a store-and-forward diabetic retinopathy screening program, and an e-consult program connecting primary care providers with specialists.

We also present virtual training programs across a number of disciplines for health professionals and for patients. We rely heavily on the FCC's rural healthcare program for affordable connectivity between facilities.

However, prior to COVID–19, geographic and other originating site restrictions and fee-for-service Medicare, a lack of alignment by many State Medicaid programs and private insurers, outdated prescribing regulations, and other policy barriers severely limited the large-scale integration of telehealth into everyday care. In particular, due to the 1834(m) restrictions, Medicare does not reimburse for telemedicine services furnished to a patient at home or in a metropolitan statistical area.

As with other healthcare systems, UVA Telehealth response to COVID–19 has been a multi-pronged effort designed to maintain patient access and ensure continuity of care while reducing exposure to this deadly virus.

Between February and May, as is the case as described by Senator Alexander, we experienced a greater than 9,000 percent increase in the use of telehealth. At UVA, we converted tens of thousands of in-clinic patient appointments to virtual patient visits. Within our medical center and our emergency room, we configured more than 100 isolation rooms to enable patients, providers, and family members to interact virtually with one another, conserving personal protective equipment.

We expanded our remote patient monitoring programs to include home-quarantined COVID–19 patients. Our providers make virtual rounds at home for these patients as needed, 24/7.

We deployed telemedicine equipment to support patients in high-risk, congregate care settings, such as long-term care facilities, to enable our clinicians to consult and escalate care as needed.

We launched a virtual urgent care clinic staffed by our emergency physicians.

We have expanded training of the health professional workforce via Project ECHO and other online continuing education tools.

Our HRSA-funded Mid-Atlantic Telehealth Resource Center has seen more than a 1,000 percent increase in requests for technical assistance.

Patients have overwhelmingly embraced digital transformations in care. Indeed, nationwide, patient satisfaction data are exceptionally high.

Building upon the critical actions taken nationwide during the COVID–19 pandemic, to prepare us for subsequent surges or any future public health emergency, and to ensure that patients do not lose access to telehealth-supported care when the declared COVID–19 emergency expires, we strongly urge Congress to act now to advance telehealth payment reform, to align incentives for adoption within Medicare, Medicaid, and the commercial insurers.

The simplest and most important action needed is for Congress to authorize the Secretary of Health and Human Services to make permanent many of the telehealth policy changes enacted during the public health emergency.

In addition, as was referenced, Congress should provide support for further broadband deployment, including to the home as appropriate, to reduce geographic and sociodemographic disparities in access to care.

Also needed is increased funding for the HRSA-funded telehealth resource centers and for innovative models of virtual continuing education programs for health professionals to improve outcomes.

Over the past 20 years, many thousands of peer-reviewed studies have repeatedly demonstrated the benefits of telemedicine, but it has taken a global pandemic to showcase its full potential.

Mr. Chairman, the time has finally come to fully utilize telehealth in the delivery of healthcare services. Millions of Americans and health systems across the Country would be the beneficiaries. As a pediatric cardiologist, who regularly uses this valuable tool and has seen firsthand the healthcare benefits, I urge you and your colleagues to take the needed actions discussed more fully in my written testimony and that of others.

Thank you so much.

[The prepared statement of Dr. Rheuban follows:]

PREPARED STATEMENT OF KAREN S. RHEUBAN

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 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 percent 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 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 nine 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.

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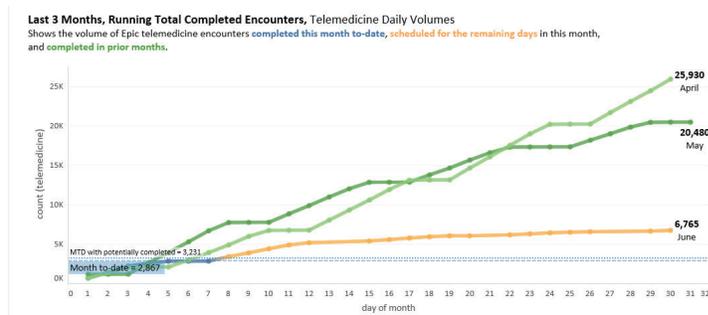
[2] Gossen, Allison, Beth Mehring, Brian S. Gunnell, Karen S. Rheuban, David C. Cattell-Gordon, Kyle B. Enfield, and Costi D. Sifri. "The Isolation Communication Management System. A Telemedicine Platform to Care for Patients in a Biocontainment Unit." *Annals of the American Thoracic Society* 17, no.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

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.

Last 3 Months, Running Total Completed Encounters, Telemedicine Daily Volumes
Shows the volume of Epic telemedicine encounters **completed this month to-date,** scheduled for the remaining days in this month, and **completed in prior months**.

- 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 percent 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

Zip Code Map

April, 2020 telehealth visits

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

■ 5-6%

■ 4-5%

■ 3-4%

■ .1-3%
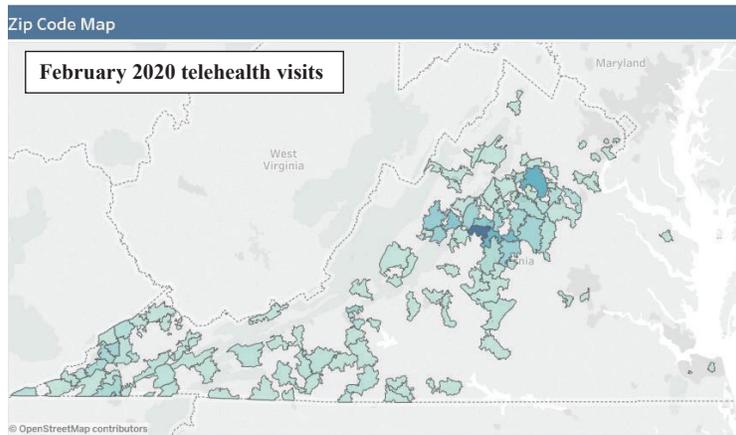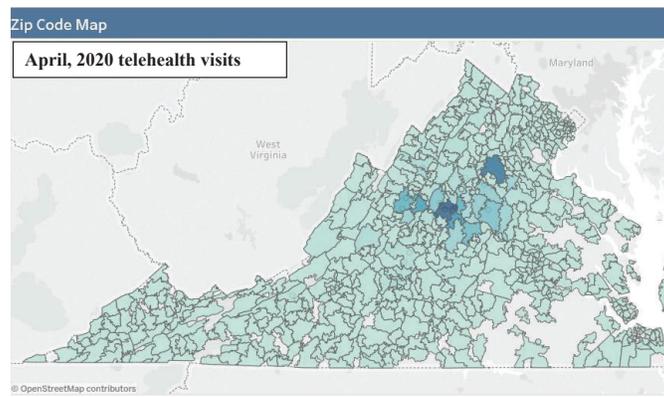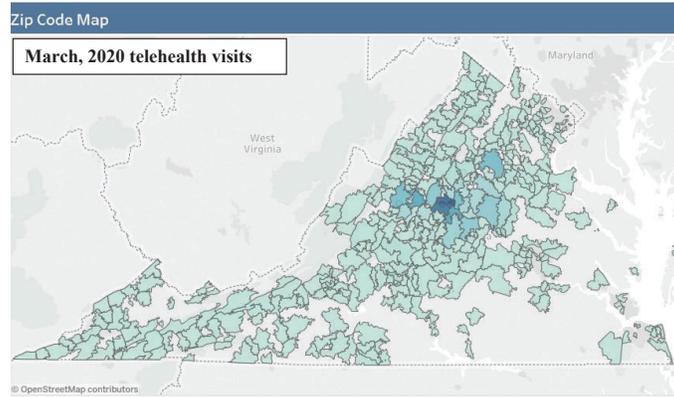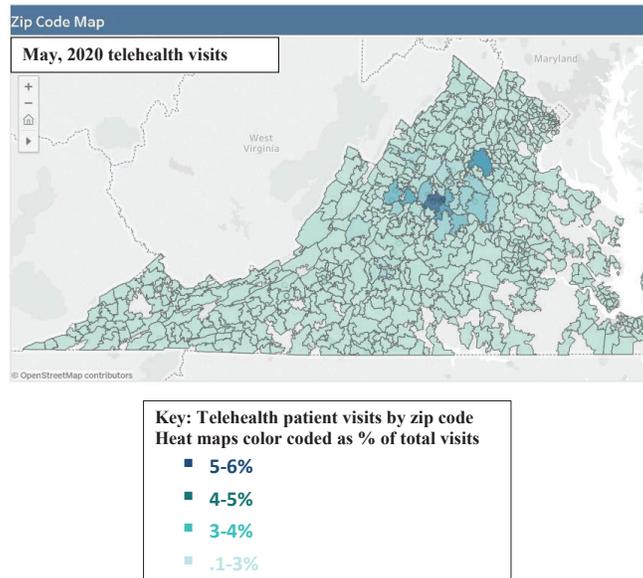
Patient satisfaction:

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 percent 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 percent range).

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 percent were likely to recommend their care provider
- 90.1 percent were likely to recommend our video visit service
- 83.4 percent 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;

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

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 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 percent 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 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 cov-

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[4] K Rheuban, EA Krupinski , Understanding Telehealth, 2017 McGraw Hill.
[5] *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf.*

ered 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 lim-

ited 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.

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[SUMMARY STATEMENT OF KAREN S. RHEUBAN]

Telehealth tools are playing a critically important role during the COVID–19 pandemic. Because of recent regulatory and statutory changes related to the COVID–

19 public health emergency, and by necessity, patients and providers have turned to digital health platforms, devices and services to provide and receive care in place, and avoid unnecessary exposure to the novel coronavirus.

As with other healthcare systems, UVA's telehealth response to COVID–19 has been a multi-pronged effort designed to maintain patient access and ensure continuity of care, expand monitoring of COVID–19 infected patients, reduce exposure and where appropriate, conserve personal protective equipment (PPE). Within our medical center, we have configured more than 100 rooms with videoconferencing that serve as "virtual PPE". We have expanded our remote patient monitoring programs to include COVID–19 patients, and have converted tens of thousands of in-clinic patient appointments to virtual visits. We have also deployed telemedicine equipment to long-term care and skilled nursing facilities through which we make virtual rounds and support vulnerable patients and have advanced training of the workforce virtually through Project ECHO and other tools.

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 invest further in broadband expansion to reduce or eliminate disparities, increase funding for the HRSA funded telehealth resource centers, expand training of the healthcare workforce in telehealth, and support innovative models of virtual continuing health professional education such as Project ECHO.

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The CHAIRMAN. Thank you, Dr. Rheuban.

Dr. Kvedar, welcome, and congratulations on your new position.

STATEMENT OF JOSEPH C. KVEDAR, M.D., PRESIDENT, AMERICAN TELEMEDICINE ASSOCIATION, PROFESSOR, HARVARD MEDICAL SCHOOL, VIRTUAL CARE, MASS GENERAL BRIGHAM, EDITOR, npj DIGITAL MEDICINE, BOSTON, MA

Dr. KVEDAR. Thank you so much, Chairman Alexander, Ranking Member Smith, distinguished Members of the Health, Education, Labor, and Pensions Committee, and fellow testifiers.

Thank you for inviting me to testify virtually on behalf of the American Telemedicine Association. I have been affiliated with ATA since its inception and remain committed to its vision that people should have access to safe, effective, and appropriate care where and when they need it.

As a practicing physician at the Massachusetts General Hospital in Boston, I have seen firsthand the many ways telehealth bridges the gap between a critical provider shortage and a growing patient population. The problem, by the way, that was here before COVID and will continue after.

During the past few months, we have all witnessed what ATA and its members and I have known for decades—that telehealth works. Telehealth services include real time audio, virtual video visits; a synchronous chat-based interaction; and remote monitoring. And research has shown that telehealth is as safe and effective as in-person care.

My own health system, which includes the Mass General and the Brigham and Women's Hospitals, has seen over—has had over 605,000 virtual encounters since March, and post-pandemic, we expect telehealth usage to be approximately 250,000 visits per month compared to 1,600 in February. So, like others, lots and lots of expansion has happened.

In short, telehealth has saved lives, helped flatten the curve, and enabled providers to scale the response of an overwhelmed healthcare system. COVID–19 has fueled the rapid transformation in how care is delivered.

However, this expanded access has only been possible because Federal and State Governments finally removed many of the antiquated barriers to telehealth. ATA wholeheartedly supports these policy changes that led to this transformation.

At the Federal level, temporary changes to restrictive requirements have enabled access to telehealth for all Medicare beneficiaries and allowed providers to reach those—more individuals, including those living in underserved and rural communities.

While telehealth will not and should not be entirely replacing face-to-face care, it should remain an important and active option. Given the high level of satisfaction and the clear value it delivers, patients and providers alike will demand access to telehealth indefinitely. Federal policymakers must take specific actions before the end of the public health emergency to make access to these services permanent.

Chairman Alexander, you referenced your white paper, planning—Preparing for the Next Pandemic. It takes a very thoughtful view of public health policy, and I would like to quote, because we appreciate your recommendation to "ensure that the United States does not lose the gains made in telehealth."

Specifically, Congress should first modernize the current statutory restrictions on patient geography and originating-site limitations. These limitations serve no other purpose than to restrict access to care.

Congress should also ensure that HHS has the flexibility to expand the list of eligible healthcare providers and maintain the authority to add or remove specific telehealth services as supported by data to make certain all eligible services are safe, effective, and clinically appropriate.

Congress must build on the changes made under the CARES Act and ensure federally qualified health centers and rural health clinics are empowered to deliver virtual care to underserved communities with fair and appropriate reimbursement moving forward.

We also need to support telehealth infrastructure through grants and technical assistance programs, including those that expand broadband to rural communities. To ensure that we leverage this technology, states will need to streamline provider licensing to ensure access across state lines.

Ultimately, we need your support to ensure that patients and providers do not go over the telehealth cliff. As our Nation eventually emerges from this pandemic, we must make sure that essential telehealth services do not abruptly end with the public health emergency, especially as we look to enhance preparedness for future public health crises and reorient our healthcare system to deliver 21st Century care.

Thank you for inviting me here with you today. I welcome your questions and further discussion about how we can work together to ensure that all individuals receive care where and when they need it in the future.

Thank you.

[The prepared statement of Dr. Kvedar follows:]

PREPARED STATEMENT OF JOSEPH C. KVEDAR

Chairman Alexander, Ranking Member Murray, and distinguished Members of the Senate Health, Education, Labor, and Pensions Committee. Thank you for inviting me to testify at today's hearing on behalf of the American Telemedicine Association. I am proud to serve a second term as ATA president and to have the opportunity to share with each of you—virtually—how telehealth has enabled healthcare providers to continue to deliver safe, effective, and needed care, both within and outside the hospital, providing a lifeline for patients across the country during the COVID–19 pandemic.

As a practicing physician at Massachusetts General Hospital in Boston, I have seen first-hand the multitude of ways telehealth has bridged the gap between a critical provider shortage and a growing patient population—a problem that existed before the pandemic, and one that will only worsen due to an aging population and the increasing burden of chronic disease. In my own telehealth clinic, I can deliver specialty care to patients in rural and underserved areas, without the need for them to travel hours to see me, take time off from work, or find someone to care for their child. This is not just happening at my institution but is occurring at hospitals and doctors' offices every day across the country.

Nearly 30 years ago, when I founded the Center for Connected Health at Partners HealthCare—a healthcare system including two Harvard Medical School-affiliated academic medical centers, community and specialty hospitals, community health centers, a physician network, home health, and long-term care services, now known as Mass General Brigham—I envisioned care delivery that was time and place independent. As technology has advanced, so too has healthcare innovation, creating new and better ways to connect patients and providers, empower individuals to manage their health better, and create more efficient and effective care and improved clinical outcomes. Even just a few short months ago, we could not have anticipated a public health emergency of this magnitude, nor the role telehealth would play in helping to 'flatten the curve' while delivering care to millions of Americans.

Founded in 1993, the ATA is the leading non-profit professional association representing the telehealth industry. Our member organizations include hospital networks, technology solution providers, academic institutions, and payers, as well as partner organizations and alliances from around the world. I have been affiliated with the ATA since its inception and remain fully committed to its mission—to create a healthcare system where more people have access to safe, effective, and appropriate care when and where they need it.

Over these past few months, Members of Congress, regulators, patients, and providers across the country have witnessed a reality that the ATA, its members, and I have known for decades: telehealth works. This pandemic has forced America's healthcare system into the 21st century. Telehealth has not been merely a novelty; telehealth has kept the entire healthcare system afloat and has enabled patients to continue to receive care.

For those previously unfamiliar with telehealth, I realize there may be questions about how virtual care and digital health technologies have been used during the pandemic and whether we should continue to allow providers to care for patients remotely in a post-pandemic world. I hope today I can shed light on the critical role telehealth has played during the pandemic and why we need to ensure Congress continues to allow individuals access to safe, effective, quality care as our world adjusts and our healthcare system evolves to meet our new reality.

Telehealth has saved lives, helped reduce the spread of the virus, and enabled providers to scale the response of an overwhelmed and under-prepared health system during the pandemic. Telehealth options also helped keep older adults connected to their healthcare providers and extended care to at-risk and underserved patient populations, especially in areas where healthcare resources may be limited.

Many of us who have been using telehealth know that virtual visits, remote monitoring, and asynchronous interactions with patients are as safe and effective as in-person care.[1] During the public health emergency, even more providers across the country have turned to telehealth to deliver primary care, specialty consultations and disease management, while making significant investments in technologies to better care for more individuals. Likewise, patients have grown accustomed to the convenience, safety, and quality of remote visits. Right now, three-quarters of U.S.

