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on

The Importance of Permanency of Telehealth Payment Coverage

before the

United States Senate Finance Health Subcommittee

Chairman Cardin, Ranking Member Daines, and distinguished members of the Senate Finance Committee thank you for the opportunity to testify on behalf of the University of Alabama at Birmingham and the American Medical Group Association. I am a Professor of Medicine in the Division of Nephrology at UAB and I am the Medical Director of the UAB Health System Telehealth Program.

My role in telehealth started in 2013 when I recognized that one of my elderly dialysis patients was driving 2 hours twice monthly to get her dialysis care in Birmingham, Alabama. Furthermore, many of my patients with rare diseases, primarily with Fabry Disease, an inherited disease which causes patients to suffer from severe pain, kidney failure, stroke, and heart failure, were also driving hours to see me. Their commutes and time spent in the waiting room were part of their disease burden. I believed that my patients' lives could be made just a little better if we could deliver the same quality care remotely. Furthermore, for every patient that could make the drive and wait for me, were there more patients that couldn't? **What if we could reach everyone?**

UAB is home to UAB Hospital, the 8th largest hospital in the country, and performs over 1.7 million outpatient patient visits yearly. It is a world-class institution and ranks 11th in NIH research dollars awarded amongst public institutions. I am proud to call UAB not only my employer but also my home. But how can you have a world-class healthcare institution in a state which ranks 46th in healthcare outcomes? **What if we could remove even one barrier, such as geography, to improve access to care?**

So UAB, in collaboration with the Alabama Department of Public Health, worked for 2 years and developed a way through telehealth for me to see my dialysis and rare disease patients in a number of county health departments across the state. In 2015, we did the first fully comprehensive telehealth visit on a peritoneal dialysis patient.

There was a critical need for telehealth starting in 2020.

In March 2020, the President issued an emergency declaration for all states, given the magnitude of the COVID-19 public health emergency. UAB had already begun positioning ourselves for a rapid transition to telehealth delivery of care. Because of the groundwork laid years prior for Alabama patients to receive care over telehealth, by April of 2020, UAB transitioned over 74% of our outpatient clinic visits to telehealth. This allowed us to protect providers and our patients from the COVID-19 virus in the only way we knew how against an unknown pathogen at the time.

Furthermore, we watched telehealth transform rural hospitals. Prior to COVID-19, UAB was providing telehealth inpatient care, including tele-critical care, tele-stroke, and tele-nephrology. When we started delivering telehealth services to Whitfield Regional Medical Center in Demopolis, Alabama, the average census of the hospital was around 20. In 2018, we started a tele-stroke, tele-critical care, and tele-nephrology program at Whitfield, and the census started increasing; the average census is around 50 today. This is a significant benefit to the patient and their families. Equally important, keeping the care in the community helps our important rural health partners keep their doors open.

In many cases, telehealth provides better care than the previous in person alternative. Previously, if a dialysis patient arrived at Demopolis with life-threatening high potassium, they were given a medicine to remove the potassium through the stool. The patient would then be put in an ambulance and transported to the nearest dialysis-ready hospital, which would take at least 90 minutes. The ambulance had to wait at the hospital while the patient waited on a bed, and finally, around 8 to 12 hours later, the patient would be dialyzed. It was the best we could do at the time. But this was a disservice to the patient. An ambulance is used each time a patient is transferred to a larger center from Demopolis. Marengo County, Alabama, only has 3 ambulances, so if 2 patients were being transferred due to a lack of local services, that leaves only one ambulance to cover the whole county. With telehealth, we are able to do a nephrology consult on the patient in Demopolis; the rural hospital keeps the patient, and we are able to start dialysis within 1 hour of the patient's arrival, thus saving a transfer and time needed to treat the high potassium. Finally, UAB Hospital now has an open bed that can accept even sicker patients.

