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Subcommittee on Health

Telehealth to Digital Medicine: How 21st Century Technology Can Benefit Patients

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Mr. Chairman, Mr. Ranking Member, and Members of this Committee – I thank you for the tremendous opportunity of testifying before you today. I am here today on behalf of my company, American Well, one of our nation's leading telehealth technology providers. Based in Boston, Massachusetts, American Well was founded in 2006 by two brothers who happen to be physicians. Our mission is to 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 has always focused on demonstrating value and effectiveness, bringing overall satisfaction to patients who rely on our solution, and being an integral partner in the delivery of quality health care.

I am acutely aware that I sit this morning before a panel of distinguished policy leaders who know all too well that we, as a nation, are at a critical juncture in our healthcare journey. Even prior to the expanded coverage through the Affordable Care Act, our health care system was facing enormous headwinds ranging from access to costs. And now, millions of newly-eligible Americans are entering an already heavily burdened health care system.

Primary care shortages, specialty care diversification, a thinning pool of health professionals, and rural access challenges – will continue to rise.

As a nation, we must do what we always do in times of struggle. We must enterprise, we must invent, we must innovate. And I'm pleased to report that we have been. Sitting squarely at the intersection of innovation, technology, and healthcare – is telehealth.

Telehealth – real-time, synchronous audio-video encounters between patients and providers – presents the opportunity to reverse the longstanding paradigm of placing the burden on patients to seek care where it's physically available. Telehealth brings healthcare directly to the patient, when and where they need it – similar to an old-fashioned "house call." It's our latest tool to improve access and quality of care, while doing it in a cost-efficient manner using a patient-centered approach.

These technologies offer the opportunity to move <u>appropriate</u> care to lower cost settings – into the home or the 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 utilization, hospitalizations, and even general overhead, as well as support preventative care efforts for chronic care patients.

Telehealth delivers safe, secure, and cost-saving access to healthcare for Americans who face a multitude of barriers to receiving care in person.

As I said earlier, we have been doing our job as innovators. Momentum for telehealth is accelerating at an undeniable rate.

For example, American Well's telehealth platform is the industry's leading telehealth solution, connecting state-licensed providers and patients for live, immediate, synchronous audio-visual, and clinically meaningful encounters from any location to any location, at any time. Care can be accessed over the web, via smart phone or tablet – literally care in the palm of your hands. Our patented, web-based technology addresses traditional barriers to healthcare access while enabling providers to deliver quality care in a flexible, convenient manner. The system is designed to be HIPAA compliant and secure, and is able to integrate with back-end systems (e.g., claims and gaps-in-care systems, Electronic Medical Records) to support robust continuity of care and information-driven consultations. The solution can integrate with diagnostic and medical devices, enabling truly meaningful and informed care, and supports multi-disciplinary collaboration, including Accountable Care Organizations and Patient Centered Medical Homes.

We clearly don't stand alone. Hospitals and delivery networks like the Cleveland Clinic have been examining their business models. Movement towards population-based payment has sparked an exploration around managing the cost of care, treating the patient as a "whole", and a race to lead in innovation. As a result, hospitals and networks of all shapes and sizes across the nation are actively considering the value of online medical care, both for urgent, acute, symptomatic care, as well as chronic care management.

Physicians in both hospital and private practices are embracing telehealth to extend their reach and follow up with their patients at home. Even retailers and pharmacies like CVS and Walgreens are getting on board, offering their customers access to medical services by combining onsite providers with off-site telehealth-based physicians.

And the dollars are following the interest. As we enter 2014, nearly all state Medicaid programs now reimburse for some form of telehealth service. Nearly half of all states mandate telehealth reimbursement for commercial plans, often on par with in-person visits. These policies are rapidly expanding, with new proposals emerging on an ongoing basis.

