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RPTS ZAMORA

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TELEHEALTH TO DIGITAL MEDICINE: HOW 21ST

CENTURY TECHNOLOGY CAN BENEFIT PATIENTS

THURSDAY, MAY 1, 2014

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:02 a.m., in Room 2123, Longworth House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Shimkus, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio), Pallone, Dingell, Engel, Green, Barrow, Christensen, Waxman (ex officio).

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Also present: Representative Harper.

Staff Present: Clay Alspach, Chief Counsel, Health; Sean Bonyun, Communications Director; Noelle Clemente, Press Secretary; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Chris Pope, Fellow, Health; Macey Sevcik, Press Assistant; Heidi Stirrup, Health Policy Coordinator; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Minority Staff Assistant; Kaycee Glavich, Minority GAO Detailee; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; and Matt Siegler, Minority Counsel.

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Mr. Pitts. Subcommittee will come to order. Chair will recognize himself for an opening statement.

Telemedicine and digital medicine in all their forms present a host of potential benefits to both patients and providers. Virtual doctor visits are one way to help address provider shortages, particularly in rural areas where patients may have to travel a great distance at their own cost to see a doctor in person. Telemedicine can allow in-home monitoring of chronically ill patients and facilitate patient education.

Provider-to-provider virtual consultations may also lead to greater efficiencies in the system by providing continuity of care and reducing duplicative testing and services. The ability to Skype or use a video call can also reduce the inappropriate use of resources by patients. For example, a parent with a small child who is sick in the middle of a night could access a provider via web cam and potentially avoid an unnecessary trip to the emergency room.

For all of its potential benefits, concerns about the appropriate way to support such technologies abound. If not done carefully, some fear the potential for good that many envision in this space can instead lead to waste, fraud, and abuse. Therefore, the purpose of today's hearing is to explore the types of technologies that hold great promise and hear ideas that allow the Federal Government to realize this potential to reduce cost, improve efficiencies, and ensure quality in

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our healthcare programs.

To that end, Ranking Member Pallone and I will be releasing a call for ideas following the hearing. We will be looking for specific policy and legislative ideas on how the Federal Government can support technology adoption in our healthcare programs for the express and explicit purpose of reducing cost and increasing the overall quality and efficiency of the programs.

We are also looking for ways in which the Federal Government currently inhibits the use or adoption of such technologies by all players in the healthcare system, be they insurer, provider, or patient. The more specific and targeted policy, the greater chance it will hold for congressional support down the line.

I would like to welcome all of our witnesses to the subcommittee hearing today, especially Dr. Tom Beeman, president and CEO of Lancaster General Hospital, the largest hospital and one of the largest employers in my congressional district.

I would like to yield the remainder of my time to the gentleman from Mississippi, Mr. Harper.

[The prepared statement of Mr. Pitts follows:]

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Mr. Harper. Thank you, Mr. Chairman. I appreciate your attention to this important subject.

And, Ranking Member Pallone, I value your shared interest in telehealth.

Over the last couple of years, I have had the privilege of being a part of this exciting conversation on telemedicine. My staff and I have engaged in a years-long discussion and dialogue with patients, providers, and many other industry stakeholders to determine the most appropriate way for Congress to advance telehealth.

The bottom line is that until we can attract more physicians to underserved communities and tighten the access gap, the best and most cost-efficient alternative is to improve telehealth networks. That is why I have introduced the Telehealth Enhancement Act, a bill to strengthen Medicare and enhance Medicaid through expanded telemedicine coverage.

But most importantly, it is really about fairness. Access to care should not be limited based on where Americans choose to live. My goal is to build on existing telemedicine reforms that States like Mississippi have advanced and pioneered. The University of Mississippi Medical Center, for example, has been a leader in advancing telemedicine. Along the way, I hope also that we can help States, as well as the Federal Government, to lower healthcare costs by encouraging people to adopt healthier lifestyles and reducing

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avoidable hospital visits.

Just this past Monday, the State of Mississippi was devastated in many communities from a series of tornados. Yesterday, I was able to fly down with our two United States Senators and another Congressman to view the damage, and particularly hard hit were areas in Tupelo, in my home county of Rankin County, and the cities of Richland, Pearl, and Brandon, but most extensively was in the city of Louisville, which experienced about a 0.75 of a mile to a mile-wide tornado that was on the ground for some distance, with many deaths. And so the University of Mississippi Medical Center was able to utilize telemedicine to help on the ground there and continuing to do so. And these are things that, I think, have a great future.

So thank you, Mr. Chairman. And I yield back.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Harper follows:]

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Mr. Pitts. Now recognize the ranking member, Mr. Pallone, 5 minutes for an opening statement.

Mr. Pallone. Thank you, Chairman Pitts, for agreeing to hold today's important hearing on telehealth. As ranking member of this subcommittee and a member of the Communications and Internet Subcommittee, telehealth has been an interest of mine for some time. And I also know there are many members of the committee and across Congress who share this interest. So I am glad we are having this opportunity.

An aging population and an expansion in healthcare coverage means that more Americans will be using healthcare services in the coming years. And as new demands are placed on our national healthcare system, I strongly believe as policymakers we need to be actively working to leverage technology to lower costs, increase access, and improve quality of care.

The convergence of medical advances, health information technology, and a nationwide broadband network is transforming the delivery of care by bringing the healthcare provider and patient together virtually. Telemedicine has the potential to serve a large portion of the U.S. by expanding the reach of medical resources while reducing cost and increasing quality. And while we continue to advocate transforming our system from one of treating the sick to preventing people from getting sick, telemedicine can play a pivotal

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role.

For example, persons who have difficulty leaving the home, the elderly and the physically disabled, could easily and regularly access health care from the comfort of their home. Telemedicine also has the ability to assist people with diabetes, obesity, heart failure, and mental illness, as well as other diseases by reducing the number of readmissions to hospitals.

When Congress passed the Affordable Care Act we strongly felt that the status quo was not sustainable. Not only did we have to expand coverage in this country for the uninsured, but we also needed to change our system to reflect and incentivize both quality and efficient care. And as a part of that broader goal, the law includes a variety of provisions aimed at expanding the use of telehealth, recognizing that doing so can help to increase the quality of care through monitoring and specialization.

For example, the Independence at Home Demonstration is testing whether providing chronically ill patients with a range of services in the home setting can reduce hospitalization and improve health outcomes. It also includes an option for States to provide health homes for Medicaid enrollees with chronic conditions. And of course the greater use of ACOs can play an important role in the expansion of telehealth services.

Telehealth also allows patients' health to be constantly

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monitored between doctors visits and makes it easier for patients to connect with more specialists. Evidence shows the specialists utilizing telemedicine are still able to accurately evaluate and diagnosis patients without person-to-person contact. Telephone, video conferencing, computers, and Internet applications or apps are all employed. Hospitals and medical centers use telehealth to reach patients in underserved rural areas. The military makes use of telehealth in its health program, and States within their bounds are working with universities to practice telemedicine.