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[1] *https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002098.pub2/full.*

hospitals are using digital technology to reach their patients via video, audio, chat, or email.[2] Patient use of telehealth is up from 11 percent in 2019 to 46 percent this year, with 76 percent of consumers saying they are interested in using telehealth in the future.[3]

I can share with you some extraordinary numbers from my organization that includes Massachusetts General Hospital and Brigham and Women's Hospital. In just the last three months, our healthcare providers completed over 605,000 virtual visits, including nearly 247,000 in just the month of May. What's equally impressive is our projections for telehealth usage post-pandemic. Mass General Brigham providers will go from approximately 1,500 virtual visits per month to 250,000. Pre-pandemic, only .2 percent of all ambulatory outpatient visits were conducted via telehealth. Now, we anticipate 60 percent of ambulatory care will be delivered remotely.

In my case, as a practicing dermatologist, I cared for many patients using these tools during the pandemic. My patients were universally happy and grateful for the experience. Perhaps more importantly, I was able to diagnose several skin cancers (those patients were directed to come into our emergency dermatology clinic for further care) and reassure several others that the lesions they were concerned about were benign and could wait until their next scheduled visit.

Again, it's not just my organization that has implemented a significant shift in care delivery by leveraging the benefits of technology-enabled care. Many of our ATA members have also seen staggering increases in virtual care services.

For example, Providence St. Joseph Health (PSJH) cared for the first confirmed COVID–19 case in the U.S. and subsequently cared for 1,400 infected patients across its seven-state footprint. An established virtual care leader, PSJH's telehealth network was able to scale services from 70,000 telehealth visits in a year to 70,000 in one week to support the COVID–19 surge. Their clinicians leveraged telehealth technologies in many ways, including helping diagnose appendicitis in a young patient, working with a first-trimester pregnant patient to guide her using a fetal heart rate monitor, providing a more calming experience for behavioral health patients, and staying engaged with frail and elderly patients. Underscoring the power of telehealth, Providence's reported patient satisfaction was higher for virtual visits than standard in-person care.

Health systems, including Tennessee-based HCA Healthcare and LifePoint Health, are effectively using telehealth for specialty care, including but not limited to orthopedics, ENT, and urology. Under the current Medicare telehealth flexibilities, LifePoint Health, representing over 85 community-based hospitals on the front lines responding to the COVID–19 emergency, can now provide specialty consults to their patients via telehealth without the restraints or limitations of an in-person visit. LifePoint also has leveraged providers in other locations to help care for patients in hard-to-serve communities and its telehealth utilization has grown from a few hundred to more than 28,000 telephone-based visits and 26,000 video-based visits a month.

Telehealth companies like Amwell, Teladoc Health, and Zipnosis have also played a critical role during this crisis with their on-demand platforms and asynchronous solutions, enabling overburdened healthcare systems to effectively respond to the extraordinary patient demand throughout the Nation. These companies managed, as you know, record increases in volume and services in the first several weeks of the public health crisis. For example, in the first 45 days of the pandemic, Teladoc Health recorded a 67 percent year-over-year increase in patient volume nationally and an 84 percent increase in Tennessee.

Healthcare providers and policymakers often talk about the urgent need for healthcare transformation to address the challenges we are facing, including rising provider shortages, burgeoning patient populations, and growing financial pressure. COVID–19 has fueled a rapid transformation, with telehealth and virtual care driving the new paradigm in care delivery.

While many envision telehealth as real-time audio or video interactions between a patient and provider, many platforms are combined with remote monitoring capabilities, allowing for a virtual care model that offers patients around-the-clock clinical support and convenience. This expanded care model is especially critical for individuals who engage with the healthcare system frequently, including patients with

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[2] https://www.beckershospitalreview.com/telehealth/telehealth-may-see-big-long-term-gains-due-to-covid-19-10-observations.html.

[3] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid–19-reality.

chronic conditions such as diabetes, hypertension, and congestive heart failure, as well as behavioral health conditions.

Today, 147 million Americans live with chronic conditions, accounting for 90 percent of our total annual healthcare costs. With telehealth, we can improve access to care while reducing many of the acute and long-term health complications that stem from chronic conditions. For example, remote monitoring also allows individuals to self-monitor their health and securely share data with their healthcare providers. This technology has proven to reduce hospital readmissions and trips to see the doctor. Also, by effectively applying data science, many leading remote monitoring companies, such as Livongo Health, can contextualize health trends, determine which individuals might benefit most from a telehealth visit, and offer patients real-time, personalized and actionable recommendations on how to stay healthy—critical for individuals with chronic conditions.

In response to the pandemic, Federal and state governments finally removed many of the antiquated barriers to telehealth that were keeping providers from reaching their patients remotely. The ATA wholeheartedly supports these policy changes.

At the Federal level, temporary changes to the unnecessarily restrictive requirements in section 1834(m) of the Social Security Act now allow all Medicare beneficiaries—including those living in both rural and urban areas—to benefit from telehealth. 'Originating site' restrictions were also waived, enabling providers to interact with new and existing Medicare patients over a range of telehealth modalities—including the telephone—no matter where the patient is. For underserved and rural communities, federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can finally serve as distant sites, enabling these essential safety net providers to reach patients they serve in ways they have never been able to before. These examples of proactive, common-sense policies paired with significant new funding opportunities and loosened restrictions on licensure, cost-sharing, and the use of certain technologies, have changed the way our Nation delivers and receives health care.

In states across the country, Medicaid policies have largely kept pace with the needs of patients and providers. A recent analysis from the Medicaid and CHIP Payment and Access Commission (MACPAC) found that 44 states and territories expanded telehealth services by changing Medicaid policies in response to the pandemic. Additional state-based policies now allow a patient's home to qualify as an originating site, provide payment parity for telehealth visits, enable other providers to deliver services through telehealth, and allow providers to consult with their patients over the telephone. [4]

These policy changes have enabled unprecedented telehealth utilization during this public health emergency. However, I advise you not to be distracted by these numbers. The overwhelming acceptance and implementation of telehealth during the pandemic—and the significant levels of patient and provider satisfaction—clearly speak to the value of these technologies. In fact, a recent poll of Medicare Advantage beneficiaries found that more than 90 percent of respondents view their recent use of telehealth as favorable, and nearly 80 percent reported they would use telehealth for a medical appointment in the future. [5]

Telehealth will not and should not entirely replace in-person care post-pandemic. It should, however, be an option. As patients again feel safe to enter healthcare facilities for nonemergent care, we may see a natural decline in the use of telehealth. Some patients and providers will prefer in-office interactions, while others will want to use telehealth for some aspects of care, and still, others may opt to forgo virtual care altogether. Given the patient and provider satisfaction we have seen, I believe many, if not most, providers and patients will want to continue to use telehealth in some way indefinitely.

Now that Medicare beneficiaries have improved access to telehealth, Federal policymakers need to take specific actions to make these services permanent. Failure to do so will result in unnecessarily restricting access to high-quality care. However, if the Federal Government—and specifically Congress—does not act before the end of the declared national public health emergency, Medicare patients and providers will not have the option to continue to use remote care.

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[4] https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf.
[5] https://www.betterMedicarealliance.org/sites/default/files/BMA%20Memo%20CT%20D2%5B%5D.pdf.

Chairman Alexander, your recent white paper, *Preparing for the Next Pandemic*, takes a thoughtful approach to public health policy, and we specifically appreciate your recommendation to "ensure that the United States does not lose the gains made in telehealth." [6] To accomplish this, Congress must move quickly to enact targeted telehealth reform legislation before the national emergency, and public health emergency declarations are rescinded. The ATA and I welcome the opportunity to work with lawmakers to inform these policies.

Moving forward, Congress should first address the current statutory restrictions on patient geography and originating site limitations. These restrictions are out-of-date and must be modernized to enable Medicare beneficiaries to continue to benefit from telehealth no matter where they are, including in their homes. We have seen the value of waiving these specific limitations during the current crisis and learned that they serve no other purpose than to restrict access to care.

Congress should also ensure the Secretary of the Department of Health and Human Services (HHS) has the flexibility to expand the list of eligible practitioners and therapy services and, similarly, maintain the authority to add or remove specific telehealth services, as supported by data, to make certain all eligible services are safe, effective, and clinically appropriate. Allowing the Centers for Medicare and Medicaid (CMS) to determine and manage the range and scope of telehealth services through a predictable and transparent regulatory process will ensure patients and providers have certainty and clarity on the future of telehealth.

Congress showed great leadership in strengthening the capacity of providers treating our Nation's most vulnerable populations by allowing FQHCs and RHCs to be distant sites under the CARES Act. As our Nation grapples with how to address disparities in health care access and health outcomes, Congress should work with stakeholders so that our Nation's FQHCs and RHCs are empowered to deliver virtual care to underserved communities with fair and appropriate reimbursement.

These reimbursement challenges represent the most critical barrier at the Federal level to the provision of telehealth in a post-pandemic world. Understanding how these specific waivers have improved access to quality care during the pandemic, and how keeping these changes once the public health emergency declaration is rescinded, should be at the forefront of all our minds.

These are not the only policy changes that will be required to ensure telehealth can continue post-pandemic, but they are the most immediate Federal policies that must be addressed. Additionally, technology and telehealth infrastructure remain a critical need. Congress can support recent COVID–19 investments by continuing to fund targeted grant, and technical assistance programs at the Federal Communications Commission and Health Services and Resources Administration or consider launching new infrastructure initiatives under HHS.

Federal agencies must also seriously consider other policies that have been loosened during the pandemic to determine if they are appropriate to continue. Such policies include flexibilities to use telehealth for remote prescribing of controlled substances and flexibilities around HIPAA requirements. In addition, states will need to continue to work together to offer more streamlined licensing across state lines. Congress should pay attention to all of these policies, but first and foremost, Congress should ensure Federal law does not unnecessarily impede access to telehealth.

Ultimately, we need your support in ensuring patients and providers do not go over the telehealth "cliff" as our Nation emerges from the pandemic. Essential telehealth services will abruptly end with the national emergency, and beneficiaries who have come to rely on critical virtual services will be forced back into a world with restricted access to convenient, digitally enabled care. Ensuring HHS and CMS have the needed flexibility to support high quality, safe, and effective virtual care is more important than ever as we look to enhance preparedness for future public health crises and reorient our healthcare system to deliver 21st century care.

Thank you again for inviting me to be here with you today, and I welcome your questions on how we have seen telehealth reach and serve patients during the pandemic and how we should work together to ensure all individuals receive the care they need—where and when they need it—in the future.

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[6] *https://www.alexander.senate.gov/public/cache/files/0b0ca611-05c0-4555-97a1-5dfd3fa2efa4/preparing-for-the-next-pandemic.pdf*.

About the American Telemedicine Association (ATA)

The mission of the ATA is to support the ability of telehealth to transform healthcare and the patient and provider experience through enhanced, efficient and more convenient delivery of healthcare services. The ATA is dedicated to promoting a health care system where more people have access to safe, effective, and appropriate care when and where they need it.

The ATA also plays a central role in introducing and supporting reforms in public health policy that can expand access to virtual care. In just one example, in response to the COVID–19 pandemic, the ATA joined with members to partner with Congress and rapidly identify and address a range of regulatory barriers that could prevent our Nation's ability to expand the use of telehealth services in a period of unprecedented demand for remote patient care.

The ATA continues to work to make sure that regulations and guidelines related to the use of telehealth reflect the needs of patients and providers as well as advances in technology. Some issues where the ATA and its members are working to introduce changes that will benefit patients and providers include limiting restrictions on access to telehealth services for Medicare beneficiaries, expanding the use of advanced technologies that can improve patient care, and supporting appropriate licensing requirements for providers.

The ATA believes policies that allow providers and patients to access care when and where they need it—using safe and effective technologies—can help improve patient outcomes at reduced costs. As such, we believe Congress must enact policies that will empower patients and allow for provider discretion when choosing how to best treat patients.

We believe Federal telehealth legislation should reflect the following principles:

1. Ensure patient choice, access, and satisfaction
2. Enhance provider autonomy
3. Incentivize 21st century care
4. Enable healthcare delivery across state lines
5. Empower advanced practice providers
6. Expand access for underserved and at-risk populations
7. Support seniors and expand "aging in place."
8. Protect patient privacy and ensure cybersecurity

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[SUMMARY STATEMENT OF JOSEPH C. KVEDAR]

In response to the COVID–19 pandemic, federal and state governments finally removed many of the antiquated barriers to telehealth that were keeping providers from reaching their patients remotely. The ATA wholeheartedly supports these policy changes.

At the Federal level, temporary changes to the unnecessarily restrictive requirements in section 1834(m) of the Social Security Act now allow all Medicare beneficiaries—including those living in both rural and urban areas—to benefit from telehealth. 'Originating site' restrictions were also waived, enabling providers to interact with new and existing Medicare patients over a range of telehealth modalities—including the telephone—no matter where the patient is. For underserved and rural communities, federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can finally serve as distant sites, enabling these essential safety net providers to reach patients they serve in ways they have never been able to before. These examples of proactive, common-sense policies paired with significant new funding opportunities and loosened restrictions on licensure, cost-sharing, and the use of certain technologies, have changed the way our Nation delivers and receives health care.

Now that Medicare beneficiaries have improved access to telehealth, Federal policymakers need to take specific actions to make these services permanent. Failure to do so will result in unnecessarily restricting access to high-quality care. Moving forward, Congress should first address the current statutory restrictions on patient geography and originating site limitations. These restrictions are out-of-date and must be modernized to enable Medicare beneficiaries to continue to benefit from telehealth no matter where they are, including in their homes. We have seen the value of waiving these specific limitations during the current crisis and learned that they serve no other purpose than to restrict access to care.

Reimbursement challenges represent the most critical barrier at the Federal level to the provision of telehealth in a post-pandemic world. Understanding how these specific waivers have improved access to quality care during the pandemic, and how keeping these changes once the public health emergency declaration is rescinded, should be at the forefront of all our minds.

These are not the only policy changes that will be required to ensure telehealth can continue post-pandemic, but they are the most immediate Federal policies that must be addressed. Additionally, technology and telehealth infrastructure remain a critical need. Congress can support recent COVID–19 investments by continuing to fund targeted grant and technical assistance programs at the Federal Communications Commission and Health Services and Resources Administration or consider launching new infrastructure initiatives under HHS.

Federal agencies must also seriously consider other policies that have been loosened during the pandemic to determine if they are appropriate to continue. Such policies include flexibilities to use telehealth for remote prescribing of controlled substances and flexibilities around HIPAA requirements. In addition, states will need to continue to work together to offer more streamlined licensing across state lines. Congress should pay attention to all of these policies, but first and foremost, Congress should ensure Federal law does not unnecessarily impede access to telehealth.

Ultimately, we need your support in ensuring patients and providers do not go over the telehealth "cliff" as our Nation emerges from the pandemic. Essential telehealth services will abruptly end with the national emergency, and beneficiaries who have come to rely on critical virtual services will be forced back into a world with restricted access to convenient, digitally enabled care. Ensuring HHS and CMS have the needed flexibility to support high quality, safe, and effective virtual care is more important than ever as we look to enhance preparedness for future public health crises and reorient our healthcare system to deliver 21st century care.

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The CHAIRMAN. Thank you, Dr. Kvedar. And welcome, Dr. Arora.

STATEMENT OF SANJEEV ARORA, M.D., M.A.C.P., F.A.C.G., DISTINGUISHED AND REGENTS' PROFESSOR, UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER, FOUNDER AND DIRECTOR, PROJECT ECHO/ECHO INSTITUTE, ALBUQUERQUE, NM

Dr. ARORA. Chairman Alexander, Senator Smith, and Members of the Committee, thank you for inviting me to testify at today's hearing.

I want to start by sharing a quick story about a different use of telehealth than we have heard so far. One Friday afternoon 18 years ago, I walked into my clinic in Albuquerque to see a 42-year old woman, who had driven 5 hours with her two children. She had been diagnosed with Hepatitis C 8 years earlier. She was just now seeking treatment for the first time.

I asked her why, why now? She said that her doctor told her the treatment would require at least a dozen trips to Albuquerque over the course of a year, and she could not afford to take the time off work, so she did not seek treatment. But, now she was experiencing abdominal pain that interfered with her ability to work, and that is why she finally came to see me. But, it was too late. She now had advanced liver cancer and she died 5 months later.

I asked myself, why did this mother of two children have to die from a treatable disease? She died because the right knowledge did not exist at the right place at the right time. New Mexico had 28,000 patients with Hepatitis C, and hundreds of patients were dying every year for lack of access to treatment.

That is why I started Project ECHO. Millions of patients in the Country are unable to access specialty care on a timely basis. We

need to fundamentally reorient our healthcare system to enable us to quickly move new information and best practices from experts to providers on the front lines caring for patients in communities, and telehealth can play a major role in making that happen. The COVID–19 pandemic has only underscored this urgency.

That is where ECHO comes in. ECHO, also called Technology-Enabled Collaborative Learning and Capacity Building, is a highly scalable platform to exponentially amplify the implementation of best practices in our Nation.

But, let us look at ECHO to treat Hepatitis C in New Mexico. We launched 21 new centers to treat Hepatitis C in rural communities. Each center was run by a primary care clinician. We shared our protocols with them, and they connected with us all together once a week on video to discuss cases with us at the University and with each other. Soon, they had become experts, and the wait in my clinic fell from 8 months to 2 weeks. Many thousands of patients got treatment.

We knew we had an effective model, so we expanded it by training academic medical centers around the United States to use it. Today, we have 250 hubs in the United States, in 48 states, training professionals in 20,000 organizations for 70 different disease areas, and there is strong demand for setting up new hubs in the U.S.

The ECHO model works like this: Teams of experts at regional medical centers called hubs use one to many videoconferences to engage with local healthcare providers, the spokes, in weekly, ongoing knowledge sharing, case-based learning and telementoring. Other spokes learn from each other. Everyone's knowledge is constantly improving. We call it "all teach and all learn."

We know the model works. In a study published in the *New England Journal of Medicine*, funded by the Agency for Healthcare Research and Quality, they showed that the primary care clinicians supported by ECHO can provide care as safely and effectively as specialists. Since then, more than 200 peer-reviewed publications have demonstrated the effectiveness of ECHO.