And the U.S. Department of Veterans Affairs, arguably one of the most telehealth-progressive agencies in the nation, has not only eliminated co-payments for in-home telehealth, but supported nearly early 1.5 million episodes of care in 2012 – reducing bed stays, hospital admissions, and delivering nearly $2,000 in savings per patient.[1]

And of course, you can't underestimate the value of consumers, who are driving the discussion now more than ever – most evidently by using mobile technologies that put healthcare decision making in the palm of their hand. Mobile devices can significantly mitigate time and distance barriers, regardless of location, socio-economic status, or mobility issues. iOS and Android devices literally make on-demand , affordable healthcare – like that enabled by American Well – available anytime, anywhere. It is the epitome of patient-centered health care.

However, while innovation in telehealth progresses and doctors, hospitals, and governments take positive steps to encourage this kind of care delivery, we still have many questions to answer as a nation before telehealth can reach its full potential. This is why I applaud the committee for having this hearing. It is an ideal opportunity to both identify the great opportunity that exists, and to honestly pin point the challenges.

As I spend the entirety of my professional life working to identify and try to solve the challenges that exist within the telehealth environment, I'll do my best to do the same here.

Ensuring Patient Safety and Clinical Permissibility

First, I would like to raise an issue that should be the backbone of all of this discussion – patient safety.

[1] *Telehealth Services in the Department of Veterans Affairs* - Adam Darkins, Chief Consultant for Telehealth, U.S. Department of Veterans Affairs

Medical Boards, and similar boards across the nation, not only deal with licensure, but what is considered appropriate practice or clinically permissible care to provide to patients. Currently, there exists an inconsistent, patchwork of state laws that have inhibited the deployment of telehealth in both the private and public sectors.

With 50 sets of rules, and 50 different definitions of what telehealth is, both providers and patients are in a state of limbo, asking questions such as: Can I, as a provider, deliver care while still being compliant in all 50 states? Can I, as a patient, trust the care I receive via telehealth is safe and secure? These uncertainties have created an unnecessary barrier to realizing the true promise of telehealth.

There have been several proposed solutions to this as well:

The *Telehealth Modernization Act* (H.R. 3750), a bipartisan measure introduced this past December by Representatives Doris Matsui and Bill Johnson, both members of this Committee, provides states with clear definitions and principles they can look to for guidance when developing new policies that govern telehealth. These principles are consistent with the existing standards for in-person care so as to ensure the safe and secure use of telehealth in medical practice.

And just this past weekend, the Federation of State Medical Boards (FSMB) ratified new model national policy - the *Appropriate Use of Telemedicine in the Practice of Medicine* – at its annual meeting in Denver. This marks the first time the medical community has unilaterally acknowledged the impact technology has had on the practice of medicine, and like the *Telehealth Modernization Act*, offers guidance to states looking to modernize their existing telehealth rules.

Both of these pivotal documents support the concepts that a treatment relationship can be established online, and that every telehealth encounter should uphold the same standard of care as a face-to-face encounter, confirm the identity of the patient and provider, establish access to medical history, include full documentation, and foster continuity of care – the very standards which are upheld in doctor's offices, clinics, and hospitals throughout the country.

Whatever the solution to the 50-state regulatory environment, we need to strike the balance between promoting further innovation and evolution in healthcare, while ensuring the proliferation of verifiably safe and secure telehealth models.

Licensure

Second, we also face issues with licensure.

Currently, there exists a "home field rule." Providers must be licensed in the state where they provide care. Before recent technological advances, this wasn't as much of an issue. Providers generally lived and worked in the same state. Now, doctors and other healthcare professionals can be physically located in one state, while their expertise is required in another. An endocrinologist in Boston may have expertise desperately needed in a rural Texas community. But to provide direct care to patients via telehealth, that physician needs a Texas license as well. Licensure is a lengthy and costly process for providers, and each state has its own rules around standards-of-care and scope-of-practice regulations, particularly where telehealth is concerned.

There are many ways to address this. In 2000, the National Council State Boards of Nursing launched the Nurse Licensure Compact to expand the mobility of nurses. The Compact allows nurses to have one multistate license, through a streamlined process without additional applications or fees, with the ability to practice in both their home state and other party states. To date, it's been adopted by 24 states.