Telemedicine can also reduce healthcare costs. It would enable doctors and other specialized professionals to come together and effectively reach more patients, which is important as the ACA is being implemented and more Americans are becoming insured. It also allows for diseases to be tracked so they can be treated before they become more costly. And telehealth proponents suggest that these technologies can relieve medical workforce shortages and the unequal distribution of clinicians in the United States.

For patients, telehealth can mean connecting with medical expertise not locally available, saving time, money, and travel, reducing unnecessary hospital visits, and improving the management of chronic conditions.

And that is why I joined with my Republican colleague, Representative Devin Nunes, a member of the Ways and Means Committee,

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to introduce the Telemedicine for Medicare or TELE-MED Act, which aims to increase access to telemedicine in the Medicare program. Specifically, it would permit Medicare providers who are licensed to practice medicine physically in one State to treat patients electronically across State lines.

Under that bill, the State in which the license is issued would have enforcement authority regardless of the patient's location. And by connecting the Medicare patient and provider virtually at the point and time of care, the TELE-MED Act gives Medicare patients access to the best health care anywhere at any time. It also directs the Secretary to report to Congress on how we can ensure increased use of telemedicine in the Medicare program.

Now, I know there are stakeholders who remain concerned about the approach we have taken in this bill. I also know that telehealth raises operational questions and faces serious challenges. For example, most clinicians have not been trained in telehealth, and there are also security and privacy concerns. As a strong advocate of preserving and strengthening Medicare, we must ensure program integrity is preserved and utilization costs do not rise.

So we have a lot of work to do, Mr. Chairman, but I hope that we can still find common ground. We have a great opportunity to come together to expand the use of telehealth in this country. That is why I am proud to join with you in calling for an exchange of ideas. And

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as you said, we intend to set up a process in which all stakeholders can share with our subcommittee their views on this topic. Our goal is to use this process to further inform the subcommittee on what public policies that, if adopted by Congress, might allow for improved delivery and access to health care.

Thank you, Mr. Chairman.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Pallone follows:]

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Mr. Pitts. And now recognize the chairman of the full committee, Mr. Upton, 5 minutes for an opening statement.

The Chairman. Well, thank you, Mr. Chairman.

We are here today to explore the opportunities 21st century technology presents to improve the lives of patients and advance our healthcare system. The introduction of digital forms of communication and applications, such as wireless technologies and smart phones, hold tremendous and great promise for the future of our healthcare system.

Twenty-first century technologies can allow providers to monitor patients released from an inpatient hospital, help reduce the chances of relapse or even readmittance. They also can support new delivery reforms and models that were part of the focus of the doc fix SGR reform legislation that was authored by Dr. Burgess, which we passed out of this committee 51 to nothing; help improve access for those in rural areas like South Haven, Michigan; reduce the overall invasiveness and risk related to healthcare procedures and illnesses.

I want to commend particularly you, Chairman Pitts and Ranking Member Pallone, for your collaboration on today's hearing. As you have discussed, we will be soliciting ideas for how technology can be incorporated into our healthcare system to improve the cost, quality, and delivery of health care across the country.

And in support of that effort there are a number of questions that need to be answered. Which technologies hold promise for improving

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the quality and delivery of health care in this country? What role, if any, exists for the Federal Government in supporting such technologies? How can Congress help foster and realize the promise of 21st century technologies to improve the lives of all Americans?

This will be a priority of the Committee on Energy and Commerce over the next couple of years as we work together towards fostering innovation that will lead to more treatments and cures for issues related to personal illnesses and the overall delivery of health care. The topics discussed today will certainly be a vital part of the 21st Century Cures initiative that was unveiled yesterday and will continue in the weeks and months ahead.

I also want to recognize the efforts of committee members Greg Harper, Bill Johnson, Doris Matsui, and Peter Welch, who have helped author legislation that in part made today's hearing possible. I yield back the balance of my time to gentleman from Texas, Dr. Burgess.

[The prepared statement of The Chairman follows:]

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Dr. Burgess. I thank the chairman for yielding and thank the chairman for the recognition about the SGR bill. It is a landmark achievement.

You know, I will never forget the time in practice when I learned about the CPT Code 99371. It was a code that paid for a telephone consultation. I thought my life would be forever changed because now all of these hours at night I spent on the telephone could be reimbursed. But little did I know it fell into the broad category of codes with no reimbursement. All right.

Medicine has changed a lot in the 21st century, and a lot of it has been for the good. Some of the policy has been the opposite of good, but many of the things that are happening on the technological front are certainly dramatically changing the practice of medicine, and telemedicine is helping to improve access to care and make practices more efficient. The convergence of medical and technological advances; everyone is now carrying a smart phone. The nationwide broadband network is transforming the delivery of care by bringing providers and patients together, together in a virtual world that previously did not exist.

In Texas, providers from across the State can now treat patients in remote locations. A Texas law passed in 2013 enables physicians to more easily collaborate with rural nurse practitioners via teleconference, helping to expand vitally needed primary care services

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to patients. Thus the role of the physician extender is finally being fulfilled.

It is important that these services be provided in a manner that is safe and that is effective for patients. The technological advances before us and those just over the horizon have great potential to connect patients to cutting-edge care, but it must be practiced by those appropriately trained for the maximum potential benefit. For that reason, I am grateful that we have the panel before us today, certainly, an all-star panel of people who live in this world every day. I am looking forward to their testimony. And I will yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Burgess follows:]

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Mr. Pitts. I now would now like to ask unanimous consent to include the following statements for today's hearing record from the American Osteopathic Association, the American Academy of Dermatology Association, American Medical Association, and the American Academy of Family Physicians. Without objection, so ordered.

[The information follows:]

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Mr. Pitts. We have on our panel today five witnesses. I will introduce them in the order in which they should speak. First, Dr. Rashid Bashshur, executive director for eHealth, University of Michigan Health System. Secondly, Dr. Ateev Mehrotra, policy analyst, RAND Corporation. Then Dr. Tom Beeman, president and CEO of Lancaster General Health. Mr. Gary Chard, Delaware state director, Parkinson's Action Network. And Ms. Kofi Jones, the vice president of public affairs of American Well.

Thank you very much for coming. Your written testimony will be made a part of the record. We will give you each 5 minutes to summarize your testimony. There is a little system of lights on your table, so when you see red, that means you should wind up, if you please.

And Dr. Bashshur, we will start with you. You are recognized for 5 minutes for your opening statement. Poke the button on there, please. Yeah. The light should come on and then you are on.