All along, we believed that ECHO could be put to work in a meaningful way in a pandemic, and 12 weeks ago, the world changed. Now we are deploying our entire network to ensure healthcare professionals know what to do with COVID–19. We are now—hundreds of partners are running 30 training sessions a day and answering hundreds of questions, from how to use personal protective equipment in the midst of a shortage, how much oxygen to deliver, and what ventilator settings to use. We are training more than 200,000 public health professionals, doctors, and nurses in the U.S. on COVID–19.

What does this all mean for going forward? In 2016, Congress, with broad bipartisan support, passed the original ECHO Act. It cleared the Senate by 96–0 and was signed into law. Last year, the Senate and House introduced a new act to take the next step of exploring how to build a sustainable funding stream for Technology-Enabled Collaborative Learning and Capacity Building models like ECHO for the healthcare system, and which include in—the most recent House-passed recovery package takes provisions from the

ECHO Act to create a grant program under HRSA to support organizations that are using ECHO-like models.

I urge you to support inclusion of provisions from the ECHO Act as the Senate considers the next recovery and response package.

Discussions have also turned to CMS. More than 20 Senators, including multiple Members of this Committee, signed a letter to HHS Secretary requesting that CMS issue guidance to stage some financing strategies available through Medicaid and Medicare. I encourage the Committee to follow-up on that letter.

In closing, I hope this Committee, and the Congress more broadly, will commit to exploring longer term challenge—longer term changes to healthcare financing that would help realize the promise of telehealth, to de-marketize access to specialized knowledge, and ultimately seeing the day when no mother dies because of her lack of access to a specialist.

Thank you for this opportunity to present.

[The prepared statement of Dr. Arora follows:]

PREPARED STATEMENT OF SANJEEV ARORA

Chairman Alexander, Ranking Member Murray and Members of the Committee. My name is Sanjeev Arora. I serve as Director and Founder of Project ECHO at the University of New Mexico, Health Science Center.

Thank you for inviting me to testify at today's hearing exploring telehealth and lessons from the COVID–19 pandemic.

I want to start by sharing a quick story that explains why I am here with you today.

One Friday afternoon 18 years ago, I walked into my hepatitis C clinic in Albuquerque, New Mexico, to see a 43-year-old woman who had driven 5 hours with her two children.

She had been diagnosed with hepatitis C 8 years earlier. Yet she was just now seeking treatment for the first time.

I asked her why—why now?

She said that her doctor told her that treatment would require her to make at least a dozen trips to Albuquerque over the course of a year—and she couldn't afford to take the time off work. She needed that money to feed her family.

She didn't seek treatment.

But now she was experiencing abdominal pain that interfered with her ability to work. And that's why she finally came to see me.

But it was too late. She now had advanced liver cancer. She was not a candidate for a liver transplant and the cancer was too large to be removed surgically. There was nothing we could do to prolong her life.

She died 5 months later.

I asked myself: Why did this mother of two children have to die?

We had the medicines and the expertise to treat her. But she didn't have the resources to get to us. And no doctor in her community had the knowledge to treat her disease.

A five-hour car drive was too great a barrier for her to overcome.

That's why I started Project ECHO over a decade ago. And that's why I'm here testifying to you today.

We need to fundamentally reorient our healthcare system to enable us to quickly move new information and best practices from top experts at academic medical centers to providers at the frontlines caring for patients in communities. The COVID–19 pandemic has only underscored the urgency with which we need to tackle this challenge.

Instead of placing the burden on patients to find us—the medical experts who can treat and cure them—we need to share our expertise with the providers in communities where these patients live. We need to enable patients to get the care they need, when they need it, in or near the places where they live.

Telehealth can play a major role in making that happen. But it starts by understanding that telehealth is more than technology.

Technology can help us bridge wide geographic divides in ways we wouldn't have imagined possible 20 years ago. But technology is simply a tool that enables essential human interaction.

For example, technology allows us to have the virtual hearing we're participating in today, but it's not the technology that makes this discussion valuable. What matters is what the technology enables—the discussion we're having, the expert testimony, the answers we provide to your questions, and, most importantly, how it all informs the decisions you make going forward.

Likewise with telehealth, the technology enables us to interact in ways that ultimately improve health and save lives.

That's where Project ECHO comes in.

Project ECHO is a model for telementoring or what's now called a technology-enabled collaborative learning and capacity-building model. Essentially, models like ECHO leverage technology, including videoconferencing platforms such as Zoom, to ensure that clinicians on the ground have the latest best practices, mentoring and support they need to treat patients in their communities.

On the spectrum of telehealth, it differs from telemedicine, which is typically a one-to-one provider and patient virtual visit. It's also different from an eConsult, which is usually one specialist consulting with one provider about the care of one patient. Technology-enabled collaborative learning models like ECHO involve a team of specialists in a specific disease area connecting to multiple teams of community providers in an ongoing learning community.

Each of these telehealth approaches is needed and valuable. But for the purpose of my testimony, I will be primarily focused on technology-enabled collaborative learning and capacity building, which is the area I know best.

To explain this difference, I often use the example of teaching your daughter to drive a car. I ask how many people would be willing to give their daughter a text book, and then give her the keys to the car. This example points out that for very complex tasks, we need more than a protocol, we need guided practice to help master complexity over time. This guided practice is what the ECHO model provides—and is what makes it different from traditional telemedicine. The ECHO model builds system capacity to implement best practices at scale over time.

When I started ECHO to treat hepatitis C in my home state, I realized that in order to convince clinicians in rural clinics to treat this complicated disease, I needed to create something that mimicked the grand rounds experience of their residencies. We needed to bring the experts to these rural clinicians over video to share up-to-date best practices—and the clinicians needed to present their own cases and get ongoing guidance and mentorship from experts.

We launched 21 new centers of excellence to treat hepatitis C in rural communities. Each center was run by a primary care clinician. We shared our treatment protocols with them, and they connected with us all together once a week on video to discuss cases with us, at the university and with each other. Soon they had become experts and the wait in my clinic fell from 8 months to 2 weeks. Tens of thousands of patients got treatment. We knew we had an effective model . . . so we expanded it by training academic medical centers around the United States to deploy for more than 70 healthcare conditions.

The all teach and all learn ECHO model works like this:

Teams of experts at regional medical centers (called "hubs") use one to many videoconferences to engage with local healthcare providers (the "spokes") in weekly ongoing knowledge-sharing, case-based learning, and tele-mentoring.

Hub and spokes learn from each another. Everyone's knowledge is constantly improving.

Based on the tremendous need, ECHO has grown from addressing a single disease in one state to addressing 75 different health conditions across 48 states and reaching learners in 154 countries. There are now ECHO projects at more than 250 organizations across the U.S. alone, many of these at major academic medical centers.

We know the model works. A study published in the New England Journal of Medicine [1] and funded by the Agency for Healthcare Quality and Research focusing

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[1] S Arora, K Thornton, G Murata et al. Outcomes of Treatment for Hepatitis C Infection by Primary Care Providers. *N Engl J Med* 2011 Jun 9;364(23):2199–207. doi: 10.1056/NEJMoa1009370. Epub 2011 Jun 1.

on our hepatitis C work in New Mexico showed that patients treated by an ECHO-trained community provider got the same quality care they would get if they went to a specialist. There are now more than 235 published papers published on different aspects of the model.[2]

Prior to COVID–19, we had trained more than 100,000 healthcare professions in 20,000 organizations in all corners of the Nation. And there was strong demand for setting up new hubs in the United States.

We had long believed that ECHO could be put to work in a meaningful way in a pandemic. And 12 weeks ago—the world changed.

Now we are deploying our entire network to ensure healthcare professionals know what to do with COVID–19. We mobilized our ECHO community to respond to the pandemic on two levels:

- **To amplify the public health response to COVID–19** in areas like rapid testing, isolation of patients who test positive, contact tracing and follow-up to contain the spread of the virus.
- **And, to scale the clinical delivery response**. What do doctors, nurses, EMTs and other clinicians in the field need to know to treat patients with COVID–19? Remember, this is a completely new disease. There is so much we still don't know about COVID–19, yet we need to provide guidance on best-practice care even in the absence of firmly established science.

ECHO projects in at least 33 states have pivoted their efforts to COVID–19, including states represented on this Committee like Kentucky, Kansas, Maine, Pennsylvania, Minnesota, Nevada, New Hampshire, and Massachusetts.

In addition, the ECHO Institute has partnered with the Office of the Assistant Secretary for Preparedness and Response (ASPR) at HHS to launch a COVID–19 Clinical Rounds that serves as a peer-to-peer learning platform for frontline clinicians across the country and around the world. It's supported by more than 15 major medical societies and includes expertise from the National Emerging Special Pathogen Treatment and Education Center established by Congress after the Ebola outbreak. Every week, some 400 to 1,700 clinicians log on to navigate the unknowns of COVID–19 together.

We and our partners are running an estimated 30 training sessions a day, answering questions from how to address personal protective equipment in the midst of a shortage and how much oxygen to deliver and what ventilator settings to use. We have trained more than 200,000 additional healthcare professionals (nurses, doctors, community health workers, pharmacists, emergency response personnel etc . . .) on COVID–19.

In addition, to underscore the interconnection of different telehealth approaches, multiple ECHO projects are now equipping providers to do telemedicine effectively. We need ongoing learning communities to ensure that the doctors, nurses and other health professionals who almost overnight were thrown into a world of virtual medicine get access to best practices and the guidance to implement them.

What does this all mean for going forward? How can lessons from COVID–19 and the experience of telehealth during this pandemic help us to reshape our healthcare system to move life-saving information more quickly and efficiently?

Going forward, we must understand that with healthcare, as with so many other areas, you get what you pay for. Steps that Congress and CMS have taken in areas like increasing broadband access in rural communities and expanding coverage for the virtual services clinicians can provide are really important ones.

But we also need to continue to move beyond the emphasis on the technology part of telehealth to the health part. Again, like the hearing today, it's what's being virtually delivered across the medium and how that allows us to take action that matter most.

In 2016, Congress—with broad bipartisan support—passed the original ECHO Act. It cleared the Senate by a 96–0 vote and was signed into law. We're grateful for the support of that measure by so many of the Committee members here today. That legislation formally recognized technology-enabled collaborative learning and capacity-building and directed HHS to produce a report (released in March of last year) to explore barriers and opportunities to its use and better understand the evidence base supporting it. It was a significant building block in our ongoing efforts to scale up the ECHO model across the country and globe.

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[2] *https://echo.unm.edu/about-echo/research.*

Last year, efforts emerged in the Senate and House to take the next step of exploring how to build a sustainable funding stream for technology-enabled collaborative learning and capacity-building in the healthcare system. There are now House and Senate ECHO authorization bills that establish a grant program through HRSA. The House included language in the most recent House-passed recovery package draws on the ECHO authorization bill in the House to create a grant program under HRSA to support organizations that are using technology-enabled collaborative learning and capacity-building for COVID–19 response. If enacted, that program will be a critical support to many efforts connecting providers on the frontlines of the pandemic with the emerging best practices and expert guidance they need to treat their patients.

I urge you to support the House-passed provision of the most recent stimulus bill (HEROES Act, H.R. 6800) as the Senate considers the next recovery and response package. It would be a major next step in terms of both supporting current COVID–19 response efforts and helping to set the groundwork for a more responsive health care system in times of public health emergencies.

While efforts to establish a grant program have proceeded, discussions have also turned to CMS. More than 20 Senators—including multiple members of this Committee—signed a letter to the HHS Secretary requesting that CMS issue guidance to states on financing strategies available through Medicaid and explore existing authorities through Medicare as well. *I encourage the Committee to consider directing CMS to move quickly on that guidance*.

I hope this Committee—and the Congress more broadly—will commit to exploring longer-term changes to healthcare financing that would create sustainable and ongoing funding for effective telehealth approaches, and specifically for embedding technology-enabled collaborative learning and capacity-building into the system.

If not COVID–19, their lives will be affected by the opioid epidemic, cancer, HIV, diabetes, autism or many other diseases or conditions.

I am committed to working with you to help realize the promise of telehealth, and ultimately seeing the day when a mother's survival doesn't rest on her ability to take a five-hour car ride twelve times a year.

If we together can make that happen, this will have been the most powerful telehealth session I've ever been part of.

Thank you for providing me with the opportunity to testify before you today. I look forward to answering your questions.

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[SUMMARY STATEMENT OF SANJEEV ARORA]

Responding to the Committee's request for greater understanding of how the COVID–19 pandemic has changed telehealth, Dr. Arora's testimony will focus on the role that the ECHO model, as a technology-enabled collaborative learning and capacity building model, has played in supporting the response to COVID–19.

A specialist at the University of New Mexico Health Science Center, Dr. Arora's testimony will provide a brief overview of the rationale for why he developed the ECHO model. Seeing a severe lack of access to specialty care, Dr. Arora developed the ECHO model as a way to democratize expert knowledge widely and create mini-experts among primary care providers around the state of New Mexico.

What began as a means to support treatment for a single disease, hepatitis C, over time the ECHO model has come to be used by academic medical centers throughout the United States as a powerful telementoring modality to help providers, especially in rural and underserved areas, to receive access to ongoing mentorship and professional development.

At the start of the pandemic, there were more than 250 academic medical centers, managed care organizations, Departments of Health, and nonprofits operating ECHO programs in 48 states. In cities and states around the Nation, many ECHO programs shifted these networks of experts and providers to support the rapid dissemination of information about evolving COVID–19 best practices.

Today, this network is running at least 30 training sessions a day and answering hundreds of questions, from how to reuse personal protective equipment in the midst of a shortage, to how much oxygen to deliver and what ventilator settings to use. As best practices continue to evolve and the 'new normal' is defined, technology enabled capacity building networks such as Project ECHO are vital to supporting the healthcare community in this country and preparing for future unforeseen public health emergencies in the future. Dr. Arora will ask for the HELP Committee

Members to support the provision of the HEROES Act, (H.R. 6800, Section 30613) that calls for the creation of a grant mechanism within HRSA to provide support for COVID–19 related technology-enabled learning and capacity building models. The bill provides for an authorization of $20 million to support this work. The Committee's support of this section of the bill in the Senate would be very much appreciated and would go a long way toward enabling University hubs around the country to expand their response to COVID–19.

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The CHAIRMAN. Thank you, Dr. Arora.
Now, Dr. Willis, welcome.

STATEMENT OF ANDREA D. WILLIS, M.D., M.P.H., F.A.A.P., SENIOR VICE PRESIDENT, CHIEF MEDICAL OFFICER, BLUECROSS BLUESHIELD OF TENNESSEE, CHATTANOOGA, TN

Dr. WILLIS. Good morning, Chairman Alexander, Ranking Member Smith, and Members of the HELP Committee.

I am Dr. Andrea Willis, and I have the privilege of serving as the Chief Medical Officer at BlueCross BlueShield of Tennessee. Our mission is peace of mind through better health. And, as a tax-paying, not-for-profit health insurer, we serve 3.5 million members, who are enrolled in a variety of coverage options, and we participate with other Blues plans across the Nation as part of the BlueCross BlueShield Association. It is my honor to join you today to discuss telemedicine and lessons we are learning from the COVID–19 pandemic. We have experienced and seen the effects of this pandemic on our members, and even within our own families.

As we all know, the healthcare system is ever-changing, and BlueCross responded rapidly to meet the needs of individuals and families during this unprecedented time. Our foundation provided $3.25 million to Tennessee food banks, as well as funds to municipal governments to support free COVID–19 testing.

Telemedicine is a good example of our member-focused response. As the pandemic spread, we joined with other payers in relaxing requirements and began covering telemedicine visits to retain our members' access to care, and we were the first major insurer to commit to making in-network telehealth services available for good, even after this crisis ends. BlueCross Tennessee made this decision because it was clear our members and providers wanted the choice to use virtual care. It was another way to collaborate with in-network providers to make quality care more convenient, and it was the right thing to do for our members and the providers who care for them.

Prior to COVID–19, utilization rates for telemedicine was consistently below 30 percent for members with that benefit. Adoption has since risen exponentially, and the key was partnering with our in-network providers. In general, those doctor-patient relationships transformed and thrived in this newly embraced method of interaction.

Because the data is still accumulating, it is too early to definitively say that the expansion of telehealth has improved health outcomes, but it has undoubtedly improved access to care. It has highlighted the keen abilities for providers to hone in on the chief complaint and pertinent history of the patients to make an informed diagnosis and plan of care.

We wanted to ensure adequate reimbursement for medical providers treating our members so that there would be no barrier to doing so, especially now considering the financial impacts this pandemic has had on physician practices and hospitals. Expanded telemedicine allows for continued visits with primary care providers and specialists, behavioral health providers, and other therapists.

We also believe the availability of telemedicine is reducing some inappropriate emergency room and urgent care use. From mid-March through mid-May, we saw 50 times more telemedicine claims than the same time period last year.

With the rapid and widespread adoption of telemedicine, we recognize there will be some needed changes that could not be addressed initially. Existing processes related to credentialing, contracting, reimbursement, and audit policies will be useful tools to guard against fraud, waste, and abuse.

While we have privacy and security measures in our current physician agreements, we believe there needs to be further discussions to continue protecting those served by telemedicine.

As the saying goes, we don't believe we should let perfect be the enemy of good. We can address these challenges while continuing to support telemedicine. We don't have all the answers today, but we are committed to collaborating to build a sustainable path forward.

I am honored by this opportunity to share BlueCross BlueShield's of Tennessee approach to telemedicine as we continue promoting affordable access to quality, evidence-based care for the people we serve.

Thank you.

[The prepared statement of Dr. Willis follows:]

PREPARED STATEMENT OF ANDREA WILLIS

Good morning, Chairman Alexander, Ranking Member Murray, and Members of the HELP Committee. I am Dr. Andrea Willis, and I have the privilege of serving as the Chief Medical Officer at BlueCross BlueShield of Tennessee. As a board-certified pediatrician who has had the honor of serving as Deputy Commissioner for the Tennessee Department of Health and the first director of CoverKids, Tennessee's State Children's Health Insurance program, I am also a proud public health advocate and champion for the health and wellness of Tennesseans.