The FSMB is now considering another approach that would result in facilitated multiple state licenses. This method would accelerate the licensure process for physicians who meet the eligibility requirements by consolidating application paperwork.

Another approach was signed into law just under two years ago, the bi-partisan STEP Act for Department of Defense healthcare professionals does away with location requirements. This spurred the bipartisan VETS Act (H.R. 2001), currently pending before Congress, which would enable Department of Veterans Affairs' health professionals to serve any veteran in the U.S. without the need for multiple state licenses.

And the bipartisan TELE-MED Act, H.R. 3077, introduced by Representative Frank Pallone, the Ranking Member of this Subcommittee, and Representative Devin Nunes, would allow Medicare patients to be cared for by a licensed provider from any state.

Ultimately, the issue of licensure will need to be addressed if we are to allow telehealth to reach the potential of balancing provider supply and patient demand – as these two variables do not particularly pay attention to state boundaries.

Whatever the solution, we will still need an effective and efficient system to both allow providers to provide care when and where it's needed, while providing the oversight necessary to ensure patient safety.

Reimbursement

Finally, we should address the issue of payment – reimbursement.

As I stated earlier, many states have mandated commercial payers to reimburse for telehealth consultations, but such practices are not necessarily required. Health plans like WellPoint, through its LiveHealth Online national telehealth initiative, have made telehealth encounters an integrated benefit for all of their customers over the next 24 months. Patients pay their standard cost-share to visit with a state-licensed and credentialed physician, specifically trained in providing care via telehealth.

But we cannot have a conversation about telehealth reimbursement without talking about Medicare. CMS sets the tone for healthcare in this nation, and both public and private leaders follow suit.

Section 1834m of the Social Security Act defines telehealth and how Medicare will reimburse for telehealth services.

This language was crafted in 2000. One year before the IPod was invented. Three years before the first Toyota Prius hybrid came off the assembly line, and 7 years before the first IPhone – the IPhone you can now get real time, audio/visual, HIPAA compliant, informed healthcare on.

Imagine what this language would look like if we crafted it today.

The outdated language from 2000 says that patients can only receive care if they are in rural area, presenting in a clinical originating site. That means patients still have to drive to receive the care they could actually get on this phone in order for reimbursement to take place, and if they live in a city, all bets are off. Considering the wait times to see a provider in some of our nation's urban areas, this appears prohibitive.

This rural, originating site stipulation contained within Section 1834m has had a powerful effect. The majority of the 46 states which have used the latitude afforded them to create their own telehealth reimbursement policies under Medicaid, have basically mirrored the Medicare policy.

Further, many state medical boards have implemented telehealth policies which require patients to be at originating sites in order for care to be considered "compliant."

Section 1834m is widely viewed as one of the major barriers to the full and complete deployment of telehealth. Granted, re-writing it would substantially increase access, but naturally lead to questions of utilization and cost – since more recipients would have access to care electronically.

However, Congress, and the Congressional Budget Office would have the insight of the US Department of Veterans Affairs, payers like WellPoint, and some of the more innovative state Medicaid programs to look towards as it examined questions of health outcomes, efficiencies, and cost savings. Colorado, Kansas, and Washington are among the states which have used various tools at states disposal to create thoughtful Medicaid reimbursement practices.

Further, organizations like the American Medical Association, the American Academy of Family Physicians and, West Health have also committed to examining access and cost savings associated with the wide utilization of telehealth.

Much of this work has been done.

Conclusion

In summary, by the end of the decade, the terms online care, virtual care, telemedicine, and telehealth will all be relegated to the history books. Just as this generation conducts its banking transactions on their iPhones and has access to nearly every product and service online, students currently entering medical school will start practice in a healthcare environment where technology and care delivery are intertwined.

Telehealth will simply become healthcare, and replace a significant portion of in person care. As these technologies are proven to improve outcomes and reduce costs, they will become the status quo.

The question for us is, how do we lay the infrastructure to ensure that these technologies are safe, secure, efficient, accessible, and cost efficient, and I, for one, am eager to be a partner to you.

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