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STATEMENTS OF DR. RASHID BASHSHUR, EXECUTIVE DIRECTOR FOR EHEALTH, UNIVERSITY OF MICHIGAN HEALTH SYSTEM, PROFESSOR EMERITUS, UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH; DR. ATEEV MEHROTRA, POLICY ANALYST, RAND CORPORATION, ASSOCIATE PROFESSOR OF HEALTH CARE POLICY AND MEDICINE, HARVARD MEDICAL SCHOOL; DR. TOM BEEMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, LANCASTER GENERAL HEALTH; GARY CHARD, DELAWARE STATE DIRECTOR, PARKINSON'S ACTION NETWORK; AND KOFI JONES, VICE PRESIDENT OF PUBLIC AFFAIRS, AMERICAN WELL

#### STATEMENT OF RASHID BASHSHUR

Mr. Bashshur. Thank you very much. I am delighted to be here to discuss telemedicine with you. Thank you for the opportunity. For convenience, I will use the term "telemedicine" throughout my discussion, also referred to as telehealth, e-health, m-health, and connected health.

If I may, Mr. Chairman, I would like to thank the distinguished Members of Congress who just spoke for making my job easy. They have already said it: No one has to prove that ready access to expert medical consultations at reasonable cost can save lives; that obviating travel and reducing waiting times for patients and their families by providing appropriate quality care in their local community and

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referrals only when necessary is a step in the right direction; that ready access to evidence-based medicine by providers is in the best interest of patients; that giving providers immediate access to electronic health records, which include patients' medical history, allergies, medications, would enable them to make better clinical decisions and to avoid errors and adverse events from medication contraindications; that enabling patients to adopt healthy lifestyles and take an active part in their own care is inherently good and saves money; that avoiding unnecessary medical visits for pre- and post-surgery appointments; the list goes on.

On a more personal level, no one needs to prove that saving the life of a young boy presenting with cardiac arrest in a remote community hospital is worth the limited cost of a multipurpose telemedicine network. I know of one tragic event where such a boy died en route to a tertiary care hospital when a remote consultation with a pediatric intensivist could have saved his life.

Telemedicine can save money by early intervention, rapid response, and empowered patients. It can avoid costly complications of chronic diseases. Its tools can be used to reduce human resource cost, travel cost, and wasted waiting times as a substitute and not an add-on service.

The expansion of this modality of care with proper goals, ongoing assessment, together with attendant adjustments and quality controls

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would save money and improve health outcomes. It is most effective when limited assets across State lines can be brought into play. Consumer feedback is necessary to avoid potential abuse and incompetence. National reciprocity with minimal paperwork and national databases are necessary.

The technologies that can be used to promote adoption of healthy lifestyles with enormous implications for cost savings are wearable sensors, smart phones, and mobile devices, likely to become the dominant telemedicine technology. These technologies have produced efficiencies in the delivery of service to the point of need in entertainment, banking, commerce, and education. The same applies to health care.

With continued public support for research and development for further deployment and refinement of these systems, there will be winners: patients, providers, and the public purse. Thank you.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Bashshur follows:]

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Mr. Pitts. And now recognize Dr. Mehrotra 5 minutes for an opening statement.

#### STATEMENT OF ATEEV MEHROTRA

Dr. Mehrotra. Thank you, Chairman Pitts, Ranking Member Pallone, and the distinguished members of the committee, for inviting me to testify. My name is Ateev Mehrotra. I am a physician and researcher at the Beth Israel Deaconess Medical Center, the RAND Corporation, and Harvard Medical School.

One of my core research interests is understanding the impact of delivery innovations, and I have termed the burgeoning number of new delivery options as the convenience revolution in health care. My hope is that these new care options can address the common complaint I hear from my own patients: that they often have difficulty getting care in a timely manner.

My testimony today is organized around four points for the members of the committee to consider. First, frame telehealth broadly. One form of telehealth is simply replacing a face-to-face visit with a video conference. And while this form of telehealth technology is important, I believe telehealth should be framed much more broadly. Telehealth essentially means using technology to deliver care in a mode other than a traditional face-to-face visit.

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The great diversity of telehealth technologies makes Congress' job very difficult. While it might be tempting to begin to define, regulate, or pay for telehealth on how it is delivered, technology changes very rapidly, and any definition that specifies the type of technology runs the risk of being outdated quickly. One reason I advocate for global payment methods is the payment is not specific to how the care is provided, and this is a point I will return to later in my testimony.

My second point is do not always assume that telehealth improves care. As with all new technologies and delivery models, it is important not to assume that telehealth always improves care. While many studies have shown that telehealth can have a positive impact, others have found telehealth is ineffective and sometimes even harmful. For example, one recent study of home monitoring for older adults found that the home monitoring led to an increased risk of death.

To ensure that telehealth is beneficial, we need more population-based quality measures instead of our current quality measures, which are often specific to how the care is delivered; for example, care in a nursing home. Also, it is hard to make blanket statements about whether a given telehealth technology is effective or ineffective. Rather, the impact of the telehealth technology depends on what are the patient and the clinical situation. And so the complexity emphasizes the need for more ongoing evaluation of

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telehealth and what works and what doesn't work.

My third point is that telehealth may improve access but not always for the populations we expect. I believe telehealth can improve access for people who live in rural areas. However, it is important to recognize that people who live in urban areas and wealthier communities may be the most likely to use telehealth. They may preferentially turn to telehealth because they are equally attracted to the convenience and may have more access and familiarity with technology. Recognizing telehealth's broad appeal is essential because policies should not be crafted just for rural communities.

My fourth and final point is that telehealth can be cheaper per clinical encounter, but could also increase utilization and spending. Telehealth can reduce healthcare spending. Many studies, including my own, have documented that telehealth can lead to be cheaper on a per-visit basis. However, lower costs per visit does not ensure that telehealth reduces spending. To reduce spending, the telehealth visit must replace an in-person visit.

The concern is that telehealth could drive greater utilization and increase spending. In other words, people who otherwise would have not sought care use telehealth to get care. Now, if this increased use of care leads to better treatment, better health, then this new utilization is good for society. However, the concern is this new use could be overutilization, that is care that does not lead to

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improvements in health, and therefore this increased utilization does not have any benefit.

The very advantage of telehealth, its ability to make care convenient, is also potentially its Achilles' heel. In some cases telehealth can be too convenient. This possibility of overutilization can be tempered through bundled payment. Under a bundled payment system, providers have more flexibility on deciding upon the most appropriate and cost-effective means of delivering care for a given patient in a clinical situation.

To sum up, I am a firm believer in the potential for telehealth and other delivery innovations to improve quality, decrease costs, and increase access, but there are many complexities that require consideration to ensure that telehealth reaches that potential.

Again, let me thank you for allowing me to appear before you today, and I would be happy to take any questions.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Mehrotra follows:]

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Mr. Pitts. Now a special welcome to my constituent. I call him Mr. Tom Beeman, but he is listed as Dr. Beeman. He is also Admiral Beeman.