At BlueCross Tennessee, a taxpaying, not-for-profit health insurer celebrating its 75th year, our priority is the health of our 3.5 million members and the communities we serve. Our workforce is comprised of 6,800 colleagues, including 900 nurses, and as the state's largest health plan, we provide benefits to more than 11,000 Tennessee companies and partner with over 29,000 providers across the state to help carry out our mission: peace of mind through better health.

Our members are enrolled in a variety of coverage options, including Medicaid, Medicare Advantage and commercial plans. We also administer coverage for large, self-insured groups and participate with other Blues plans across the Nation as part of our affiliation with the BlueCross BlueShield Association.

First, we empathize with those across the Nation and in Tennessee who have lost loved ones, have been furloughed or laid off, and seen their world change in ways none of us could have imagined.

Like other parts of our health care community, we've experienced the effects of COVID–19—and most importantly, we've seen the effects of this pandemic on our members. We recognize the health disparities that have been exacerbated by this disease outbreak and are committed to doing our part to address those. We've also been fortunate to witness amazing and encouraging acts of empathy, compassion, dedication and innovation during these past few months. I am extremely proud to be a part of the community of medical professionals. I stand in complete awe, with reverence for the many health care servants who set aside their own personal safety

to be on the front lines in this fight. And I believe we all owe a tremendous debt of gratitude to all of those who are putting the needs of others above themselves each day.

Our health care system is sometimes slow to change, but I've been encouraged at how BlueCross Tennessee and our partners in Tennessee have responded so quickly to meet the needs of our communities during these unprecedented times. Telemedicine is certainly one of the areas in which we've seen change happen quickly and for the benefit of our members.

We've worked hard to adapt to meet the evolving needs of our members as COVID–19 spread throughout Tennessee. We were among the first plans to commit to waive testing costs and expand access to telehealth for our members—and we were the first major insurer to commit to making in-network telehealth services available on an ongoing basis after this crisis ends. We wanted our members to retain virtual access to the physicians they knew and trusted.

We have long supported telehealth interactions between specialists at one location interacting with other health care providers alongside their patients at another location. In fact, one of our earliest partnerships started back in 2012 to support high-risk maternity care.

COVID–19 vastly opened up direct telemedicine interactions between health care providers and their patients. This included physical and behavioral health services, and we reimbursed providers for these services at their currently contracted rate, or parity.

Prior to COVID–19, BlueCross Tennessee, we had seen utilization rates for telemedicine consistently below 30 percent for members with that benefit. As we expanded and encouraged telemedicine throughout the crisis, we saw utilization rates rise. And from mid-March to mid-May, we saw 50 times more telemedicine claims than during the same time period last year. The key was partnering with in-network providers. In general, those doctor-patient relationships transformed and thrived as they both turned to this method of interaction.

As a result of this growth in member interest and provider adoption, BlueCross Tennessee announced last month that we will extend our coverage of telemedicine services going forward. It was clear our members and providers wanted the choice to use virtual care and telehealth services was another way to collaborate with in-network providers to make quality care more convenient. We believe this was the right thing to do for our members and for the providers in Tennessee we rely on to care for those members.

Because the data is still accumulating, it's too early to definitively say that the expansion of telehealth has improved health outcomes, but it has undoubtedly improved access to care. As a result of this expansion, providers are able to continue delivering necessary care while maintaining social distancing. Telemedicine has highlighted the keen abilities that providers have to truly listen to their patients and to hone in on the chief complaint and pertinent history of the patients to make an informed diagnosis and plan of care. We wanted to ensure adequate reimbursement for medical providers treating our members so that there be no barrier to doing so especially right now, considering the financial impact this pandemic has had on physician practices and hospitals.

The increased use of telemedicine we've seen in Tennessee include visits with primary care providers and specialists, behavioral health providers, and other therapists. While we don't yet have quantifiable data to verify it, we also believe the availability of telemedicine is reducing some inappropriate emergency room and urgent care use by allowing patients to get in touch quickly with their primary care physician. That was certainly important as we were collectively prioritizing facility services for those with the most severe symptoms and needs. Access to physician services via telemedicine also helps our members access care they may have foregone otherwise, and without the increased risk of infection.

It is easy to see how this mode of interaction can effectively break down a barrier to access to care. Improving access to care in rural areas has been a priority in my state of Tennessee and this expansion plays an important role toward doing just that. Telemedicine allows access to care during work hours in lieu of taking an entire day off. It can allow for follow-up interactions with high-risk patients that may be negatively impacted by sitting in a waiting room. The use cases are many.

With the rapid and widespread adoption of this new method of care delivery, we recognize we may identify and make changes to address issues we couldn't address during the crisis that began in March. Existing processes related to credentialing, contracting, reimbursement and audit policies will be useful tools to guard against

fraud, waste and abuse—and they need to be a part of telemedicine practice. In addition, we carefully monitor data to ensure that our network providers are rendering the services and that the level of care is appropriate to the practitioner delivering the services. We are closely monitoring prescriptions that are generated from telemedicine. And most importantly, we listen to both the compliments and complaints coming from the consumers. These actions are aligned with our role as a member advocate committed to providing access to affordable, evidence-based care.

In addition, we believe there needs to be a discussion around what measures need to be in place to protect the privacy and security of our members as they interact with their physicians. We have those protections and requirements in place with our existing physician agreements so we have a basis from which to start. But given the speed at which we enabled telemedicine services in March, that's an area we believe warrants some additional conversation.

I do believe we can address these issues while continuing to support telemedicine. As the saying goes, we don't believe we should let perfect be the enemy of good. We do not need to pull back from where we are today to address these challenges. We don't have all the answers today, but we are committed to collaborating and building a sustainable path forward that serves the interests of our members and the providers who care for them.

I'll conclude by sharing a final thought about telemedicine and its ability to improve our health care system:

We all recognize the need to reduce the cost of care in our Nation's health care system. And we likely agree that a payment model which places a priority on quality and improved health outcomes is a better approach than continuing to pay for services on an at unit-cost basis, also known as "fee for service."

Creating a regulatory environment which expands the tools health care professionals have available to engage with their patients and offer services should be our shared goal. Likewise, the ability to apply penalties for abuses of telemedicine should be a necessary component to protect those that this is meant to serve.

As I mentioned earlier, access to care is a key component of improving quality and outcomes. Telemedicine provides that opportunity and is one of those tools. The increase in utilization demonstrates that our members and providers—your constituents—have come to appreciate this capability.

More than 85 percent of primary care physicians in our provider network in Tennessee participate in at least one value-based program with BlueCross BlueShield of Tennessee. These are programs which reward physicians who can successfully engage members, help them manage their care and improve overall health.

Telemedicine can help them achieve that goal. And when that happens, our members benefit and we get one step closer to achieving our mission of peace of mind through better health.

I am honored and have appreciated the opportunity to share BlueCross of Tennessee's approach to telemedicine as we continue to support affordable access to services and high-quality care in line with our mission.

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[SUMMARY STATEMENT OF ANDREA WILLIS]

Overview and Recommendations

BlueCross BlueShield of Tennessee (BlueCross Tennessee) has long supported the utilization of virtual care as a part of our long-term strategy to improve access to care and patient experience. Prior to COVID–19, telehealth offerings in Tennessee were either purchased as an additional service or delivered when a member and provider consulted with a different provider in a separate location. During the COVID–19 pandemic, BlueCross moved quickly to work with our over 29,000 in-network provider partners to expand access to telehealth for our members as we saw the need to balance access to care with the need to practice social distancing. BlueCross Tennessee immediately witnessed a significant increase in utilization of telehealth services and increased member satisfaction. Subsequently, BlueCross Tennessee announced the expansion of telehealth offerings provided by our in-network providers beyond the pandemic. We believe these actions further demonstrate our commitment to affordable, accessible and quality health care. At this point, it is too early to share quantifiable data that demonstrate the impacts on healthcare outcomes, however, we are closely monitoring a plethora of datasets including, but not limited to, utilization, fraud waste and abuse, medical efficacy standards and patient safety.

It is often said that healthcare is "local". Congress should consider policies that ensure the maximum flexibility that is appropriate for the health care consumers, providers and payers in those markets. It requires a delicate balancing of technological advancements while meeting consumer healthcare and financial needs. Further, we recommend policies that increase access while incorporating measurable patient outcomes that contribute to the health of Tennesseans and all Americans. Finally, we suggest efforts that enhance the privacy and security of health information in compliance with the HIPAA laws.

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The CHAIRMAN. Thank you, Dr. Willis, and thanks to all of our witnesses.

We will now begin a round of five-minute questions, and I would ask the Senators and the witnesses to try to keep within the five-minute time so all Senators can participate.

Sometimes we just rush through things without recognizing their significance. I think we ought to stop and think for a moment about how significant a change this is and how—and whether it would have even possibly happened without this crisis.

As I mentioned earlier, we had 884 million doctor-patient visits last year, according to CDC. If 20 percent of those, or 25 or 30 percent of those, continue to be telehealth visits that is hundreds of millions of doctor-patient visits that will occur by telemedicine rather than in person. I do not know enough to know whether that is the biggest change in healthcare delivery services in our history or not, but it would be hard to think of one that is more significant. So, we have really had 10, 20, 30 years of experience crammed into 3 months in a pilot program to determine what the effect of this would be, and we want to do that carefully.

Now, Dr. Willis, let me ask you first, and I only have 5 minutes. Of the 31 changes that the Federal Government made in policy, two seem to me to be the most important—the originating site rule and that Medicare and Medicaid begin to reimburse providers for nearly twice as many telehealth services. Do you agree that those two changes should be made permanent?

Dr. WILLIS. Sir, we would definitely agree with those changes. We definitely think while telemedicine largely focuses on the technology in some ways, we definitely recognize that the power behind this truly is the provider and the clinical——

The CHAIRMAN. Okay. Well, let me keep—we only—I only have 5 minutes. So the answer is yes, right?

Dr. WILLIS. Yes, sir.

The CHAIRMAN. Okay. Now, I am interested in—you are stepping out—and that is a pretty big risk for BlueCross BlueShield of Tennessee, isn't it? When I first heard that you were going to cover all these services, I thought, well, that is going to cost a lot of money and raise insurance premiums. But, then I thought, well, maybe it will save money.

As we look at cost, quality, and patient experience, what have you found in the short period of time that you have begun to cover these services? Does it cost more or does it cost less?

Dr. WILLIS. We are still accumulating data, so we don't really know that yet, but we do think that we are going to gain efficiencies. We are going to keep people out of the E.R. that do not need to be there, and we think people are going to get care that

they may have foregone. So, down the line, we do think that it will save money.

The CHAIRMAN. Do you have any reports on patient satisfaction yet?

Dr. WILLIS. We do. Overwhelmingly, the patients are very thankful for this, as well as the providers.

The CHAIRMAN. Have you looked at the other Federal policy changes other than the two that I mentioned? And do you have an opinion about whether they should be made permanent or not?

Dr. WILLIS. Things as far as licensure goes, we definitely realize through the compact experience that there is some positives behind that, so we definitely want to do that, but still maintaining a personal relationship with the provider. We do not want to create fragmentation of care.

We definitely realize, that connectivity is an issue, so anything that we can do along the lines of broadband, and anything we can do to make sure we migrate to secure platforms that have HIPAA as a foundation is definitely something we would be interested in.

The CHAIRMAN. Have any other insurers around the Country, to your knowledge, adopted your policies on covering telehealth?

Dr. WILLIS. Not that I am aware of at this point. We have received a lot of questions from others, and so we know the interest is out there.

The CHAIRMAN. Okay. I have a minute left. I want to ask the other three witnesses, who have a lot to say and they will get a chance to say it with the other Senators, if they agree or disagree that the two provisions that I mentioned that have been temporarily changed should be made permanent. One, the originating site rule; and two is the Medicare and Medicaid reimbursement of providers for nearly twice as many types of telehealth services.

Dr. Rheuban.

Dr. RHEUBAN. I entirely concur, sir, that those are incredibly important for us. We have a critical access hospital that is considered an urban area because of the geographic restrictions—it is crazy— federally qualified health centers that are located in what otherwise seems like a rural area but are not qualified to be——

The CHAIRMAN. Okay. I have 17 seconds left. Excuse me. Dr. Kvedar and Dr. Arora, do you agree that at least those two changes should be made permanent?

Dr. KVEDAR. Yes. The ATA would very much support that.

Dr. ARORA. Senator, I agree.

The CHAIRMAN. Thank you very much. We will now go to Senator Smith for questions.

Senator Smith.

Senator SMITH. Thank you, Chairman Alexander. I would like to start by asking unanimous consent to submit into the record a letter from the American Connection Project.

[The following information can be found on page 59 in the Additional Material.]

Senator SMITH. This is a letter to our Committee. It is a partnership with Land-O-Lakes and the business community and many healthcare providers, like Mayo Clinic and others, that—they have created this project to talk about filling the rural broadband gap, and specifically related to telehealth.

In this letter, they say, as an example, that Mayo Clinic has conducted more telehealth visits during the pandemic than in all of the visits combined in 2019. And Health Partners in Minnesota have seen a 10 percent increase in completed visits for mental health over a two-month period. So, I think this reinforces what we are all saying about how there has been a dramatic expansion of telehealth services and how it has helped to expand access.

In Minnesota, the community mental health centers and clinics have been using telehealth to help their patients get regular mental healthcare treatment, so I want to focus in on that.

Interesting, no-show rates are down and patients are able to get the care that they need from home. And it has been a real life changer for folks that are living with homelessness and for students who usually get their healthcare services when they are in school, and of course they are not in school now.

Let me ask this question. Maybe I will start with Dr. Rheuban. Can you just talk to us a little bit about how access to behavioral health and substance abuse disorder services via telehealth has changed during the pandemic and what we can learn from that?

Dr. RHEUBAN. Well, to begin with—that is an excellent question. But, to begin with, access to behavioral health services was our No. 1 request for services prior to the pandemic.

Senator SMITH. Right.

Dr. RHEUBAN. Those have endured. What we have seen is those have been provided also by telephone because many of the patients do not have access to broadband services, and so those mental health services had been conducted via multiple different formats. So, it is incredibly important, especially as we see greater need for mental health access, because this pandemic has led to many challenges for our patients.

There are some changes that have happened in the pandemic, which include the waiver of—by the DEA to allow prescribing of controlled substances to occur when the patient is seen via the home; and also, to allow an initial visit to be conducted via audio and visual together, video-based services. So, there have been some major changes that have been really positively affecting the access to mental healthcare services.

Senator SMITH. Thank you so much. I have heard from some of my constituents that some folks are even more likely to access the mental healthcare services that they need, behavioral healthcare services, if it is via telehealth rather than in person. Part of that is it might be just sort of their reluctance to be—because of the stigma around mental health. Have you seen that? Dr. Kvedar, would you like to comment on that?

I think you are muted. There you go.

Dr. KVEDAR. Oh, great. Thank you very much for asking and for bringing up behavioral health. It is such a critical issue all the way around, and it is a perfect—I will just underscore perfect—use of the tool for telehealth, whether it be phone or video, because mental health interactions with patients are all about a conversation with the patient, so——

As has been pointed out, the provider can learn things seeing you in the—in your home that she might not learn in the office. And the patient, as you say, does not have to endure, which is some-

times an arduous task of traveling to, waiting in a waiting room, et cetera.

All around, could be, we think, better than face to face. But, most importantly, for access. The access part is critical, and it is a real boom for that. So, very much endorse your idea.

Senator SMITH. Could you comment on how we can make these changes permanent while also protecting patient privacy?

Dr. KVEDAR. I would be happy to. I—privacy is something that, as a healthcare provider, is a No. 1 priority. As you mentioned, as others mentioned, we have, of course, HIPAA as a backbone for that. But, I would say that—it might be oversimplifying to say this, but for our suppliers in the industry, the vendors that help us with these tools, they should be—would be willing to sign business associate agreements and be part of HIPAA regulations. That would solve a lot, I think, if we were simply able to do that. I do not know that it makes sense to say one tool or another cannot be in the mix, but they should all be willing to protect patients' privacy.

Senator SMITH. Well, and I want to just also note in the seconds I have left that we continue to have a need, I think, for parity in reimbursement for mental healthcare services, as well as, physical health services. And it seems to me that there is an opportunity to address that here, as well, as we move forward.

I want to just mention to my colleagues as I wrap up that I have bipartisan legislation with Senator Murkowski. It is the Telehealth Mental Health Improvement Act that would help to expand access to telehealth services reimbursement during the pandemic. But, clearly, I think this is an opportunity for us to move—think about what systemic change we can make after we emerge from this public health crisis.

Thank you, Chairman Alexander.

The CHAIRMAN. Thank you, Senator Smith.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman, and welcome to all our witnesses today.

Dr. Rheuban, I read your testimony and you mentioned that 20 years ago, you—now 20 years ago, you testified in front of the Energy and Commerce Committee. I was on the committee at the time. And I am reminded that policy requires a degree of vision on the part of policymakers, and I am not sure 20 years ago we envisioned technology making the rapid advances that we did. But, it has, and we are at a different point at a different time, and part of successful policy is being visionary as we go forward.

By the end of this year, Starlink, which is part of SpaceX, will have the ability to deliver broadband to every footprint in America—urban, rural, does not distinguish. So, the answer on the broadband access may be solved by the commercial marketplace at high speed, and affordable. And, I say to my colleagues, this is important as we put together policy. This is not reliant on us putting fiber optics in the ground and getting the last mile to a home. We have a commercial option, I think, that will leverage even faster than private sector marketplace to bring these services to every American.

Dr. Rheuban, in 20 years, what did we get right and what did we get wrong since your testimony in front of the Energy and Commerce Committee?

Dr. RHEUBAN. Well, we did get right that telehealth was a covered service, because prior to that, fewer than $14,000 worth of telemedicine services were actually reimbursed by Medicare. So, we have come a long way, but we have a much longer way to go.

I do believe broadband is an important issue, whether—however it gets to the home of the patient. And I am pleased that the Federal Communications Commission's rural healthcare programs have been expanded, and that they also now have launched a Connected Care Pilot Program to bring broadband to the home of the patient. Because, as Senator Smith indicated, it is a health equity issue, and there are many patients who otherwise could not afford reliable broadband.