During COVID-19, there were times when Vanderbilt, Emory, Ochsner, and UAB were all full and could take no additional patients. Patients with COVID-19 needed high-risk ventilation and, at times, needed dialysis. I would be notified of these patients who otherwise would be left to die in a facility with no way to care for them. I notified one rural hospital without telehealth to transport their critically ill patient to one of our rural sites that had access to tele-nephrology and tele-critical care. For the first time ever, patients were life-flighted into rural Demopolis, Alabama, which now had the resources to care for them. This demonstrates that telehealth has the potential to transform a rural hospital bed from available but unusable to available and useful. This is one of many examples of how telehealth is transforming care across the country.

The primary regulatory changes on both the federal and state level that allowed for this complete and successful pivot to telehealth was:

1. The elimination of the geographic limitation;
2. The elimination of the originating site requirement;
3. The universal adoption of both private and public payers in parity for telehealth visits and
4. And the allowance of audio-only visits and pay parity

Unfortunately, these regulatory "flexibilities" are not permanent. They have been extended multiple times, with the current expiration being the end of 2024. At the end of the COVID-19 public health emergency, healthcare providers that had successfully pivoted to telehealth, which was not an easy transition for most, were left with a seemingly endless barrage of new regulations regarding licensure, variations between private and public insurers, regulations in the prescribing of controlled substances, etc. Furthermore, the possibility that none of the previous "flexibilities" would be permanent added to provider frustration. We had been to war battling COVID-19 armed with telehealth only to find we were

now battling new regulations. All of these regulatory hurdles increased to pre-pandemic levels. They left many providers confused and frustrated, **finding it easier to give up on telehealth rather than to face an impossible onslaught of regulations.** As a result, the utilization of telehealth began to decrease. But just as there was a need before COVID-19 for telehealth, there is a need for telehealth now, and there will be a need in the future. **Incorporating strategies, including telehealth, is the only way we will be able to organize our healthcare into meaningful systems to deliver equitable care across our vast geographic area in the United States.**

As we look to the future, how will telehealth play a major role in the success of any healthcare delivery system?

1. **Telehealth is vital to the survival of rural healthcare-** my father is now a retired physician. When he started his practice, it was not uncommon to be on call 7 days in a row every month, and that was if you were lucky enough to have 3 other providers to partner with. This type of call schedule is still common in rural areas. We are not training providers to be on call in this manner, making recruiting providers to rural practice difficult. Furthermore, the idea of practicing in a rural area without access to subspecialist help can be enough to decrease interest in establishing a practice in a rural area. The average age of providers in rural areas everywhere is increasing. Telehealth can help by providing call coverage and access to subspecialty support to rural providers, thus improving recruitment of primary care to these areas.

2. **Telehealth will play an ever-growing role in value-based care**- the applicability of telehealth strategies, including home-based telehealth visits and remote patient monitoring, has been proven specifically in high-risk patients. As the utilization of telehealth declines in the face of regulatory struggles, we may lose some of the momentum needed to truly realize the benefit that can be seen in value-based care approaches.

3. **Telehealth will continue to allow for the delivery of inpatient subspecialty services to urban and rural settings-** the inpatient delivery of subspecialty care is vital for both small urban and rural areas. These approaches allow for the distribution of a subspecialty workforce largely centered in large urban areas.

4. **Telehealth can alleviate nursing and provider staffing shortages by leveraging urban or national-based workforces.**

Telehealth has other advantages above and beyond what it provides for healthcare delivery. Since its inception, UAB telehealth has saved 28,500,000 miles of driving to and from doctor's visits. That is equivalent to the reduction in CO2 emission of 2619 passenger vehicles off the road for an entire year, saving patient's gas money, commute time, and time away from work and family. Alabama gained 16,1470,00 dollars in productivity by patients being able to work the times that otherwise would have been spent driving alone to doctor's appointments. We are one institution that uses telehealth, but multiply this by every institution, and you have improved CO2 emissions and improved utilization of our fuel.

What do we need to do as a country to ensure that we continue to deliver telehealth now and ensure its survival to fully develop its potential within our national healthcare delivery infrastructure and ensure its availability to scale up during times in the future, such as COVID-19?