But whichever title you would like, Tom, you are welcome. You are recognized for 5 minutes.

#### **STATEMENT OF TOM BEEMAN**

Mr. Beeman. Good morning, Mr. Chairman, Ranking Member, and distinguished members of the House Commerce Subcommittee on Health. My name is Thomas Beeman, president and CEO of Lancaster General Health. Thank you for allowing me to represent our perspective and share how 21st century technologies can benefit patients.

An integrated not-for-profit health system, Lancaster General Health, includes 690 beds, 40 outpatient sites, home care and infusion therapy services, a family practice residency program, the Pennsylvania College of Health Sciences, through which we educate over 1,600 future medical professionals annually. We employ over 7,100 employees and are aligned with a medical staff of over 1,000 physicians and advanced practice providers.

Our leadership defines telehealth as the use of technology to connect the right people at the right time and place in order to improve the patient experience and health outcomes. Today, through the use

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of Web-based solutions, the affordability of mobile devices, and an increasingly tech-savvy population, the innovative solutions are seemingly without limit. These innovative solutions help us to reach our patients outside the walls of our system and outside the confines of a traditional workday.

Our current state of technologies includes a HIMSS Level 7 integrated platform that spans all care settings and incorporates our \$100 million investment in Epic as our electronic health record. Our investment in Epic connects providers with clinical evidence decision support tools and patients via our patient portal called MyLGHealth, which gives patients access to their medical record anywhere Internet is available. Additionally, our health system participates in Healteway, connecting us with a national health information exchange.

With our limited time today, I would like to elaborate one example from the written testimony which highlights how we leverage our technological resources. This program is a pilot we call Care Connections. We know that a small percentage of the population accounts for most of the healthcare costs, most of which are generated through avoidable emergency department visits and inpatient stays.

Leveraging the information gleaned from our electronic health records and billing department, we learned that at Lancaster General Health 480 patients accounted for \$36 million in charges between 2008 and 2009. With this in mind, in 2011 we launched the Superutilizer

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Project, which incorporates a multidisciplinary team of a case manager, lawyer, medical care providers, pharmacists, psychologist, and social worker to manage a group of 30 patients.

Since 2011, we have formalized the program and dubbed it Care Connections and expanded enrollment to 100 patients. Our latest results show that inpatient days in the hospital decreased by 84 percent and emergency department visits by 26 percent. Limited available cost data reveals after enrollment per-member per-month spend decreased \$670 or for 100 patients savings of more than \$800,000 in 1 year.

While this level of success requires superior clinical management and great effort on the part of a multidisciplinary team, the foundation upon which the program is built is telehealth. The entire Care Connections team is mobile, with secure iPads, iPhones, and laptops, upon which they connect in patient's homes using Microsoft Lync to have a visual connection with a provider in the office to allow for virtual communications, video conferencing, and patient education.

Care Connections helps decrease our operational needs for physical space while achieving our optimal goal of treating the patient in the appropriate setting and engaging them in their own care. This is further supported with alerts the team receives whenever any of their patients enter an emergency department in the area so we can continue to monitor and intervene in their care.

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Finally, we also leverage commercial products such as Find My Friends mobile app to identify exact locations of our caregivers in the field to ensure the safety of our workforce.

Our written testimony includes other examples of programs that we have instituted at Lancaster General Health that similarly blend technology and medicine in exciting and collaborative ways. As care providers, we ultimately believe that better informed and better engaged patients lead to better health, and better health is the ultimate reform, the best and most definitive solution to controlling the ever-spiraling percent of GDP that the Nation spends on healthcare.

Mr. Chairman, it has been my honor to appear before you today. I would be pleased to respond to any questions that you or members of the subcommittee may have.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Beeman follows:]

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Mr. Pitts. Mr. Chard, you are recognized for 5 minutes for opening statement.

#### STATEMENT OF GARY CHARD

Mr. Chard. Good morning, Mr. Chairman and Ranking Member Pallone and members of the subcommittee. My name is Gary Chard, and I am the Delaware state director for the Parkinson's Action Network. Thank you for the opportunity to speak before you regarding the role telehealth technology can play in the lives of Parkinson's disease patients in the 21st century. As a person with Parkinson's, please hear me with the voice of my fellow persons with Parkinson's moving and shaking right along with me.

I am a 62-year-old vibrant and healthy resident of the State of Delaware. I was diagnosed with this insidious disease in the spring of 2008 when I was anticipating another 10 to 15 years of productive work life. I am a financial representative by practice, as well as a husband, father, grandfather, church and community member of whom much was expected. To say that many of the hopes and dreams of my family, community members, and clients were dashed with the progression of my PD is an understatement.

I come to you today to tell you how technology can revolutionize the treatment and care of people living with PD and how it has personally

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helped me. Please hear me that the employment of telehealth technology is not limited to benefit only persons with Parkinson's or people in deep rural communities, but it is an asset that can provide safe, secure and in-depth diagnostic and evaluative care to the immobile and infirm, bringing them to experts who may otherwise be inaccessible.

Parkinson's Disease is a neurological disorder that stems from reduced dopamine production in the substantia nigra portion of the brain leading to tremors in the limbs, slowness of movement, rigidity, and impaired balance and coordination. It also exhibits itself through cognitive changes such as confusion, forgetfulness, loss of thought pattern, and sleep disruptions. If my voice begins to fade this morning, please recognize it is a typical example of my PD.

Parkinson's is a disease that impacts between 500,000 and 1.5 million Americans and has an economic burden of at least \$14.4 billion a year in the United States, and prevalence is estimated to more than double by the year 2040.

With the advent of telehealth, my access to Dr. Ray Dorsey, my diagnosing specialist in Rochester, New York, or Dr. David Perlmutter, my neurological health coach in Naples, Florida, can be achieved with the use of existing and improving technology, thereby providing me with the counsel and tracking I rely on in a safe and comfortable environment, saving me and my family costs for care, travel, and productive time.

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With use of a telehealth link established between Dr. Dorsey and the University of Delaware's Nurse Managed Health Care facility, I can now safely visit with Dr. Dorsey on a frequent basis consistent with my diagnosis in a medically staffed local facility and receive his evaluation of my disease progression and recommendation for treatment.

Part of the invaluable experience of telehealth is a real-time visit with my specialists. As long as I am in a private environment, I feel that I can speak as candidly with my doctor as I can when face to face. The improvements of this technology serve to enhance and expedite the one-on-one interaction with a specialist, not detract from it. I can say that I don't feel as comfortable as I do with an office visit, but in lieu of traveling long distances, waiting to be seen in an office, and experiencing the other logistics of planning for an office visit, telehealth technology serves to provide me with a doctor-patient consult that surpasses searching for and traveling to a specialist who may be hundreds of miles away or more.