Our plan is more, better connected, and to encourage adoption to incentivize providers to invest in the telemedicine technologies. We need to change the Medicare reimbursement rules, and Medicaid, as well.

Senator BURR. Well, to all our witnesses and to all my colleagues, we would not be having this hearing if it wasn't for our use of the internet. Most agencies update daily on COVID based upon their internet connection, not based upon a physical presence, and I think it is important for us to remember how we are advantaged by these electronic connections.

Let me move to Dr. Kvedar. Is the growth of telemedicine a bigger challenge for patients or for providers?

Dr. KVEDAR. Well, in my almost three decades of doing this, Senator, I would say I have not met a patient who was not happy with it. You get this what I call magic—when you get it, you get this magic convergence of access, quality, and convenience. And for anyone receiving any service, that is a happy thing.

Up until the pandemic, it was a challenge for providers, primarily because we were very busy with our office space practices. We were adopting electronic records. We all had our hands full with important issues that just was hard to get telehealth on the radar.

I am quite proud of my colleagues that, during the pandemic, they rose to the occasion. We have heard of no untoward events. And, they keep telling me anecdotally when I talk to them, and I have talked to a lot of them, that they are ready for this new world where a good, solid chunk of our service offerings are telehealth.

I think we have made a lot of progress in that regard, and we are really looking forward to the future.

Senator BURR. Thank you for that. And let me open this up to any witness that would like to answer.

What is the biggest hurdle to us utilizing telemedicine in the future? Is it private insurance or is it Government regulation?

Dr. KVEDAR. Well, I would be happy to start. I don't—it might be a tie. It is really important that we, as we have all said now, relax the 1834(m) restrictions. That is an incredibly important next step for the Federal Government. And it is important that Medicare and Medicaid pay at parity. So, those are really foundational elements.

The private sector needs to step up, as well, and it would be very difficult to conduct this care model in a world where we get some payment for some things and didn't get paid for others. So, it is hard for me to choose a favorite on that one.

Senator BURR. Anybody else?

Dr. RHEUBAN. I would like to concur with Dr. Kvedar in that, as a healthcare system, it is really hard to—it was really hard to stand up an expansive telemedicine program with multiple different payers covering different services. So, as much harmonization as possible would be a huge incentive for adoption and expansion.

Senator BURR. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Burr.

Senator Casey.

Senator CASEY. Mr. Chairman, thank you very much for this hearing, and I want to thank you and Senator Smith for the opportunity to ask these questions today to this distinguished panel.

We know that because of telehealth and telemedicine that access to quality medical and behavioral healthcare can be available to everyone regardless of their location or their age or other ways that they would not access care under normal circumstances. There are some concerns, as already have been noted, with regard to racial disparities, with regard to poverty and insurance coverage, as well as issues that limit our ability within Government.

I wanted to focus the attention of all the panel Members on I guess it is about seven categories of Americans. I will call this list of Americans vulnerable Americans because of the circumstances they face.

Number one would be children, seniors, people with disabilities, LGBTQ+ Americans, those with behavioral and substance use disorder problems, and the homeless. And that is not an exhaustive list, but when you consider those populations of Americans, I really have about three questions for each panel member and I will ask them together.

How has increased access to telehealth services helped these vulnerable populations and improve their overall health? That is one question.

The second question is, what are the risks of pulling back to those populations?

Then number three, what additional steps can we take to bring this kind of quality care to these Americans?

How have they been helped, what are the risks, and what are the next steps? We could go in order of testimony, starting with Dr. Rheuban.

Dr. RHEUBAN. Thank you, Senator Casey. It is an excellent question, and I want to commend your state for some amazing telemedicine programs across Pennsylvania—Lehigh Valley, University of Pittsburgh, University of Pennsylvania and CHOP, among others.

Without question, vulnerable populations see benefits of telemedicine services. We can, for example, with remote patient monitoring monitor vital signs of patients, blood pressure, heart failure. Many clinical conditions that are—would otherwise require in-person visits. And, so, therefore, we can lower the cost of care but improve outcomes. There is plenty of published data in that regard.

I'm sorry. What was the second question?

Senator CASEY. Oh, the—in addition to how they have been helped, what are some of the risks to pulling back for those——

Dr. RHEUBAN. Oh, absolutely. Yes. So, access to healthcare should be, frankly, a right. And, if we pull back patients that have been relying on these technologies, these services, they will lose that access, especially when they are remotely located.

We have supported infant—high-risk pregnant women, infants, seniors after discharge from the hospital with, complex conditions. So, I think there is a huge risk that those services will not be continued if we do not continue to support telemedicine.

Senator CASEY. Anything on next steps you would hope or——

Dr. RHEUBAN. Well, so, I want to put a plug in. I served as board chair of Virginia Medicaid. Virginia Medicaid expanded Medicaid, again, enrolling new patients in 2019. We have enrolled more than 425,000 Virginians. I think those connections allow for improved care. And, having favorable regulations both in Medicare and Medicaid will enable continued services to be provided and better outcomes for our patients.

Dr. KVEDAR. Thank you for the question. I would echo my colleague's comments and not repeat them. That does not mean—I want to make sure I emphasize how important they were.

But, to broaden the conversation, I would just call attention to two things. One is the reimbursement for telephone encounters, which was really helpful in crossing the digital divide during the pandemic. There is a lot we can do by telephone. For instance, as a dermatologist, patients send me images of various skin lesions or rashes over our patient portal, and I am able to converse with them by telephone and conduct care perfectly well. Other clinicians have done the same. Of those numbers I mentioned earlier in my testimony, 605,000 visits, about 60 percent were by telephone. So, let us not forget that.

I would just say we should continue that level of reimbursement, if for no other reason than to address this underserved population problem that you have brought to our attention.

That is really the only thing I would add to what Dr. Rheuban said.

Senator CASEY. Thank you, Doctor. Dr. Arora.

Dr. ARORA. Senator Casey——

Senator CASEY. Ten seconds.

Dr. ARORA. Senator Casey, I think there are two issues here. Our underserved population, certainly telehealth or telemedicine will help alone.

But, there is a bigger problem, a much bigger problem, elephant under the table, that these people, even in the old system, never had access to specialty care. If they had Medicaid, it was extraordinarily poor.

In addition to really overcoming the geographic divide, there is a massive capacity shortage in this Country for taking—providing specialty care for underserved patients of the type you describe.

In your state alone, Penn State, AmeriHealth, Neighborhood Health Centers of Lehigh Valley are using it for mental health, substance use, are using ECHO for capacity expansion where you are increasing what we are doing. You have got forced multiplica-

tion, exponentially improving capacity, because telemedicine alone will not increase capacity, ever. You just put the person on a camera, it is not going to have more specialists in the Country.

Senator CASEY. Doctor, thank you. Dr. Willis, maybe——

The CHAIRMAN. Senator.

Senator CASEY [continuing]. Provide your comment in writing?

The CHAIRMAN. Senator Casey, we need to move on. I am afraid we are about a minute over.

Senator CASEY. Thank you.

The CHAIRMAN. Thank you very much for your questions.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

As a senator representing a large rural state, I have long been a proponent of telemedicine since we have such a shortage of healthcare providers, particularly in our rural areas. I want to ask the panelists about the types of clinicians that should be able to use telemedicine and be reimbursed under the Medicare and Medicaid programs, and I will give you an example.

A speech language pathologist at Waldo General Hospital in Maine contacted me some time ago about elderly patients with head and neck cancer who were unable to eat due to the effects of chemotherapy and radiation. Some of them required feeding tubes, in some cases unnecessarily, because of a lack of available swallowing therapy.

These patients live in rural areas. They cannot easily get to a specialist who could help them with their swallowing problems. He was frustrated that, while commercial insurance and Medicaid in the State of Maine allowed the practice to bill for telehealth services, Medicare did not. Today, for the duration of the pandemic emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telemedicine services, including speech language pathologists.

My question—and if I could get just short answers to my long question—for each of the panelists, do you support continuing these waivers so that non-physician healthcare providers can be reimbursed for their telehealth services?

Dr. RHEUBAN. I will start, and I say absolutely, I agree with you.

Senator COLLINS. Thank you.

Dr. Kvedar.

Dr. KVEDAR. Yes. Thank you. Likewise, the ATA would support your question. It is a very positive answer, yes.

Senator COLLINS. Dr. Arora.

Dr. ARORA. Senator, I support it completely. But, in addition, I would argue that even in the cities of this Country where you live next to these speech and swallow specialists, there are long waits to see them. We also need to expand the number of people in our Country that can actually provide these services through de-marketizing the knowledge of these experts so everyone who needs this can get this service.

Senator COLLINS. Dr. Willis.

Dr. WILLIS. My answer is yes, as well, and we look forward to best practices.

Senator COLLINS. Thank you all. One footnote on the discussion of the provision of mental health services, which is of great interest to me.

The CEO of St. Mary's Hospital in Lewiston, Maine has said that the compliance rate—the no-show rate has plummeted with behavioral health telehealth medicine visits. In other words, that people who are being assisted with mental health problems were actually much more likely to keep the appointment if it was through telehealth than if they actually had to go to the office of the therapist. I think that is a really interesting data point for us.

One other quick question in my time that remains. The Pew Research Center notes that half of adults 65 or older do not have broadband at home, and rural residents and seniors living below the poverty line are less likely to have access to broadband.

Senator Jones and I have introduced a bill to expand broadband access. But, as we continue to work to eliminate this disparity, for families without access to reliable broadband, can audio-only telemedicine be deployed effectively? Is audio-only as effective as being able to see your healthcare provider? The second question to that, is there a chance of fraud if we go more to audio for those areas without broadband access? And I will just ask that question to one of our witnesses, Dr. Kvedar.

Dr. KVEDAR. I think audio-only is very effective. It is not 100 percent effective. There are certainly times when a visual inspection of the patient is important. But, we have been so impressed by how much we can get done with audio because so much of our diagnostic and therapeutic decisions are around data. So, audio can be incredibly effective.

I think the fraud and abuse question is an important one, but I would say that there are ways to authenticate people, and it is probably a straightforward way for us to be able to do that, so I wouldn't let that stand in our way.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins. I thank the witnesses for their succinctness in the answers.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. I want to thank all the—all of our witnesses.

Just dovetailing on what Senator Collins was speaking about with regard to telephone-only telehealth. I just recently heard a story from one of the health systems in Wisconsin, Marshfield Clinic, about an individual who—a farmer, who was suffering with severe depression, made a telephone-only contact and was greatly helped, and probably would not have reached out in other—in any other way. So, very much hearing that telephone-only can be as successful as in person or video also.

I have a couple of follow-up questions to some of my colleagues who have already asked questions. I want to get back to the issue of substance abuse disorder, the propensity or the fact that life during the pandemic can exacerbate a number of issues with regard to mental illness or substance abuse disorder.

It strikes me that some of those—it strikes me that the clinics that treat folks may have huge variability in their access to various telemedicine platforms, and so I have joined Senator Shaheen in

making sure that in our next COVID package, we look at the provider's side, as well as the patient's side, in terms of telemedicine platforms. But, what is the sense of the just great variance that exists in terms of the ability of different clinicians in different fields to do telehealth to begin with? And who needs more help than others?

Dr. RHEUBAN. I can start. So, telemedicine has played a huge role in the management of substance use disorder, but we did have some challenges. Prior to COVID–19, patients would need to be seen at an eligible originating site until the SUPPORT Act allowed for services to be provided from the home.

The DEA still has a ways to go in terms of the scenarios through which they allow for prescribing of controlled substances via telemedicine. There is a waiver in place right now. It would be wonderful for that to be continued. Otherwise, the patient would need to be seen in the presence of a DEA-registered provider or at a DEA-registered facility. The SUPPORT Act called for a special registration process, but that still has not yet happened. So, I think that would support providers who wish to provide these services post-COVID–19, as well. Thank you.

Senator BALDWIN. Dovetailing on that answer, what restrictions exist about the location of the provider? I know that there were restrictions on where the patient would have to be located in order to receive telehealth that have been lifted. Can the provider be teleworking?

Dr. RHEUBAN. Yes. Well, under the waiver process, yes. It was clarified that they can.

Senator BALDWIN. And——

Dr. RHEUBAN. They need to be in the same state, as well, as the patient. They need to be licensed in that state.

Senator BALDWIN. Okay. And is that a waiver that you would like to see continued in the future?

Dr. RHEUBAN. Yes.

Senator BALDWIN. One thing I am curious about is we are talking about the explosion of the use of telehealth between healthcare providers and patients. What have we seen in terms of changes between—telehealth between providers? And let us use the example of a rural, critical access hospital that wants to get a specialist's eyes on, say, x-rays or some other diagnostic. Has that changed significantly also during this pandemic, or is that kind of holding steady?

Dr. RHEUBAN. I believe those have been—those encounters have been supported all the more so during the pandemic, in addition to the use of e-consults, which was initially funded by CMMI, Center for Medicare and Medicaid Innovation, but now has been incorporated into everyday care, especially in the 2019 physician fee schedule. But, there were some rules surrounding that which were problematic. Those have been relaxed, so that allows a structured consultation between a provider in one location and a provider in another location. Those rules have been relaxed, and we would like to see that continue.

Senator BALDWIN. Okay. Thank you.

Dr. RHEUBAN. You are welcome. Thank you.

The CHAIRMAN. Thank you very much, Senator Baldwin.

Senator Cassidy.

Senator CASSIDY. Yes. Thank you to all the panelists. While you all have been testifying, I have been cleaning up my house, and so it is an incredibly convenient platform.

Dr. Kvedar, in our GOP Republican memo, they mention that although platforms are—not all platforms commit to being HIPAA compliant. Indeed, some use a platform in which they will monetize the information they gather from using the platform.

By the way, you are a dermatologist. I showed my dermatologist my daughter's rash on a Friday evening. He called in the prescription. Of course, it was topical steroids. I could have done it myself. But, nonetheless, she was, if you will, healed by the morning. Convenient for him; convenient for her. Saved money.

That said, what can providers do to make sure that they are using platforms—because we used Facetime. What can providers do to be sure they are using platforms in which people are not monetizing that information?

Dr. KVEDAR. Well, thank you for that, Senator, for that question, and can—I would say the first thing to underscore in responding is the importance of HIPAA compliance and having your vendors sign a business associate agreement. I believe that would cover both of your questions. I know it would cover the privacy side, and it is very important for us to be careful about data governance in the new future——

Senator CASSIDY. Now, let me ask, though. In your practice, where you practice, a very prestigious hospital, do you have a list of online platforms that your providers can use or not use to otherwise alert, if you will, a provider that someone might be monetizing?

Dr. KVEDAR. What we do now is we use one, Zoom. It is integrated into our electronic medical record in our patient portal, and that is what we do. So, we have sort of solved that. We were maybe a little bit ahead of the curve on that because we had that going before the pandemic.

Senator CASSIDY. If I called you on a Friday night, showing my daughter's rash on, just whatever platform, would—how would you have handled that? It might not have been I don't think applicable as this, but let us imagine somebody did. How would you have handled that?

Dr. KVEDAR. We would have asked you to send me those pictures via our patient portal, which is secure, and then I would have called you back on a telephone.

Senator CASSIDY. Got you. Okay.

Ms. Willis, there has been discussion here that—of course, providers are going to say this, and I am a doctor, so I am going to get that—that telemedicine being reimbursed at the same as an in-health——

But, frankly, I am a physician. If I had 1 day of my life in which I was only doing telemedicine, I would have sent everybody home, gone to my closet, sat in front of my computer with my EHR on this screen and my Zoom on that screen, and I would have just typed away, answering phone calls, speaking through the internet. And, really, my overhead would have been markedly diminished in terms of personnel.

Now, on the other hand, there is the fixed cost of the initial investment. So, how is BlueCross BlueShield handling that? Will you pay the same, or will you say, once there is an initial investment, really, future costs are less? I think that is going to be of a lot of interest to the providers.

You are muted.

Dr. WILLIS. Can you hear me now?

Senator CASSIDY. Yes, ma'am.

Dr. WILLIS. Okay. So, we did pay parity going into this. We did not feel like we could have that kind of conversation in a crisis situation, and we are not in a rush to abandon that. But, we are going to be looking to the data to make sure that we see the efficiencies we think that we are going to see. And, what we don't want to do is to inject additional healthcare costs into the system. So, we think that is a conversation that we are going to need to evaluate, and we agree with Administrator Verma in her stance on that, as well.

Senator CASSIDY. Okay. So TBD?

Dr. WILLIS. Yes.

Senator CASSIDY. Dr. Arora, I remember on my visit to New Mexico, you pointed out that technically, you are not telehealth; you are, rather, telehealth education. I think one thing that is of interest is whether or not homecare providers, as in a husband or wife, could access your telehealth education.

Now, I also remember, though, your Hep C program, and you would have a weekly 6 months of therapy—not therapy, of education for the provider. So, it was not a, wham bam. It was no, we are going to gradually educate you.

What is the potential of your platform to educate people to provide help to a relative? That sort of not formal training, but the training that a relative would need in order to—what am I going to do for my husband with Alzheimer's sort of thing?

Dr. ARORA. Senator Cassidy, thank you very much also for your visit and for your question.

I think that the most important problem we are trying to tackle, Senator, is there is a worldwide shortage of expertise in the world. Six billion people in the world do not have access to the right knowledge at the right place at the right time, and maybe 100 million in the U.S. So, we have to do task shifting. And I can think of no——

That is what ECHO is designed for. We have many ECHOs where we train community health partners. There are family members who care for patients.

But, really, we have to—I am to the idea of de-marketizing the knowledge of experts. By putting a specialist in front of a camera on telemedicine, you cannot increase the total capacity of the system, and the system is direly lacking capacity in problems like dementia, elder care, substance use disorders, and so on and so forth. And yes, in most parts of the world, we use ECHO that way. In HIV in Africa, their entire care is provided by nurses and the support by family members.