1. **The elimination of the geographic restrictions needs to be permanent. Prior to COVID-19, patients had to do their telehealth in a medical facility in a rural area. The COVID-19 pandemic removed this restriction, which will expire at the end of 2024.** I'll never forget a patient of mine who was unable to walk who lived in Birmingham. His father would take him to the clinic and was about to lose his job from driving his son to and from clinic visits. The patient lived no more than 2 miles from our clinic, but getting in and out of a vehicle and parking close to our clinic was enough to make any clinic visit a half-day event. He found out I was seeing patients through telehealth and brought me an article in which I had been featured. And he asked me, "Is this for me? “And the answer was "no" at the time because he lived in an urban area. Another example of the need for telehealth in urban areas relates to transplants. UAB is the only transplant center in the state, yet a patient in Mobile, Alabama, which is 4 hours away but urban, had to drive to a rural county to receive their transplant care. Why? Care for rare and ultra-rare diseases can sometimes only be found multiple states away. We all would want our children to go to the "expert." Yet if the geographic restriction comes back, this would not be possible over telehealth for those living in urban centers. Access to care problems is not geographically restricted, so why should our regulations be?

2. **The elimination of the originating site requirement needs to remain permanent.** Delivery of telehealth care within brick-and-mortar sites is a great way to care for patients who do not have access to technology. However, the operational hurdles, including contracting for space in external sites and scheduling across systems and electronic medical records, are not such that it can be the sole manner to deliver telehealth services. The home is adequate and will continue to improve as a site of care as the accessibility to in-home diagnostics continues to improve.

3. **Coverage for telehealth needs to continue at parity for in-person visits and needs to be permanent**. The delivery of telehealth is not just a video visit with your provider. For these visits to be efficient, the same staff is needed to ensure the visit is a success. Someone has to schedule the visit; someone has to do med reconciliation and, in many cases, "room" the patient electronically. Furthermore, there are ongoing technology costs, including subscriptions to platforms, information technology support, etc. Should the reimbursement drop below parity, given the ongoing costs, providers will be unable to provide telehealth visits, which will be a great disservice to patients who now rely on technology as a lifeline to good care.

4. **Audio-only visits should continue to be covered**. Although video visits are a preferred method for delivering telehealth services, not all patients can access video visits. Suppose a provider attempts to get a patient on video due to technology access. In that case, the patient cannot get on video; this is documented, and care is rendered. That time should be reimbursed commensurate with the time-based codes for in-person visits. An hour's visit on the phone is still an hour of provider time. Furthermore, physicians trying to care for the most disparate of populations are going to be the hardest hit financially by regulations that reduce reimbursement for audio only telehealth. Unfortunately, the reality for some patients is audio only care versus no care at all.

5. **Controlled substances that are not Schedule 2 should be allowed to be prescribed over telehealth.** For many not in the medical field, controlled substances immediately conjure images of opioids and benzodiazepines. However, other medications are included, and some may not realize that anti-seizure medications are in these categories. It does not make sense that a patient with epilepsy, whom we have restricted from driving, cannot get a prescription for their anti-seizure medications over telehealth when appropriate. Furthermore, data has shown that suboxone, used to treat opioid addiction and prevent overdoses, can safely and effectively be prescribed for a limited quantity over telehealth, followed by quick in-person follow-up to ensure access to this drug. My colleagues who treat OUD at UAB were able to provide rapid access to addiction treatment and overdose prevention via telehealth during the pandemic. Now, regulatory barriers make it hard to get new patients, such as those recently released from rehab or jail, into addiction treatment using telehealth. Overdose deaths rose 11% in AL last year. We must extend the lifeline of telehealth to halt the overdose crisis.

6. **Direct supervision of residents should also remain possible via telehealth.**

In closing, we must maintain and support telehealth through permanent legislation as it is critical to the survival of rural health, the future of our healthcare system's ability to deliver equitable care regardless of geography, and is integral to our ability to deliver on the promise of value-based care. Just as important as its importance to the structure of healthcare delivery is that behind each of these asks are human beings who have grown to rely on this technology as a lifeline to care. Thank you.