In establishing the telehealth link at the University of Delaware, issues of patient privacy, across-State licensure, reimbursement, and the always looming liability immediately came into play. It took the interaction of several legal and government channels months of negotiating before allowing Dr. Dorsey from New York to speak with me in a doctor-patient relationship in Delaware, leaving me without interaction with a medical specialist for more than 18 months.

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Why? Because the legal financial and licensure channels are so convoluted that it took that long to sort through the terms and conditions in order to allow this exercise to proceed.

For the Parkinson's community, telehealth has the potential to be an extremely useful tool in providing greater access to specialists, such as neurologists or movement disorder specialists. In order to provide the data needed to inform the needed policy changes, Dr. Dorsey, in partnership with the National Parkinson Foundation, is currently executing a Patient Centered Outcomes Research Institute-funded study on the quality and effectiveness of treating people with Parkinson's via video conferencing. Dr. Dorsey and NPF hope to build on previous smaller studies to prove that expert care is important for Parkinson's patients and that it can be delivered via virtual house calls.

In conclusion, for people with Parkinson's or other complex diseases, I believe telehealth is a present day solution to address the serious issue of access to proper medical care. Through advocacy organizations such as the Parkinson's Action Network, I look forward to working with members of the committee to find commonsense solutions to the hurdles that face the utilization of telehealth in order to improve the quality of care for patients across the country.

Thank you again for allowing me to testify today, and I would be happy to answer any questions.

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Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Chard follows:]

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Mr. Pitts. And now recognize Ms. Jones 5 minutes for an opening statement. If you will just pull the mike a little bit closer, that helps members here. Thank you.

#### STATEMENT OF KOFI JONES

Ms. Jones. Mr. Chairman, Mr. Ranking Member, and members of this committee, I thank you for this tremendous opportunity of testifying before you today. I am here today on behalf of my company American Well. Based in Boston, Massachusetts, American Well was founded in 2006 by two brothers who also happen to be physicians. Their goal was simple: transform healthcare delivery through technology and improve access to quality care by removing traditional barriers to healthcare delivery, such as distance, mobility, and time constraints.

American Well's telehealth platform is used by health plans, individual providers, pharmacies, delivery networks, hospitals, and employers all over the country offering real-time, synchronous, audiovisual, HIPAA-compliant, and secure on-demand health care from any location to any location, on the Web or even in the palm of your hand through mobile apps. And health plans like WellPoint, through its LiveHealth Online national telehealth initiative, have made telehealth encounters an integrated benefit for all of their customers.

These technologies offer the opportunity to move appropriate care

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to lower-cost settings, into the home or workplace, or bring care to where it is currently not available, like schools, prisons, or rural areas, lacking facilities or healthcare providers. Telehealth has been shown to reduce unnecessary ER utilizations, hospitalizations, or even general overhead, as well as support preventative care efforts for chronic care patients.

I am acutely aware that I sit this morning before a panel of distinguished policy leaders who have already heard from a knowledgeable panel and know all too well that we as a Nation are at a critical juncture in our healthcare journey. However, despite the accelerating momentum for telehealth we have many questions left to answer as a Nation before telehealth can reach its full potential. That is why I applaud this committee for having this hearing.

First, I would like to raise an issue that should be the backbone of this entire discussion: patient safety. Medical boards and similar boards across the Nation not only deal with licensure, but what is considered appropriate practice or clinically appropriate care to provide to patients.

Now, currently there exists an inconsistent patchwork of State laws that have inhibited the deployment of telehealth in both the private and public sectors. There have been several proposed solutions to this, including the Telehealth Modernization Act, a bipartisan measure introduced this past December by Representatives

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Doris Matsui and Bill Johnson, which provides States with clear definitions and principles they can look to for guidance when developing new policies that govern telehealth. And just this past weekend the Federation of State Medical Boards ratified a new model national telehealth policy. The FSMB's new model policy marks the first time the medical community has unilaterally acknowledged the extremely beneficial impact that telehealth has had in the practice of medicine.

Whatever the solution to the 50 State regulatory environment, we need to strike a balance between innovation and patient safety.

Second, we face issues with licensure. Currently, there exists a home field rule: Providers must be licensed in the State where they provide care. These days, doctors and other healthcare professionals can be physically located in one State while their expertise is required in another.

Licensure is a lengthy and costly process for providers and each State has its own set of rules. Now, there are many ways to address this, one of which is the bipartisan TELE-MED Act introduced by Representatives Frank Pallone, ranking member of this subcommittee, and Devin Nunes, and that would allow Medicare patients to be cared for by a licensed provider in any State.

Ultimately, the issue of licensure will need to be addressed if we are to allow telehealth to reach its full potential, and that

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solution will need to both allow providers to provide care when and where it is needed while ensuring the oversight necessary to ensure patient safety.

And finally, we should address the issue of payment: reimbursement. The Social Security Act defines telehealth and how Medicare will reimburse for telehealth services. That language was crafted in the year 2000, 7 years before the first iPhone, the iPhone you now can get real-time live health care on. Imagine what this language would look like if we crafted it today.

This outdated language says that patients can only receive care if they are in a rural area presenting from a clinical site. That means patients still need to get into the car to receive care, and cities don't count. This is widely viewed as one of the major barriers to the full and complete deployment of telehealth.

In summary, by the end of the decade, the terms online care, virtual care, telemedicine, and telehealth will all be antiquated. Telehealth will simply just become health care and replace a significant portion of in-person care. As these technologies are proven to improve outcomes, they will become the status quo.

Thank you again for the opportunity for presenting before you today, and I am happy to answer any questions.

Mr. Pitts. Chair thanks the gentlelady and thanks all the witnesses for their opening statements.

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[The prepared statement of Ms. Jones follows:]

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Mr. Pitts. We will now begin questioning, and I will recognize myself 5 minutes for that purpose.

And let me start with you, Tom. How has the advancement of telehealth in recent years benefitted your health system? Be specific, if you can.

Mr. Beeman. Let me address what the electronic health record has allowed us to do in our ability to leverage the new data that we have to deploy our resources more efficiently. Before we deployed the electronic health record, we could not tell you how many diabetics we had in our health system. We care for about 300,000 patients in our community. We could tell you we have a billion bits of data, but we could not marshal that data to have good information for our patients.

Today, I can tell you that we have 280 diabetics in our Lincoln Family Medicine practice. We know that 270 of them are consistent with their regimen for insulin, 10 of them are noncompliant. We can deploy a nurse navigator on those 10 and really assist them in getting the resources that they require. As an example, we found one of our patients was a gambler, had gambled all his money, could not buy the insulin. We can help through resources to get him that insulin to really help improve his life, and that really is what, you know, health care is really about.