Senator CASSIDY. Thank you. I yield back. Thank you, Mr. Chairman, for this great Committee.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Kaine.

Senator KAINE. Thank you, Mr. Chairman, and thanks to the witnesses. This is a very important and timely hearing.

Dr. Arora, I would like to start with you. You know firsthand, and we have heard you describe how beneficial it is for providers in underserved areas to be connected with specialists through Project ECHO. It is a marvelous model. We have used it in Virginia to help support treatment of a variety of conditions.

Last year, I introduced the ECHO 2019 Act with Senator Murkowski and Senator Schatz, and I was pleased to see that portions of it were included in the Heroes Act passed in the House. And I hope as we put 10 months of—or 10 years of learning into 3 months during this time that we might in our next bill be able to include portions, as much as we can, of that act into our next COVID response.

Mr. Chairman, I would like to submit for the record a statement in support of the ECHO 2019 Act from the Alzheimer's Association.

The CHAIRMAN. So ordered.

[The following information can be found on page 62 in the Additional Material.]

Senator KAINE. If I could turn to Dr. Rheuban.

Dr. Rheuban, I was talking to a physician at the University of Virginia not long ago, and I asked her how much of her work was being done via telehealth before COVID. She said zero percent. And I asked her how much now. She said 70 percent. And then I said, what should it be when COVID is no more? And she said 70 percent.

Dr. RHEUBAN. Wow.

Senator KAINE. She has basically experienced that it really, really works, but she pointed out it doesn't work very well for a first time visit when you are getting to know your patient for the first time. And, obviously, in telehealth inquiries, something will come up where she will say, I really need to see you in person. So, that would be her 30 percent.

I had a Zoom call with Virginia Child Welfare Advocates the other day and they talked about how they are using teletechnology to provide care to children and families. But, they said the one area that they just can't use a teleconnection on is interviewing children about abuse because, in a house, the child may not know the technology, but also the parent or the adult who is potentially an abuser might be there, and the expert really cannot get a read on the situation.

Talk a little bit about as you have, over many years, done this, kind of the things where it works, but also some maybe advice or cautions to us about kinds of doctor-patient interactions where it is not going to work as well as in person and we need to prioritize in person.

Dr. RHEUBAN. Thank you for that really great question, and I am delighted that one of my colleagues has said it is working and she is doing 70 percent now.

I would say that, in general, most of our telemedicine encounters have been in the context of an existing doctor-patient relationship. However, we certainly can and do see new patients. But, when additional testing is required, telemedicine alone is not sufficient. So,

in my own practice of pediatric cardiology, I have done a number of virtual visits during the COVID–19 pandemic. But, when my patients need another ultrasound, they need to either go someplace where they can get that and have that image sent to me, or they need to come back to Charlottesville for that visit.

I think much of what can be done needs to be refined by the specialty societies themselves and the organizations that lead these efforts on behalf of patients. I know that but for behavioral health services and in the Commonwealth of Virginia, the Virginia Mental Health Access Program has enabled more telemedicine for behavioral health services for pediatric patients, as well.

I think it is a combination, and it needs to be driven by the specialty societies themselves as opposed to legislated.

Senator KAINE. Let me ask one other question and open it up to the witnesses. The thing I love about this Committee is it is not just health, but it is also education, which includes the education of the healthcare workforce. Dr. Arora has talked about the need for more specialists, but I also wonder will the growth of telehealth create other workforce needs that we need to be creative in solving.

UVA has a joint program with New College Institute in Martinsville that is called the Southside Telehealth Training Academy and Resource Center. They do training there and ultimately will provide a certificate to an individual as a telehealth technologist. That certificate is based on a program that tries to teach individuals how to either work with providers in clinical settings to set up telehealth that is effective with patients, or actually go into patients' homes for remote patient monitoring and help patients navigate and use telehealth. And the educational program is a little bit of a combination of bedside manner, technological skills, helping a provider get comfortable with the technology, helping a patient get comfortable with the technology.

How much should this education Committee be contemplating broader workforce changes if we are going to be in this new world of dramatically increased telehealth use?

Dr. RHEUBAN. That is an excellent question, and I completely concur. We have found training of health professionals at all levels in the use of telehealth is an important skill set. We have enjoyed working very much with the STAR Center in Martinsville at New College Institute. We have embraced Project ECHO to also train the workforce in the use of telemedicine specifically, as well as in the pandemic. So, I fully support additional training modules or training capacity amongst a broad range of health professionals in telehealth.

In addition, we have actually done some patient education related to telemedicine, which I consider very important, and was a previous question. We do training in diabetes self-management virtually. That was very—it was a bit challenged prior to the pandemic in that Medicare did not cover that service, but it is a covered service now.

Senator KAINE. Thank you so much. Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kaine. Dr. Rheuban, your camera is off, perhaps accidentally.

Senator Roberts.

Senator ROBERTS. Thank you, Mr. Chairman. Thank you for your leadership in holding this hearing.

In regard to this issue, I want to go back quite a bit of time. In 1978, I was working as the chief of staff for The Honorable Keith Sebelius, who represented 66 counties out on the prairie. It was called the big 1st District, and there were three—the first three ever telemedicine demonstration projects. One on an Indian reservation in New Mexico—Dr. Arora might know something about this—and an island off of Maine. Senator Collins is not here to respond to that, but I think she was probably in high school at that particular time.

Then, we were all set up, ready to be included in Cimarron, Kansas, out there on the prairie, about 60, 80 miles from Dodge City. About one week out, I called over—I said we got Denver coming in to cover this, we have Wichita coming in to cover this, got Oklahoma City coming in to cover this. This was a big deal.

They said, we really appreciate what you and Keith have done for us, and it is just a wonderful effort, but we have finally gotten word from the Canadian doctor that we were really trying to recruit to come to Cimarron, which he did. And, so, we were canceled out of that experiment at that particular time.

The doctor left after 6 months, of course, and then there we were, high and dry again. And we had made—we had—trying to be at least aware of all the possibilities we have today. In many ways, the pandemic, while being a tremendous problem for the whole Country, also is a catalyst, as you have indicated, sir, in this effort.

My main question comes from interest in audio-only telehealth, especially in our rural areas. We have some rural broadband issues. That continues to be a real challenge. So, my question to any of the witnesses, how could audio-only visits help expand access to care in places where this is an issue? I think Senator Collins raised this issue with regards to possible fraud, and that could be a problem.

But, you have a young man who takes his grandmother to the nearest rural healthcare clinic. They do not have the broadband access that they need to have, but they do have the only—the other alternative, of course, which is the audio-only system. I am not sure that we can get universal coverage for that, by the way, but I would be interested in any of the witnesses.

Dr. Rheuban, why don't you start off?

Dr. RHEUBAN. Thank you, Senator Roberts, and it is an excellent question. Since the pandemic, fully one-third, and maybe slightly more, of our telemedicine visits have been conducted via audio only. In most cases, that is in the context of an existing doctor-patient relationship or in the context of the medical—primary care medical home or specialty care home. But, it has been very effective and it has solved a challenge for our patients.

I would be in support of continuation of coverage for audio only, but it is—you cannot do everything via audio only, specifically examine the patient. But it is an important tool, and particularly for more vulnerable populations who do not have access to broadband.

Senator ROBERTS. Dr. Arora, what comment might you have, please?

Dr. ARORA. Senator Roberts, in my own experience, it has been that a phone visit is not as good as a video visit. But, as was mentioned, you don't want the perfect to be the enemy of the good, and a lot of good work can be done on the telephone. Because, as a physician, 80 percent of all the information I need comes historically and only a minority actually comes from the physical exam and— but there is definitely great value if I can touch the patient or see the patient. But, as I said, 80 percent is as good as we could get probably, and I am very happy with that.

Right now, what is happening, Senator Roberts, is people are having to make visits before this new change in the law. All the time—just other—a bill to be generated, you have to go and see your doctor, and that is not necessary. And, so, a lot of challenges would be solved with on-telephone visits.

Senator ROBERTS. Thank you very much. My time has run out. Mr. Chairman, thank you so much for your continued fight for pay parity on this issue. Thank you, sir.

The CHAIRMAN. Thank you very much, Senator Roberts.

Senator Hassan.

Senator HASSAN. Well, thank you very much, Mr. Chairman, and Ranking Member, for having this hearing today. And thank you for our witnesses for being here.

The COVID–19 pandemic has led to a rapid expansion of telehealth services, as we are discussing right now, many of which are long overdue. Telehealth can continue to increase access to care and improve health outcomes even outside of pandemic. So, I am glad that we are having bipartisan discussions about making many of these services available for patients permanent.

Dr. Arora, I want to start with a question for you, and I want to thank you for your work establishing the Project ECHO Program. And I want to thank you, too, today for sharing your experience with that patient who inspired you to take this on. Thank you for dedicating so much of your skill and your heart to making telehealth a reality for so many.

In my home state, University of New Hampshire created an ECHO hub that has expanded access to medications systems for substance use disorder. However, there are still barriers that prevent people from accessing treatment, particularly during the COVID–19 pandemic, including an outdated requirement that providers obtain a DEA waiver in order to prescribe buprenorphine. And there was a discussion between Senator Baldwin and Dr. Rheuban about this, but I want to drill into it a little bit more.

The DEA is temporarily allowing teleprescribing of medications that treat substance use disorder during the pandemic. However, because the DEA buprenorphine waiver requirement has significantly limited the number of providers who can prescribe, access to telehealth remains unavailable to many Americans. Last year, Senator Murkowski and I introduced legislation that would eliminate the DEA requirement.

Dr. Arora, how has COVID–19 exacerbated existing challenges for substance use disorder patients and providers in underserved areas? And how might those challenges, combined with administrative barriers like this DEA waiver requirement, limit treatment during the pandemic?

Dr. ARORA. Senator Hassan, thank you for your question. And, in addition to University of New Hampshire, Dartmouth-Hitchcock and John Snow Research Institute in your—also are using ECHO for substance use disorders in New Hampshire. And I—in New Mexico, when we started ECHO, there were only 33 doctors who had the DEA waiver, and we used ECHO to train 500 more and certified 500 more physicians for the—and at that time, it was physicians. Now, nurse practitioners do actually have the DEA waiver. But, what we found was that even with the waiver, most doctors do not have the expertise to take care of a patient with substance use because you also needed mental health expertise and you needed other kinds of counseling expertise. So, when we set up ECHO, what we found was we helped them with the DEA waiver, but then gave them the mental health support they needed to take care of the patient.

But my perspective is exactly the same as you, Doctor—Senator Hassan that in the event—we have now set up 100 hubs in the United States for substance use disorder, connecting at least 20,000 clinicians to be mentored for this particular problem, for which there is a great shortage.

But, in my view, when a primary care doctor and nurse practitioner in a rural area is participating in an ECHO for substance use disorder in one of the 100 networks, they do not need a DEA number for that. They have much more than a DEA number can provide, or a license. In fact, in that circumstance, waiving that will dramatically expand access to substance use disorders in our Country.

Senator HASSAN. Thank you for that. And, Dr. Rheuban, do you have anything to add? I appreciated your earlier testimony.

Dr. RHEUBAN. Just that we are appreciative of the home as an eligible originating site for patients for substance use disorder treatment, and we look forward to the DEA creating, also, the special registration for telemedicine providers.

Senator HASSAN. Well, thank you.

I have a question for Dr. Kvedar, too. As we increasingly rely on telehealth services during the pandemic, we need to ensure that electronic health records are accessible across provider settings and matched to the correct patient. Accurate interoperable electronic health records would also play a critical role in ensuring that a COVID–19 vaccine is distributed efficiently, available to vulnerable populations, and if a vaccine requires a booster, that the correct doses are being administered to the correct patient at the correct time.

Dr. Kvedar, can you briefly explain how data standardization, better demographic data collection, and improved access to electronic health records could increase provider efficiency and improve patient experience as we continue to respond to COVID–19?

Dr. KVEDAR. Well, thank you so much for the question. It is an incredibly important area for us, and slightly outside of the tight zone of telehealth, but really an important one.

For everything that you said, it turns out that there is a new set of tools in the provider—in the CODER Lexicon called APIs that it was to easily match data sets. That is very important.

The other thing that I would just mention is that the postal service has a way of matching addresses that we should take advantage of. I think that has been underutilized and is a very perhaps elegant solution to some of the problems you are mentioning. And, yes, important for all of us to have accurate information and to be able to share information, especially in this new world where everything is time-and-place independent.

Senator HASSAN. Well, and——

The CHAIRMAN. Thank you, Senator Hassan.

Senator HASSAN. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. We have a vote in 5 minutes, and we have eight Senators who have not had a chance yet to have their 5 minutes, so succinctness will be appreciated.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. I will try to be succinct. This is an exceptionally important hearing. I thank you for this.

In Alaska, out of necessity, we have been leading on telehealth for decades, most particularly within the IHS system. Our Alaska Native Tribal Health organizations have really been forerunners when it comes to bringing this technology out to our villages and to our regional centers.

I was in a hearing room somewhat like this when I first came to the Senate, now 17 years or so ago, and they were demonstrating a telehealth cart. And it was less—it was smaller than the size of the stand that is holding that TV over there.

I said, well, how does it work?

They said, well, we can take a picture of you and we can send it to Anchorage and we can get the test back.

I was getting ready to fly on an airplane to go back, and I had a stuffy ear and was wondering if I had an ear infection and they stuck—I think it was an otoscope in my ear. It showed a picture on the camera that I saw. It talked to the doctor in Anchorage and he said, you are clear to fly.

That was my first introduction to it, and it was extraordinary. It was like the invention of the telephone, how did this all work?

Well, it has been working, and we have seen it work within IHS. We have certainly started to see it take off within V.A. in Alaska. It has been slower in application in other areas.

Mr. Chairman, I want to ask unanimous consent to submit for the record a statement that was put together by—coming out of the Petersburg Medical Center. I had a conversation with the administrator a week or so ago. He is not only the administrator there in Petersburg, which is a critical access hospital, small community of about 3,000 people, accessible only by airplane or boat. It is on an island. He has also been an administrator in Nome, so he has broad experience out there. And we talked about the benefits that he has seen in his professional career as a result of telehealth. He is not only an administrator. He is also an audiologist, so he has had interest on both sides.

He said that what they have seen with the increased access to care, the improved delivery has been phenomenal. But, we have had this lag. We have not seen the gain, the traction, that we want in terms of full implementation. It comes back to reimbursement.

If you have the ability to do it but you are not going to be reimbursed for that, it is an impediment.

But, he said, and I will quote from his letter here, "More progress has been made in telemedicine and in the delivery of healthcare in the last 3 months than in the last 20 years." That is transformative. That is what is happening right now. And, so, he has outlined some of the lessons learned and some of the things that he wants to have going forward. So, I——

The CHAIRMAN. So ordered.

Senator MURKOWSKI [continuing]. include that as part of the record.

[The following information was not submitted for the record.]

Senator MURKOWSKI. But I want to ask a question, and this may be to any one of you. Senator Cassidy kind of touched on it. But, what we are seeking to do here, and the real benefit, the real win, is increased access. We all want to be able to do that, and particularly for those in our remote areas. But, in these remote areas, you have healthcare systems that are often very fragile. They are just on the margin of being able to cover their overhead, meet their expenses. So, you do not want to be in a situation here where you have built something that is now not sustainable because the method of delivery, of access, has been made more efficient.

How do you—how do we find this balance here? Can somebody address that for me? It—let me start with you, Dr. Rheuban, with your perspective on rural healthcare.

Dr. RHEUBAN. I might give a quick anecdote from your own state, which I visited a number of years ago. Stewart Ferguson, another ATA past president, shared that there was a fire in a health clinic in Northern Alaska, and the residents of the community raced in to save the telemedicine equipment. The rest of the clinic burned, but the telemedicine equipment was moved to the school. Patients truly appreciate access to care using technology.

I think we will find the balance, and I think the specialty societies themselves, organized medicine, nursing, we will ascertain what is best practice. And the fact that we have new CPT codes that have been activated in the pandemic will also enable us to identify cost savings, outcomes, and guide us as we move forward. So, I just want to give a huge shout out to your state, which has been a leader in telemedicine, as well.

Senator MURKOWSKI. Thank you. My time is just about expired. Anybody else have any quick comments? You get 2 seconds.

Dr. ARORA. Senator, your state has particularly used Project ECHO for training of the workforce out of the university, out of the Alaska Native Medical Center. But one of the challenges we face in ECHO is there is no sustainable mechanism for actually training and keeping the healthcare workforce trained and mentored with the best and latest knowledge. Medical knowledge is increasing three and a—doubling every 3 and one-half years.

We also need, in addition to a sustainable way to pay for telemedicine consultation, which is a one-to-one service, we need a mechanism, sustainable mechanism, to pay for healthcare workforce training and development.

The CHAIRMAN. Thank you very much, Senator Murkowski.

Senator Jones.

Senator JONES. Thank you, Mr. Chairman, and thanks to all our witnesses for being with us today. I would like to talk a little bit about a different form of telemedicine, and that is remote monitoring, and think about how we can help those living with chronic conditions.

In Alabama, there is well over 600,000 people with chronic conditions that need help on a daily basis. Recently, I introduced a bill with Senator McSally called the Increasing Rural Health Access During COVID–19 Emergency Act, which would provide additional funding for providers and health systems in rural America to invest in remote monitoring. Connectivity continues to be an issue, and I think that remote monitoring can help bridge that divide by utilizing a little bit better 2G, 3G technology.

Dr. Kvedar, if you could discuss how remote monitoring is used today. I know from personal experience with my parents the use of a monitor with regard to a pacemaker for heart patients. But, if you could discuss a little bit how those with living—with chronic conditions, like hypertension, asthma, kidney disease, other things can utilize remote monitoring. And what is it that we can do as a Congress to encourage the equipment and the necessary tools to do more remote monitoring?

Dr. KVEDAR. Thank you for the question, Senator. It is a wonderful—and I am so glad you brought it up because we have been so focused on video and audio interactions.

Remote monitoring is a fabulous tool. It enables, as you—just as you described, individuals with chronic illness to be able to share information about their illness—usually vital sign information, could be a heart rhythm, et cetera—with a provider at another location, and for those individuals to have care provided because they have an enriched data stream from the patient.

This has led to, particularly in conditions like congestive heart failure, savings in terms of keeping people out of the hospital, keeping people out of the high-cost part of the system, keeping them healthy in their home. And, I would say that in the last 2 years, Medicare has come on board to reimburse for those activities. There is a nice, very thoughtfully done set of codes now to reimburse for the activities. Likewise, with monitoring for hypertension, there is a set of codes to reimburse for that now.

What is left is what can Congress do? I think any way you can encourage our colleagues in the private payer space to come on board to support those codes would probably be a wonderful thing. I don't know that is in your bailiwick, but that is really what is needed next.

Senator JONES. Well, thank you for that. So, following up on that, Ms. Willis, what does BlueCross—how does BlueCross feel about that and what can Congress do to help encourage that? That seems to me a way—it is almost like reimbursing for, well-baby visits, other visits that are helping to stop real high expenses before they hit. What can we do with you in the private sector? What can the private sector do to encourage remote monitoring like that?

Dr. WILLIS. Thank you for the question. So, we do actually have Medicaid within, but we cover at BlueCross BlueShield of Tennessee, and we have supported that already in our Medicaid popu-

lation. We are looking at the lessons learned to see how we can apply it in the commercial space, as well.

I can tell you in Tennessee, we are still having conversation as to what that means because it means different to different people. So, conceptually, we are onboard with that, but I think those are the conversations that we need to have so that everybody is coming from the same place—is it the hypertension monitoring, the things like that you are talking about.

I think we are moving in the right direction on that, as well. And as soon as we have clarity between us and the providers, I think that we will have recommendations for the lawmakers.

Senator JONES. Well, thank you. Thank you for that. It seems to me that one of the things that we can do, as well, is to encourage innovation and technology in this area. It seems to me with what we are doing now that there are so many possibilities out there for this remote monitoring that perhaps Congress can figure out a way to encourage scientific breakthroughs in technology and innovation to try to help in this. Because I think in the long run, it will save America money; it will save the taxpayer money.

Thank you all for that. I appreciate it. Appreciate you being here.

Thank you, Mr. Chairman, for this important hearing.

The CHAIRMAN. Thank you, Senator Jones.

Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman.

I have been a proponent since I have been here in the Senate to drastically change how healthcare is delivered with full transparency, no barriers to entry, embrace competition.

By the way, we were doing telemedicine in my own company years ago. One of the benefits would have been that it is convenient, and it was less expensive. As a business owner, I know you can administer telehealth if you specialize at it at a much lower cost than what it would be to have an in-office visit with the overhead and so forth.

Senator Cassidy already covered it, so I won't belabor it. I was disappointed to see that already, the most recent breakthrough that shows maybe the industry is changing, has got this pricing parity. And I am going to give that while the demand is so great, maybe it warrants it. Hopefully that gets back to where it should be as a bargain and a way to reduce costs.

My question to everyone is going to be transparency in general. I am going to keep talking about it. I am going to keep pushing it through legislation when I get a chance. Is the industry ready— and I would like each one of your opinions—for transparency throughout? Exposing the charge masters, practitioners putting prices out there so we can see it, getting rid of these third-party agreements between insurers and providers, and PhRMA telling us what it costs for a drug when they advertise it on TV. Humira, for example, you can get it for as little a $5 when I know it costs roughly $75,000 a year.

I would like each of you, your opinion on transparency and how that changes the healthcare industry to be effective and affordable. Who wants to start?

Dr. KVEDAR. I will mention that, as I am here representing ATA, I am not really privy to give you my opinion. ATA does not have

a position on transparency. It is sort of out of the zone of telehealth, so I think I will pass on the question.

Senator BRAUN. Anyone else?

Dr. WILLIS. We would support transparency. I think that we have a paradigm for—with the MLR that we will—we are held accountable to, making sure that so much of the dollar goes to medical costs. So, certainly that is a concept that we would like to see applied more broadly.

Dr. ARORA. Senator, I am not an expert in this area at all, but in general, for a system to work well, I do support the concept of transparency without really—there must be some nuances to this, which I do not fully understand not being an expert, but I do generally support this idea.

Dr. RHEUBAN. I would concur with Dr. Arora. This is not my area of expertise, but I certainly support transparency, as well.

Senator BRAUN. Well, that is good to hear. I am not an expert in healthcare, even though I revolutionized how we delivered it in my own company, and it was based upon engaging my employees in their own well-being. Number one, avoid the healthcare system by keeping yourself healthy. That is why we pay 100 percent of wellness. And the other thing was to get my employees engaged from dollar one on shopping around.

For the public out there, if that does not happen, there are other ideas in terms of what needs to happen to the healthcare system, and it is mostly on the other side of the aisle, which would make it a one-payer system. I think we would lose some of the benefits if that occurs. Inevitably, we will go there, and I challenge the healthcare industry, from PhRMA, especially hospitals, providers, and insurance companies where indemnification is no longer part of what really happens. It is a prepaid plan where we all pay into healthcare, and we never ask what does it cost before we are served by it.

Telehealth, being the first thing that has come along in a while, please retain transparency. Use it, since I think it is lower cost to deliver the service, not to raise to a parity, but to start the process of lowering costs. If that is not done across the industry, there is going to be a rude awakening for it with a much different paradigm down the road.

Thank you.

The CHAIRMAN. Thank you, Senator Braun.

Senator Rosen.

Senator ROSEN. Thank you, Chairman Alexander. I know Senator Smith was with us today. I want to thank all of our witnesses, as well, for being here and the work that you do.

I would like to talk a little bit about telehealth beyond a typical office visit. As a former computer programmer and systems analyst, I have long been a strong advocate for telehealth and leveraging all this amazing technology to improve our access to healthcare. And, so, there are incredible ways that telehealth is serving patients in Nevada, even beyond the usual visits to the doctor's office.

Cleveland Clinic's Lou Ruvo Center for Brain Health in Las Vegas, it serves patients with neurodegenerative diseases, including Alzheimer's and Parksinson's. During the pandemic, they have

been able to move over about 90 percent of their clinical care to virtual or telephone visits, so all their patients, very chronically ill patients, can continue to receive care.

In the cancer space, we have heard that doctors in Nevada are able to do their planning sessions virtually, not only with the patient, but with the whole family, anyone who wants to be there, so you have everyone on this video call, participating in the patient's care as their support team. And, no patient now has to push back their critical treatment because of their inability to go to a physician.

For the panel, we have heard some of the incredible ways that telehealth is being used engaging Alzheimer's patients with virtual music therapy. We know that can help. And Nevada CAN Program is working to provide wraparound services to our homebound seniors, keeping them safe, through telehealth. They can call our 211 number right now, through the pandemic, all seniors can, and get triaged and targeted health that they need, medical and social services.

Besides standard office visits and chronic care management, we know their critical needs, but how do we maximize the full potential of telehealth, and what barriers do you need Congress to still address both during the pandemic and beyond?

I know we all cannot see each other, so I guess I will start with Dr. Kvedar, then Dr. Arora, and Dr. Rheuban.

Dr. KVEDAR. Thanks for the question.

You are quite right. Telehealth is a tool. So, you can imagine if you have a set of tools in a toolbox, all the different utilizations for it, and you have touched on a few and there are many, many others. It really needs to be decided by the clinician and the patient, as a team, what the best use of those tools are. And earlier, Dr. Rheuban referenced specialty societies playing a role in those decisions. I think that is—I would advocate for that, as well.

What can Congress do? Well, we have been over it, but just to reiterate, we—the originating site restrictions should be permanently relieved.

The ability for Federal health—qualified health centers to be reimbursed fairly, rural clinics, and those things will help.

Really, again, just being able to use the tool with the correct reimbursement, and also the idea of having interstate commerce.

Senator ROSEN. Wonderful.

Dr. Arora.

Dr. ARORA. The biggest challenges I see—well, one of the biggest challenges I see for the healthcare industry are this explosive growth in knowledge. Until two days ago, what I found—what I knew about COVID–19 was actually proven wrong when a study from the United Kingdom showing that if you basically give dexamethasone to a patient who is in the ICU, you can reduce their likelihood of death.

This exponential growth of knowledge is something that is really—we have to deal with it head on because otherwise, without the right knowledge at the right place at the right time, it is impossible to get the right care at the right place at the right time. And, therefore, I would encourage this body to use this tech—the tele-

health technology not only for direct care delivery, but also thinking of our system, optimizing the system.

For example, in the United States, we had a really great care delivery system for individuals, but when COVID–19 came along, we had no system response. We did not have an adequately working system that could respond to a community problem of this nature.

Using this technology to get the right information, at the right place, at the right time, mentor our healthcare workforce to work at the highest level of their human potential, is an urgent need, especially to get care to the underserved people of their community who otherwise would have no chance for getting care, telemedicine or no telemedicine, if there is not specialty capacity in this system.

Senator ROSEN. I believe I have run out of time. I apologize to Dr. Rheuban. We will ask our questions for the record and you can respond that way.

Thank you so much for all the work you are doing, and I look forward to partnering with you to bring more and more exciting technology to care providers and the patients and their families.

The CHAIRMAN. Thank you, Senator Rosen. And let me thank Senator Smith for serving today as the Ranking Democratic member of the Committee. Let me especially thank our excellent witnesses—Dr. Rheuban, Dr. Kvedar, Dr. Arora, Dr. Willis—for joining us today. It is appropriate to have a remote hearing on telehealth, I guess, and that—this has certainly been an effective and useful one.

As I said at the beginning, I suspect we are talking about the biggest change in healthcare delivery in a long time, maybe ever, when you think about the fact that there were 884 million doctor-patient visits last year. Very few were by telehealth. And now, the estimates are that maybe that hundreds of millions of those doctor-patient visits in the future will be by telehealth.

My recommendation, based upon the testimony that we have heard today, is that of the 31 Federal policy changes that we have had, which have helped cause this explosion of telehealth, that at least two be made permanent, which all the witnesses agreed with. One was the originating site rule, and two was the Medicare and Medicaid reimbursement rule. The witnesses—or Medicare and Medicaid reimbursement provisions, expansion of them.

The witnesses commented extensively on many of the other 31 changes, and we heard about the importance of the state changes, allowing across-state-line delivery of healthcare. And we heard about the pioneering work of the BlueCross BlueShield organization in Tennessee to step out and begin to cover telehealth services in a way that had not been done before.

What we have experienced in the last 3 months is we have crammed at least 10 years of experience into those 3 months. In fact, I am not even sure that if we had 10 more years without this horrible pandemic we are going through, that we would have made the changes in telehealth that it has caused.

Our purpose is to look at costs, experience of the patients, and quality outcome whenever we talk about delivering healthcare services, and we will continue to do that here.

Thanks very much to the witnesses. Your testimony will make a big difference in how this Committee reacts to the changes in policy

at the Federal level. And, all of us feel very privileged to be a part of a situation where we may be able to help ensure permanent changes in the delivery of healthcare in terms of costs, outcome, and patient experience in a way that we otherwise could not have done.

The hearing record will remain open for 10 days. Members may submit additional information for the record at that—during that time if they would like.

I would encourage the witnesses, if you have any additional comments that have come up as a result of today's discussion about exactly what we should do about the 31 Federal policy changes, we would welcome those.

Our Committee will meet again at 10 a.m. on next Tuesday, the 23rd, for a hearing on COVID–19: Lessons Learned to Prepare for the Next Pandemic. I put out a white paper 10 days ago with five major areas. Suggesting that our attention spans are short, we know another pandemic will someday come and, while our minds are on the subject, this year, Congress needs to act to do whatever we need to do to be better prepared for the next one.

Thank you for being here today. The Committee will stand adjourned.

ADDITIONAL MATERIAL

LETTERS OF SUPPORT

NATIONAL ASSOCIATION OF COUNTIES (NACO),
June 16, 2020.

The Hon. LAMAR ALEXANDER, *Chairman*
The Hon. PATTY MURRAY, *Ranking Member*
Senate Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC.

DEAR CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY:

On behalf of the National Association of Counties (NACo) and the 3,069 counties we represent, thank you for holding tomorrow's hearing, "Telehealth: Lessons Learned From the COVID–19 Pandemic." We appreciate your efforts to assess our Nation's telehealth capacity as we see increasing demand for health services and, most importantly, for your leadership on previous COVID–19 relief packages that helped local governments better respond to the pandemic in our communities.

As counties continue our efforts on the frontlines of the coronavirus pandemic, telehealth has emerged as an essential component of the local response to COVID–19. Counties operate and support over 1,900 local public health departments and nearly 1,000 public hospitals and critical access clinics. Additionally, counties make investments in key Federal programs and services, such as Medicaid and the Children's Health Insurance Program (CHIP) as well as county-based behavioral health services, which exist in 23 states that represent 75 percent of the U.S. population. These investments build and protect the local health safety net, which administers wrap-around human service supports for our Nation's most vulnerable residents.

Prior to the pandemic, the use of telehealth was deemed by the Centers for Medicare and Medicaid Services' (CMS) as an effective strategy in reaching those patients in remote areas and reducing the number of in-office visits. Now, this technology has become increasingly critical for counties, as the demand for vital medical, behavioral health and substance use disorder services increases, and we look for ways to protect the medically vulnerable from in-person appointments during this public health emergency.

County health providers across the Nation have rapidly adapted telehealth technologies to provide necessary services to residents. Examples include:

- **Cook County, Ill.**, has created a multidisciplinary behavioral health tactical team that brings together psychiatrists, mental health professionals,

and licensed clinical social workers (LCSWs) to provide telehealth services to individuals experiencing homelessness and residing in shelters. The team helps to develop appropriate protocols to support these individuals as they manage Severe Mental Illness (SMI) and Substance Use Disorders (SUD).

- **El Paso County, Colo., Dakota County, Minn., and Coconino County, Ariz.**, have developed programs that address the challenges associated with treating tuberculosis (TB) through a smartphone telemedicine platform that delivers directly observed therapy (DOT) to patients that are unable to come in for an in-person evaluation. The program has resulted in a cost savings of $7,000 during it's first year in Dakota County.

Beyond the health and safety benefits of using telehealth services to protect residents from the spread of COVID–19, the use of telehealth technology provides unique cost-saving opportunities for counties, who are facing growing budgetary and economic challenges as a result of the pandemic. **To ensure that counties can continue to protect our residents while providing essential health services, we respectfully urge your bipartisan support and cooperation for a new round of direct, flexible aid for local governments that could include enhanced telehealth resources for counties**.

We thank you again for this hearing and for your efforts to assess the scale of this historic crisis and ask you to come together to provide critically needed resources to help counties respond.

Sincerely,

MATTHEW D. CHASE,
Executive Director/CEO,
National Association of Counties.

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AMERICAN CONNECTION PROJECT BROADBAND COALITION,
June 16, 2020.

The Hon. LAMAR ALEXANDER, *Chairman*
The Hon. PATTY MURRAY, *Ranking Member*
Senate Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC.

DEAR CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY:

Thank you for leadership in response to the needs of communities and patients during the pandemic and for holding today's hearing entitled *Telehealth: Lessons from the COVID–19 pandemic*.

We are writing as members of the American Connection Project Broadband Coalition, a collection of 25 major companies and trade associations being led by Land O'Lakes Inc. The coalition, representing agriculture, financial services, healthcare and technology, is advocating for robust funding for Federal investment in broadband internet connectivity to advance telehealth, distance learning and the tremendous economic value that comes with internet connectivity. As the pandemic shined a light on the essential nature of connectivity, we were grateful for the responsiveness of Governors who called for policies to increase telehealth access and broadband internet service, and the Members of Congress who took unprecedented action to respond to COVID–19. Given the increased access to health care that telehealth has provided during this public health emergency, it is clear that expanded telehealth policies must be a permanent tenet of our health care system.

Our coalition's healthcare partners have witnessed the positive impact of telehealth in improving access to care and improving patient experience. For example:

- HealthPartners saw a 10 percent increase in completed visits in mental health over a two-month period of the pandemic compared to visits in 2019 and had their patient no show rate decrease by nearly 50 percent.
- Mayo Clinic conducted more telehealth visits per day during the pandemic than all of the visits combined in 2019. To highlight the utilization of one type of telehealth modality, during April 2020, Mayo Clinic completed over 45,000 video appointments direct to patients. During this time, Mayo Clinic provided care to nearly 8000 patients each day using a variety of digital healthcare tools. Importantly, recent patient surveys indicate that patients are as equally satisfied with video visits as with in-person visits overall.

- Gillette Children's Specialty Healthcare has conducted virtual care visits with nearly 3,700 children since the end of March helping ensuring continuity of care for children with disabilities and complex conditions.
- Cleveland Clinic implemented telephone and app-based monitoring of nearly 13,000 elderly, frail patients with chronic conditions, escalating to a virtual visit to address urgent issues. This resulted in a 35 percent reduction in admissions compared to a risk-adjusted control group.
- CentraCare, serving predominately rural areas and small towns, has seen significant utilization of telehealth services from patients in their 60's, 70's, 80's, and even 90's, with no reduction at all in patient satisfaction.

We must continue momentum to improve public health, now more than ever before. We urge Congress to undertake legislative action to make permanent those emergency flexibilities that have allowed providers and patients to determine where the best care takes place. For many patients, including those in both rural and urban areas, this means receiving high quality care at home or as close to home as possible, through virtual visits. Additionally, we support regulatory efforts by the Centers for Medicare and Medicaid Services to make permanent the broad array of providers and service lines newly available to Medicare and Medicaid beneficiaries during the pandemic.

We appreciate your consideration of permanently implementing the policy changes that have accelerated virtual healthcare access during COVID–19. We also know that improving Americans' access to broadband can further increase telehealth ac-

cess and improve the health and well-being of our communities long into the future. There is no investment that will deliver more impactful or immediate returns.