Just the other thing I would mention on the Care Connections. We are talking about medical assistance patients that are the most

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difficult, most troubled patients that we have in our community, the most vulnerable. They use multiple sites for health care. By coordinating their care, leveraging technology, we can bring them the dignity that they need and want and deserve, and we can also dramatically reduce the cost of medical assistance care, which many of my colleagues say can't be done. And we actually believe that you can actually manage those patients' care more effectively if you really concentrate on marshaling those costs rather than spending more money on their care.

Mr. Pitts. Just a quick follow-up. The administrative burden that Congress and the Federal Government has placed on providers also takes time away from patients. It is something this committee sought to partially address in Dr. Burgess' SGR reform bill, H.R. 4015, but much more needs to be done. In the meantime, are there ways in which you could imagine telemedicine easing the administrative burden on providers, thereby freeing up more time for the care patients?

Mr. Beeman. I think it already has. We routinely use e-visits for which we don't get paid for, but most of my physicians would say they would rather not have inappropriate visits to their office and respond through e-visits. Of course, they would prefer to get paid for it, which creates all sorts of headaches for us as far as how do you incent your physicians to focus on quality when they can't get paid for those. But most of them respond at night, early in the morning

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to a lot of their patients. So I think there is opportunities to really break through some of the barriers.

I think the best thing that Congress can do is to really focus on things like bundled payment, the MSSP program, and helping us be more at risk, and then we can leverage those technologies. And we want to be held accountable for quality and cost. Let us do that and help break down those barriers, sir.

Mr. Pitts. Dr. Mehrotra, in health care we have frequently seen new technologies promise to save money but in reality creating a new way for providers to bill the Medicare program. If Congress were to act to encourage further adoption in Medicare or other healthcare programs, how can we ensure that telemedicine actually does deliver the savings that it promises?

Dr. Mehrotra. I think you raise a critical issue, and I would maybe echo what Dr. Beeman said, which is that it is a combination of having accountability through quality metrics that actually say this provider, what is the quality of care that they are providing for this patient, irregardless of how they are providing that care; as well as the financial responsibility through bundled payment and other programs that actually make sure that they have the flexibility with the single payment to decide what is best for that patient in that clinical encounter. And I do fear that encouraging telehealth through fee-for-service might be a mechanism to actually increase healthcare

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spending.

Mr. Pitts. Dr. Bashshur, in your opinion, can the recognition and expanded use of telemedicine in Medicare help lower costs for patients and the government?

Mr. Bashshur. The expansion of reimbursement for Medicare patients is not likely to increase the cost to the government, but it all depends how it is administered. I think there are good ways and bad ways of doing things. The telemedicine intervention itself, the modality in telemedicine does not inherently encourage increased use of service. We have plenty of evidence and programs that have been pondered where the patients don't pay out of pocket where the use of telemedicine has been extremely low.

The point that my colleague, Dr. Mehrotra, raised regarding overuse of service has not been borne by any facts in the situation. Among all programs delivering care in the country none has experienced a flood of people using this modality of care. It has been extremely low.

Mr. Pitts. Thank you. I have other questions, but my time has expired, so I recognize the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. Pallone. Thank you, Mr. Chairman.

I wanted to start with Mr. Chard. Thank you for being here today to share your experience in using telehealth to help you manage your

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Parkinson's and maintain the quality of your life. It is important for people like you to speak out about when the healthcare system works for them and when it doesn't, and stories like yours are why I care a lot about this issue.

So I wondered if you could tell us a little more about your telehealth experience. What was it like before you had the ability to receive care using telehealth? Are there times when you had to travel to see a specialist because they weren't licensed in Delaware? And what you have liked about your telehealth experience. In what ways, if any, do you think it could be improved? It is a lot.

Mr. Chard. Thank you, Mr. Pallone. To start with, when I moved from upstate New York to Delaware, I had already been diagnosed with Parkinson's disease, and I began researching looking for a neurologist that could help with my symptoms and give me continuing diagnosis and treatment. And I was unable to find a movement disorder specialist in the State of Delaware.

To my pleasure, Dr. Dorsey, my diagnosing physician, moved down to Johns Hopkins University, which brought him into range at least at Baltimore, a little over an hour drive for me. But it was, you know, a half day, three-quarters of a day out of production. I would take my wife with me to make sure we got there safely in and out.

So the experience in moving to Delaware was that we were unable to find the resources that we needed in the State. We had the

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opportunity of driving up to Pennsylvania, but it was one way or the other we had to travel in order to find the resources.

In the interim Dr. Dorsey moved back to Rochester, New York, and the aspect of telehealth has been introduced through Dr. Dorsey and the University of Delaware, and as I mentioned earlier in my testimony, the licensing issues were constricting the ability to access Dr. Dorsey, who was my primary neurologist, movement disorder neurologist. So since the telehealth link has been established, I have been able to meet with Dr. Dorsey via the telehealth link in a secure setting with secure information privately and be able to share with him and he would share with me his opinion and recommendations for my care.

Mr. Pallone. And just going back to the last part, in what ways, if any, do you think we could improve telehealth experience?

Mr. Chard. Technologically, I think the improvements are all pretty strong right now. Legislatively, I would think that easing the process and making sure that there is a reimbursement program. It is out-of-pocket costs right now. Making sure there is a healthcare reimbursement program of some sort to ease the cost of establishing that telehealth link would be beneficial.

Mr. Pallone. Well, thank you very much.

Let me ask Dr. Mehrotra, again, thank you for sharing your perspective. But you noted the use of telehealth has a lot of potential

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to improve the healthcare delivery system and the Medicare and Medicaid programs are tremendously important. So as we think about expanding uses to telehealth in Medicare and Medicaid, we have got to make sure we are thoughtful, we go about it in the right way, particularly with regard to patient safety and cost effectiveness. So could you just speak a little more about the risks that my colleagues and I should consider as we look at expanded use of telehealth?

Dr. Mehrotra. You know, I think maybe an analogy would be helpful in this circumstance as we think about many patients who will benefit and many patients who may not benefit. And I might use the example of cardiac catheterization. Cardiac catheterization for many patients, either as a diagnostic or treatment for heart disease, is life saving.

On the other hand, as you are well aware from some of the press as well as research that has been done, is in many cases cardiac catheterization is used inappropriately and does not benefit care and has been overutilized and potentially could be driving healthcare spending up. That is the theme of many of the technologies that have been introduced in health care, this two-edged sword, that it helps in some cases and it doesn't. And I think that is the real issue as we try to figure out how telehealth can be beneficial.

In many cases, including Mr. Chard, telehealth is probably a very beneficial kind of therapy, but how do we make sure that it is not

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overused?

Mr. Pallone. All right.

And then, Dr. Bashshur, just briefly, if you think telehealth can be used effectively to treat more patients at lower cost, you suggested that. Can you just give us an example, perhaps?