Sincerely,

BETH FORD,
President and CEO,
Land O'Lakes, Inc.
KENNETH HOLMAN,
President and CEO
CentraCare.
DR. STEVEN OMMEN
Associate Dean,
Center for Connected Care,
Mayo Clinic.
BARBARA P. GLENN, PH.D.,
Chief Executive Officer,
National Association of State Departments of Ag.
CHUCK CONNOR,
President,
National Council of Farmer Cooperatives.
DANIEL SMITH,
President and CEO,
Cooperative Network.
BRENT CHRISTENSEN,
President and CEO,
Minnesota Telecom Alliance.
MIKE PARRISH,
Vice President of Government Relations,
Bayer.
ANDREA WALSH,
President and CEO,
Health Partners.
BARBARA JOERS,
President and CEO,
Gillette Children's Specialty Healthcare.
TOMISLAV MIHALJEVIC, M.D.,
CEO and President,
Cleveland Clinic.
ZIPPY DUVAL,
President,
American Farm Bureau Federation.
TOM HALVERSON,
President and CEO,
CoBank.
VINCE ROBINSON,
Chair,
Minnesota Rural Broadband Coalition.
DEANNA LARSON,
President and CEO,
Avera eCARE.
HUNTER CARPENTER,
Director of Public Policy,
Agricultural Retailers Association.

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ALZHEIMER'S ASSOCIATION AND ALZHEIMER'S IMPACT MOVEMENT
STATEMENT FOR THE RECORD
June 17, 2020

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Committee on Health, Education, Labor, and Pensions (HELP) hearing entitled "Telehealth: Lessons from the COVID–19 Pandemic." The Association and AIM thank the Committee for its continued leadership on issues important to the millions of people liv-

ing with Alzheimer's and other dementia and their caregivers. This statement provides an overview of telehealth policies that would help people living with Alzheimer's and other dementia, including efforts to expand capacity for health outcomes through Project ECHO, and the temporary expansion of Medicare and Medicaid coverage of certain telehealth services during the COVID–19 pandemic.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's sister organization, working in strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and development of approaches to reduce the risk of developing dementia.

Expanding Capacity for Health Outcomes (Project ECHO)

The Alzheimer's Association and AIM support legislative efforts to expand the use of technology-enabled collaborative learning and capacity-building models. These innovative education models, often referred to as Project ECHO, help build workforce capacity and improve access to care. These models use a hub-and-spoke approach by linking expert specialist teams at a 'hub' with the 'spokes' of health providers in local communities to increase on-the-ground expertise. Using case-based learning, Project ECHO models can improve the capacity of providers, especially those in rural and underserved areas, on how to best meet the needs of people living with Alzheimer's and other dementia.

The Alzheimer's Association has conducted multiple Project ECHO programs in primary care and assisted living communities. These Project ECHO models focus on increasing access to dementia diagnosis and care through primary care providers and on increasing person-centered dementia care in assisted living communities. According to an evaluation of the Association's first two pilot programs by the Center for Evaluation and Applied Research at The New York Academy of Medicine, primary care participants reported the most significant knowledge gains in identifying and screening for dementia, medication management, and communication with patients and family members. The evaluation also showed that participants from assisted living communities said the increased knowledge led to a change in their practices and gave them a better understanding of person-centered care.

The Alzheimer's Association is formalizing a global network of ECHO hubs to address Alzheimer's and other dementia, and will build momentum for additional ECHO hub creation by partnering with the research community, medical professionals, key stakeholders in the dementia care industry and policy leaders and advocates. This consortium of thought leaders across the spectrum will increase evidence around the use of ECHO in promoting best practice dementia care, accelerate the uptake of evidence into practice, and help policymakers understand and support Project ECHO dementia models.

Project ECHO is currently playing an important role in how health providers, public health officials, and scientists are sharing best practices and information for addressing the COVID–19 pandemic. Project ECHO dementia models are helping primary care physicians in real-time understand how to use validated assessment tools appropriate for virtual use to make early and accurate diagnoses, educate families about the diagnosis and home management strategies, and help caregivers understand the behavioral changes associated with Alzheimer's, which can be heightened during social isolation. Project ECHO is also helping long-term care providers in real-time understand how to train temporary staff that may not be familiar with how to best care for people with Alzheimer's, implement important health strategies, such as hand-washing and social distancing for people with Alzheimer's, and effectively communicate with residents to help them understand the COVID–19 pandemic.

The Alzheimer's Association has also developed a COVID–19–specific Project ECHO series based on our guidance *Emergency Preparedness: Caring for persons living with dementia in a long-term or community-based care setting*. This series focuses on sharing best-practice recommendations for person-centered care, illness prevention, resident engagement and connectedness to family and friends, nutrition support and mobility, and strategies related to dementia-related behaviors in emergency situations. This will help providers understand how to best respond to challenging cases related to the COVID–19 pandemic within their own communities.

The Alzheimer's Association and AIM urge the Committee to pass the *Expanding Capacity for Health Outcomes (ECHO) Act of 2019* (S. 1618/H.R. 5199) and ensure that Alzheimer's and other dementia are included. This bipartisan bill would provide Federal funding to help expand the use of Project ECHO models. This expansion and evaluation of Project ECHO would increase timely access to specialized health care, like better dementia diagnosis and care, and improve the quality of life for those that need it the most.

Expansion of Telehealth Services

The Alzheimer's Association and AIM also support the expansion of Medicare and Medicaid coverage for certain telehealth services in response to the COVID–19 pandemic. The Centers for Medicare & Medicaid Services (CMS) has temporarily expanded coverage for numerous codes that are beneficial to people living with Alzheimer's and other dementia. This population is particularly vulnerable to the effects of COVID–19 due to their typical age and their co-occurring chronic conditions, so we appreciate the flexibilities CMS has implemented to reduce the risk of their exposure to the virus and ensure regular access to quality care. We encourage CMS to evaluate the effectiveness of these temporary codes, to the extent possible, as the pandemic subsides to determine whether some are appropriate for permanent telehealth eligibility.

The Alzheimer's Association and AIM particularly support CMS's decision to allow for telehealth coverage of the Medicare care planning CPT® code 99483. Care planning is critical for people with cognitive impairment under normal circumstances to help them manage comorbid conditions and make decisions about long-term care and support services, among others. Ensuring that a plan is established, documented, and updated is now more important than ever. Making this service available via telehealth will improve access to care planning for this vulnerable population. To that end, we also urge Congress to pass the bipartisan *Improving HOPE for Alzheimer's Act* (S. 880/H.R. 1873), which would educate clinicians on the importance and availability of this crucial Medicare care planning service.

Finally,we appreciate CMS's flexibility in allowing telehealth technology to be used in home health delivery. Thirty-two percent of individuals using home health services have Alzheimer's or other dementia. The ability to receive care in the home decreases visits to unfamiliar places that may cause agitation in people with dementia and can ease some burden on caregivers. This increased flexibility can reduce interruptions in access to this kind of quality care. We also support CMS's expansion of the licensed practitioners, such as nurse practitioners and physician assistants, who can order Medicaid home health services. Twenty-seven percent of older individuals with Alzheimer's or other dementia who have Medicare also have Medicaid coverage, compared with 11 percent of individuals without dementia.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Committee and its continued commitment to advancing legislation important to the millions of families affected by Alzheimer's and other dementia. We look forward to working with the Committee and other Members of Congress in a bipartisan way to advance policies that would help this vulnerable population during the COVID–19 pandemic and beyond, through the expansion of Project ECHO models and through Medicare and Medicaid coverage of certain telehealth services.

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QUESTIONS AND ANSWERS

RESPONSES BY KAREN S. RHEUBAN, TO QUESTIONS FROM SENATOR CASEY, SENATOR WARREN, SENATOR SMITH, SENATOR ROSEN AND SENATOR LOEFFLER

SENATOR ROBERT P. CASEY, JR.

Since the Medicaid program works as a partnership between the Federal Government and the states, it does not always receive the focus Medicare does when Congress develops policies around telehealth.

Question 1.

What more can Congress do to support the inclusion of Medicaid in policies that increase access to telehealth, particularly across state lines, both now and after the conclusion of the national emergency?

Answer 1. I believe that Congress should take action to encourage or even require alignment across our Medicaid programs. Each state Medicaid program provides some form of coverage of telemedicine but there is no baseline standard for coverage determination nor alignment across the states. This remains a serious barrier to provider adoption.

Prior to the pandemic, in some states, Medicaid program engagement in telehealth has been more expansive than that of Medicare as the Section 1834m restrictions had not been applied to Medicaid. Payment, even when at parity for in-person care, remains at lesser rates than Medicare or commercial payers. Lack of alignment with Medicare coverage creates challenges for providers and/or health systems seeking to create uniform models and processes that enable the care of patients using telehealth tools. In addition, when changes occur in the annual Medicare Physician Fee Schedule, these changes are not generally reflected in Medicaid coverage which often takes state legislation to enable.

As an example, prior to the COVID–19 pandemic, Virginia Medicaid covered facility based telemedicine visits without geographic restriction, but did not cover remote patient monitoring, eConsults or enabled the home as an eligible originating site. Post public health emergency, with the support of our Governor, Virginia Medicaid greatly increased telemedicine coverage by enabling home as an eligible originating site, telephone visits, and provided limited coverage for remote monitoring (for COVID+ or suspected COVID+ patients only) along with coverage for eConsults. Those changes were not tied to the state's Section 1135 waiver, and as such, will not necessarily sunset with the public health emergency.

The impact of Medicaid program lack of alignment with Medicare is exacerbated when providers work in multiple states, in which variable coverage policies create a further disincentive to adoption. To add to the uncertainty, many states contract with managed care organizations (MCOs) who themselves may choose to offer telemedicine as an enhanced benefit for their enrollees. The need to contract with multiple MCO entities in addition to fee-for-service Medicaid, creates additional barriers for those wishing to provide care to our high risk patient populations and low income citizens who would most benefit from telehealth solutions.

SENATOR ELIZABETH WARREN

As part of your testimony, you recommended that Congress "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." This recommendation stems, in part, from your assertion that "a lack of broadband is a health equity issue." In other words, people who cannot access the Internet—or other technologies necessary to access telehealth services—will not be able to see the same benefits from telehealth as their more advantaged counterparts. According to the Pew Research Center, "racial minorities, older adults, rural residents, and those with lower levels of education and income are less likely to have broadband service at home."

Question 1.

What are the primary barriers facing people of color, older adults, rural residents, and low-income Americans who struggle to access telehealth services?

Question 2.

In addition to expanding access to broadband infrastructure, what specific policies and programs, if any, do you believe Congress should pursue in its effort to ensure equitable access to telehealth services, regardless of race, income, age, or zip code?

Answer 1 & 2. Our experience during the pandemic demonstrated that at least 25 percent of our virtual visits had to be conducted via telephone because of an inability to facilitate a video-based connection to the home of the patient. The inability to provide video-based care in those instances stemmed from a host of issues to include a lack of broadband to the home (whether because of price or unavailability), technology related factors, lack of smart phone or computer in the home, or age or disability related factors that resulted in patients falling back to receiving care via telephone. The Federal Communications Commission has done elegant broadband mapping, as have many of the states, but even having broadband available in the community does not ensure that the home itself or the patient is connected. Federal programs such as those supported by the FCC's Universal Service Fund, those of the U.S. Department of Agriculture or the Department of Commerce can bring connectivity to a community. Expansion to underserved communities and to the home should be our next priority. Amongst the Universal Service Fund programs, the Lifeline program can facilitate services to the home for low income citizens and

the recent adoption of the FCC's Connected Care Pilot Program will enable greater connectivity to the home of patients.

Of note, in the Commonwealth of Virginia, some of our Medicaid managed care organizations offer the use of a smartphone to patients with medical complexity as an enhanced benefit. This model could be expanded nationwide to dual eligible populations or for other patients with medical complexity.

SENATOR TINA SMITH

The internet gap has resulted in millions of Americans not being able to access telehealth. Hennepin Healthcare—that serves Minneapolis—has found that increased audio-only telephone telehealth services are reducing disparities driven by the digital divide. Community Mental Health Centers in Minnesota are eating the cost to buy this equipment for their patients so they remain connected to their care.

Question 1.

How is the lack of Internet access impacting telehealth, and how has the access to audio-only, phone services helped address this disparity?

Question 2.

What are the risks for patient outcomes if we rely strictly on audio-only, phones services to address this disparity?

Answer 1. I believe we need a coordinated strategy to ensure that all Americans have access to connectivity that enables the delivery of video-based healthcare services (and to follow, health related economic prosperity). Activation of telephone codes by Medicare and many Medicaid programs has been a life saver. A broader approach to telemedicine deployment requires coordinated payment policies that drive adoption across Medicare and Medicaid, and a strategy that mitigates broadband disparities.

Answer 2. Audio only, while helpful for existing patients in the context of the patient's medical home in my opinion, is not an optimal solution for new patients. Having video capability enhances the ability of the provider to examine the patient; the addition of remote examination tools enable care that comports with the standards of in-person care.

SENATOR JACKY ROSEN

Prior to the pandemic we were already struggling with a shortage of mental health services, especially for children who had experienced trauma. I have been very supportive of Federal funding for grants that pair pediatrician offices with children's mental health providers via telehealth.

Question 1.

Dr. Rheuban, how might we further expand access to mental health care services through telehealth, specifically with providers specializing in trauma, to ensure that at-risk youth and other vulnerable populations have improved access to care?

Question 2.

What else should Congress consider doing to help bring specialized mental health services to more people, including through community health centers, rural health clinics, and other primary care providers?

Answer 1 & 2. Our nation faces a critical shortage of mental health providers serving all patient age groups. Substance use disorders continue to devastate our communities. Telehealth has long been utilized to deliver mental health services to underserved communities and patients. Indeed, at UVA Health, prior to the pandemic, a full 50 percent of our telemedicine encounters were provided by adult, child and emergency psychiatry providers. During COVID–19, our psychiatrists and other behavioral health providers rapidly scaled to replace in-person services with video-based visits and where necessary, with telephone-based services.

Since passage of the SUPPORT Act permitted the home as an eligible patient originating site, many state Medicaid programs have enabled that capability. However, we still await the Drug Enforcement Agency (DEA) promulgation of rules for the special registration of telemedicine providers (called for in the SUPPORT Act) that will further enable the establishment of a doctor-patient relationship that results in the prescribing of controlled substances. Prior to COVID–19, the DEA permitted the establishment of a doctor-patient relationship via telemedicine when the patient is located at a DEA registered facility or is in the physical presence of a DEA registered practitioner.

There are important programs that integrate behavioral health into primary care settings. The Virginia Mental Health Access program is one such program which re-

ceived Federal and state funds to bring pediatric behavioral health telemedicine services into primary care. It is an appropriate solution to bring care to our patients and to raise the knowledge and skills of our primary care provides.

We also support the use of the Project ECHO model to enable one to educate many providers. UVA Health providers host a number of ECHO programs, to include training on substance use disorder, pain management and neonatal abstinence syndrome. Congress should pass and fund "The ECHO 2019 Act," which would create a program to provide grants and technical assistance to further develop and evaluate the ECHO model and other similar models.

Many of our federally qualified community health centers and rural health clinics operate in networks with multiple physical clinic locations and have hired behavioral health practitioners who may work in one location or travel to others. Prior to COVID–19, practitioners in those clinics were not permitted to serve as distant site providers. We urge Congress to continue the waiver process that enables our federally qualified health centers and rural health clinics to serve as both a patient originating site and a distant site.

Last, in order to bring specialized mental health services to more people, we support increasing Medicare's support for physician resident training, which has been effectively frozen since 1997 due to caps on the number of medical residents that Medicare supports. Adequate and continued support for the health professions and nursing workforce development programs authorized under Titles VII and VIII of the Public Health Service Act is necessary as well.

SENATOR KELLY LOEFFLER

During the pandemic, physicians have reported an increased use of telemedicine to treat mental health patients. However, there are still mental health conditions that physicians are reticent to use telehealth to treat and/or diagnose patients. For example, I have heard that some providers are hesitant to make an ADHD diagnosis via telehealth because they feel it is a complicated diagnosis. Some physicians, however, have said anecdotally that they like telemedicine for ADHD patients because it allows the provider to see patient's home environment and better understand their circumstances.

Even if we weren't in the middle of a pandemic, patients in rural areas have always faced this treatment barrier.

Question 1.

What can be done to enable physicians to embrace the potential of telehealth to not only provide continuity of care, but improve outcomes for the 1 in 5 US adults who experience mental illness every year?

Answer 1. Please see my response to the related question from Senator Rosen regarding the adoption nationwide of telemental health services in support of adult, child, emergency and substance use disorder services.

The psychiatry and behavioral health community have long embraced the use of telehealth in the delivery of mental health services. Movement toward integration of behavioral health services into primary care, where feasible, creates additional capacity, as do continuing education and training programs for health care providers such as Project ECHO. The benefits of Project ECHO could be expanded with the passage and funding of "The ECHO 2019 Act," which would create a program to provide grants and technical assistance to further develop and evaluate the ECHO model and other similar models. In addition, in order to improve access to primary and specialty care, including mental health, Congress should increase Medicare's support for physician resident training, which has been effectively frozen since 1997 due to caps on the number of medical residents that Medicare supports. Adequate and continued support for the health professions and nursing workforce development programs authorized under Titles VII and VIII of the Public Health Service Act is necessary as well. Training programs for residents, fellows and advanced practice providers would benefit from training in the use of telemedicine as a care delivery model.

Telemental health services can be conducted effectively with new patients. Our UVA Health division head of child psychiatry, Dr. Roger Burket, reports his faculty routinely diagnose initially and treat ADHD patients via telemedicine. They utilize intake information provided by the parent and school teacher, including ADHD rating scales as a part of the intake evaluation and are able to rule out other diagnoses. Where additional testing is needed, the patient is referred for that testing. Follow-up visits are effectively conducted via telemedicine as well.

It is imperative that the DEA promulgate the rules for the special telemedicine registration to enable the establishment of a doctor-patient relationship as it relates to prescribing of controlled substances, particularly when the home becomes the patient's originating site.

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[Whereupon, the hearing was adjourned at 12:09 p.m.]

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