Mr. Bashshur. The example has several parts to it, if I may explain it. There are different elements of cost here, and our cost to the consumer is rarely considered by the payers because they are not responsible for it. That element of cost is always reduced because if they don't have to travel, they don't have to encumber the cost. There is also the convenience and the waiting times and sometimes time lost from work. So there are several aspects of cost that must be considered in their totality as a way to deal with the problem.

Mr. Pallone. All right. Thanks a lot.

Thank you, Mr. Chairman.

Mr. Pitts. Chair thanks the gentleman.

I now recognize chair emeritus of the full committee, Mr. Barton, 5 minutes for questions.

Mr. Barton. Thank you, Mr. Chairman. And I am sincere in saying I appreciate this hearing. I think this is really important, what this subcommittee is discussing today.

I have two general framed questions, and I will put them out on the table and anybody who wants to answer them. First question is

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concerning the privacy of the records that are generated by the telehealth or telemedicine. How secure are the medical records if you use this technology?

And the second is a Medicare, Medicaid billing issue. I am told there are some concerns that if the doctor is in one place and the patient is in another and the health insurance is in another place, that Medicare and Medicaid sometimes are unwilling to or don't know quite how to cost the charges that result from a telehealth or telemedicine visit.

So if anybody wants to take a crack at either of those two, the privacy issue or the billing issue, I am all ears.

Mr. Bashshur. If I may, I would deal with the privacy issue and leave my colleague to answer the other question.

Mr. Barton. I will come to you after him.

No go ahead, sir, and then we will go to the young lady down there. Either one of you. You are both going to get to talk.

Mr. Bashshur. I yield to her.

Ms. Jones. Thank you.

It is an excellent question. I think privacy is of the utmost concern. Most certainly, our technology is HIPAA compliant and secure. All information contained within the encounter is secure and kept on a server. I won't pretend to be able to describe the server from a technology standpoint, but everything is HIPAA compliant and

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secure.

For the most part, you will find from a policy perspective that that is kind of the emerging understanding of what is required for a telehealth encounter to be considered secure. The emerging policy, including from the Federation of State Medical Boards that was just passed this past weekend, is that that should be in place within the context of any given telehealth encounter.

So it most certainly is within our platform. Many of the telehealth programs that are out there now support HIPAA compliance and security to protect any PHI information. So that is occurring. It is the emerging standard within policy. It is most certainly contained within the Telehealth Modernization Act that just came out this past December. So it is the emerging standard within any telehealth technologies that you see out there and critically important in ensuring patient safety and security.

Mr. Barton. Doctor.

Mr. Bashshur. Yes, I agree. We have to be HIPAA compliant, and that really answered the question about security for the patient. If we violate, we will be in deep trouble, so we avoid trouble.

With regards to Medicare and Medicaid billing, there are some differences. Typically, as you know, there is the CPT code that we have to submit for billing purposes and these are issued by CMS. Their use in the country is still extremely limited. For example, during

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the entire year of 2013 the total expenditures for telemedicine services for Medicare patients has been only \$12 million for the entire country.

Mr. Barton. So it is basically not being used for Medicare?

Mr. Bashshur. Because of the restrictions that are placed on it, yes, absolutely.

Mr. Barton. Well, if each of you will give some thought to that and put in writing some suggestions on how to correct that to the subcommittee, we would appreciate it.

[The information follows:]

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Mr. Barton. I believe we would have a bipartisan agreement that we shouldn't let a billing problem prevent doctors and patients from using this technology. We ought to be able to come up. And I don't think it will take legislative action so much as it might just take a letter from members on both sides of the aisle of this committee and subcommittee to Medicare and Medicaid and CMS to give them some guidance on what they should do in terms of billing.

So with that, I yield back, Mr. Chairman. But again, thank you for the hearing.

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RPTS KERR

DCMN WILTSIE

[11:00 a.m.]

Mr. Pitts. The chair thanks the gentleman.

We have just been called to vote. We are going to continue. The chair recognizes the ranking member emeritus, Mr. Dingell. Five minutes for questions.

Mr. Dingell. Mr. Chairman, thank you for your courtesy and thank you for having this hearing.

I would like to welcome our distinguished panel, particularly Dr. Bashshur, who is a constituent of mine from the University of Michigan and is the Executive Director of the health -- for eHealth at the University of Michigan Health System.

It is a pleasure to have the whole panel with us today, but especially you, Dr. Bashshur.

Now, I have a number of questions which I hope that you will answer "yes" or "no" in order to save time.

Doctor, is it correct that spending on chronic illness accounts for 75 percent of health expenditures in the U.S.? Yes or no.

Mr. Bashshur. Yes. In approximate --

Mr. Dingell. Now, Doctor, given your expertise in the area, do you believe that investing telehealth -- in telehealth technologies

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to improve chronic disease management will save money over the long run? Yes or no.

Mr. Bashshur. Yes.

Mr. Dingell. Doctor, I want you to know that we would like to have you submit additional information as you might feel necessary later so that we have the benefit of your full judgments here.

Now, while the Affordable Care Act has done a great job in making health care more accessible to the American people, I think most people continue to believe that much more must be done to improve access to care for the people in this country with unmet medical needs.

Now, Dr. Bashshur, I know that you have done several studies about increasing access to health care.

Do you believe that the use of telemedicine can help improve access to care in medically underserved communities like the Upper Peninsula in Michigan? Yes or no.

Mr. Bashshur. Yes.

Mr. Dingell. Now, Doctor, rural areas are not the only part of our country with citizens who have unmet medical needs, yet telemedicine in this country today is mostly faced -- mostly focused on rural areas.

Doctor, is it correct that, generally speaking, CMS has limited physician reimbursement for telehealth to services provided in rural areas? Yes --

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Mr. Bashshur. Yes.

Mr. Dingell. -- or no?

Mr. Bashshur. Yes.

Mr. Dingell. Do you believe that is a good limit?

Mr. Bashshur. No. I don't think so.

Mr. Dingell. Now, how else has CMS restricted reimbursement for telemedicine in the United States today?

This does not require a yes or no. It requires a quick answer to be followed by a followup in your -- in additional remarks.

What do you have to say on this, Doctor?

Mr. Bashshur. CMS requires synchronous live video conferencing with a presenting provider on one end at the originating site and connected to a specialist at the remote site.

This happens to be the least efficient mode of telemedicine service. The so-called asynchronous mode is more efficient.

Now, Doctor, Alaska and Hawaii are exempt from CMS reimbursement restrictions.

Is the use of telehealth more prevalent in those States in comparison to the continental 48 States? Yes or no.

Mr. Bashshur. Yes.

Mr. Dingell. Do you believe that telehealth technology used in Alaska and Hawaii are a model for the rest of the country? Yes or no.

Mr. Bashshur. Yes.

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Mr. Dingell. Doctor, I want to thank you. I want to express my respect and high regard for you and, also, to the other members of the panel.

I look forward to any additional remarks that you or any of the panel members might submit to any of the questions in order that we could have the fullest expression of your thoughts and views.

Thank you, gentleman and ladies, for being here this morning.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the vice chairman of the subcommittee, Dr. Burgess. 5 minutes for questions.

Dr. Burgess. I thank the chairman for the recognition.

Mr. Chairman, I just wanted to point out there is an online medical community called "medscape.com," and Dr. Eric Topol, who is their editor-in-chief, actually had an article addressing this issue.

His conclusion to the article: "If you fast-forward over the next 5 years, we will be doing a lot of office visits in a completely different way, and whether they are telephone consults or video links with transmission of the data in real time or in advance, it is a different look, so we should be getting ready for the virtual physician visit with patients in the years ahead."

I would like to ask unanimous consent that we submit Dr. Topol's remarks for the record.

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Mr. Pitts. Without objection, so ordered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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Dr. Burgess. And I think we have heard that same theme expressed several -- several times this morning.

I mean, you heard my anxiety, Dr. Beeman, along the old CPT code that I found one day. I thought my life was changed, my income will double, and, yet, that was a code that was available, but not reimbursed, back in the HMO days.

What are you doing with your super-utilizer network -- what are you doing to get around those issues?

Mr. Beeman. Doctor, I think one of the big challenges we have in this is we are doing tremendous demand destruction with the anticipation that providing better care and services is the ultimate benefit.

When Lancaster General Health decided to embark on population health management, we actually went through a 3-year process of restructuring our health care delivery system to take out \$100 million worth of cost, and we continue to focus on that through Lean Six Sigma so we can afford to do the demand destruction.

The problem that we have been talking about in telehealth is: It is a tool. It is not the end. And so, when we talk about paying for telehealth, what I think we need to be talking about is putting us health care providers at risk to care for a population and let us deploy the tools that we need in order to manage that.

Dr. Burgess. Let me interrupt you just in the interest of time.

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And I don't disagree with you, but you recognize the real world is -- there are going to be a lot of practices that will live in a fee-for-service world for the rest of my natural lifetime.

And the SGR reform that has been mentioned several times this morning, it tried to acknowledge that. Sure, there are going to be different models of practice, bundled payment ACOs where just the situation you talk about may make sense.

But I got to tell you. I practiced OB/GYN. I practiced for years. My greatest fear was that next-to-the-last patient on Friday afternoon was going to have a blood pressure -- a diastolic blood pressure of 88 where she had always been normal before.

And you know the drill. This is someone who simply could have an elevated blood pressure because their husband wasn't on time for the appointment, they couldn't find a parking place, or it could be the beginning of a very serious illness that within a very short period of time was going -- she was going to be critically ill.

So I am sitting in the clinic at 4:15 on a Friday afternoon. I got no way of knowing -- some other parameters you can check to be sure. But even if they are all normal, you still have no way of knowing.

How great would it be to have her with a blood pressure cuff at home and a smartphone and to be able realtime, "Send me your next 10 blood pressures and, if it is over X, let's get together right away."

The old days, what was at your disposal? Put her in the hospital

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for the weekend so that someone could monitor the blood pressure.

And if you didn't do that and she really was severely pre-eclamptic, the next visit was at 3 o'clock in the morning in the emergency room with a seizure, with organ damage. I mean, it was a big deal if you guessed wrong.

This will eliminate a lot of the guesswork out of that type of practice. And, you know, I would argue, too -- you know, someone brought up the issue of overuse.

I mean, if we reform our liability laws in this country, maybe we can get around some of those problems as well. But I would be interested in your thoughts on that.

Mr. Beeman. Doctor, I agree. I think right now we are deploying a lot of this technology in aspirational hope that it will pay for itself by better health care.

And some of it is deployed because we would rather keep the patient out of the hospital and healthy than we would seeing them one more time in the emergency department.

And, in some respects, with a medical assistant's patient who uses that as a primary care office rather than an office, it allows us to take the office to them rather than have them use the emergency department.

Dr. Burgess. Let me just ask you this. And we are going to run out of time. But, in your opinion, are there conditions where the

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potential for misdiagnosis, the potential for harm, is of particular concern and it will be inappropriate to use telemedicine?

Mr. Beeman. Yes. I think the --

Dr. Burgess. Right answer. Thank you.

Ms. Jones, I just wanted to follow up on Mr. Barton's questions on the issue of privacy. And I am glad you brought that up. I hope you will provide some thoughts to the committee in writing that he requested.

Clearly this needs to be a balanced conversation. I remember having this discussion in 2007 with a CEO of a big insurance company.

They were doing a lot of stuff with the -- just financial data where they could perhaps predict outcomes in future medical issues.

And one of things he said to me was, "You have got to define privacy and stop changing your minds every 3 months." And I hope you will help us with that conversation because it is a critically important conversation to have.

Ms. Jones. Certainly. We are more -- more than eager to be partners in this conversation.

I think one of the things that we have always uphold -- upheld as an organization is that there are some principles that uphold the highest common denominator of care, some things that should be in place so that providers who are providing care via telehealth have the ability to use the very same discretion that they use in person while they are

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providing care electronically.

And the infrastructure that is kind of required there are things like HIPAA compliance, documentation of care, continuity of care. There is some discussion around formulary and what kind of prescribing isn't appropriate, identity of the provider being affirmed, identity of the patient being affirmed.

So I think some of these kind of principles that create the infrastructure for safe and secure telehealth need to be discussed because, when you have those in place, then, again, you are in a position where you are creating a safe and secure environment and these physicians can decide -- use the very same discretion that they use in a face-to-face encounter to say, "Yes. This is appropriate for care," "No. This is not appropriate for telehealth care," "Yes. I have this expertise," "No. I need to refer for in-person or refer to another expert."

And those are very important discussions to have and ones that we have on an ongoing basis.

Dr. Burgess. Mr. Chairman, thank you very much for the time. I know a vote is close. So I will yield back.

Mr. Pitts. The chair thanks the gentleman.

Unfortunately, we have been called to the floor on the vote. I think we only have a couple of minutes to go to get there. And so we have lost our Members.

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Members will have a lot of other questions we would like to submit to you. We will ask that you please respond promptly in writing.

This is not the end of the discussion. It is just the beginning. I look forward to working with my colleagues, with all of you, as we pursue this issue.

I remind Members that they have 10 business days to submit questions for the record, and they should submit those questions by the close of business on Thursday, May the 15th.

This is a very important issue. Thank you very much for your time, for coming, for your expertise. And we will continue to work with you.

Without objection, the subcommittee is adjourned.

[Whereupon, at 11:11 a.m., the subcommittee was adjourned.]