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Subcommittee on Health**

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Chairman Guthrie, Ranking Member Eshoo, and Members of the Health Subcommittee of the Committee on Energy and Commerce, thank you for the opportunity to testify today about the importance of telehealth on behalf of the American Heart Association and its more than 40 million volunteers and supporters. My name is Lee Schwamm, MD, FAHA. I have been an advocate for the American Heart Association for nearly 25 years, including service on the Association's national board of directors and its advocacy committee. I am a past chair of the American Stroke Association Advisory Committee and the Association's Quality Healthcare Certification Science Committee, in addition to having served and continuing to serve on numerous Association committees including its Artificial Intelligence Advisory Taskforce, Virtual Care Initiative, and Center for Telehealth Expert Panel. I am a lifelong champion for the use of telemedicine and digital health solutions to increase access to care and reduce health disparities. Under my leadership, the American Heart Association Get with the Guidelines—Stroke Registry was created in 2001 (with funding from the Centers for Disease Control and Prevention's National Acute Stroke Program honoring the late Georgia Senator Paul Coverdell) to translate evidence into practice and reduce hospital-based care disparities. In the past two decades it has grown into the world's largest stroke registry with more than 8 million patient encounters, has changed stroke practice at hospitals across the United States, and set a global standard for stroke care.

I pioneered the development of telemedicine for stroke care, called telestroke—now a routine part of acute stroke care. What began in partnership with Senator Edward M. Kennedy and the introduction in the Senate of the “Stroke Treatment and Ongoing Prevention Act of 2001” culminated in the 2019 Furthering Access to Stroke Telemedicine (FAST) Act that required Medicare to reimburse for telestroke services regardless of where a patient receives treatment. I also developed and ran the first, large-scale, national, academic telestroke and teleneurology network that supports more than 50 rural, community and suburban hospitals across multiple states nationally. Lastly, I serve on the Expert Panel of the recently launched American Heart Association Center for Telehealth, guiding the development of evidence-based telehealth certification programs.

Now celebrating our 100th year, the American Heart Association is the largest nonprofit funding source for cardiovascular and cerebrovascular disease research, next to the federal government. The Association has funded 14 Nobel Prize winners and several important medical breakthroughs, including techniques and standards for cardiopulmonary resuscitation (CPR), the first artificial heart valve, implantable pacemakers, cholesterol inhibitors, microsurgery, and drug-coated stents.

I am also a practicing physician with 30 years of patient care and an academic medical center leader. I currently serve as the Associate Dean of Digital Strategy & Transformation at the Yale School of Medicine and the Senior Vice President and Chief Digital Health Officer for the Yale New Haven Health System. I am also a professor of Neurology and Biomedical Informatics & Data Sciences. In my roles as Associate Dean and Chief Digital Health Officer, I help lead the development of a new digital health strategy for the school and the health system and serve as an influential physician leader and an agent of change to catalyze the equitable adoption of virtual care and digital enablement throughout the enterprise.

Before joining Yale, I spent three decades of service at the Mass General Brigham Health System in academic and administrative leadership roles. I was the inaugural C. Miller Fisher Chair in Vascular Neurology, Executive Vice Chair of Neurology and Director of the Center for TeleHealth at Massachusetts General Hospital, Vice President for Digital Patient Experience and Virtual Care, and Chief Digital Advisor for the Mass General Brigham Health System, and a Professor of Neurology at Harvard Medical School. I oversaw all systemwide virtual care and telehealth activities including synchronous and asynchronous virtual visits and consults, remote patient monitoring, virtual urgent care, and online second opinions. During the first six months of COVID pandemic, I led adoption efforts for more than 10,000 clinicians to provide more than 1.7 million virtual visits and introduced a suite of innovative inpatient virtual solutions.

I am an internationally recognized expert in stroke diagnosis, treatment and prevention and a Fellow of the American Heart Association, American Academy of Neurology, and the American Neurological Association. My research has been funded by many institutions including the American Heart Association, National Institutes of Health (NIH) Patient Centered Outcomes Research Institute (PCORI), Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), and others, and I am the author of more than 600 peer-reviewed articles and have chaired many of the current practice guidelines for stroke and telehealth-enabled care delivery. I have received numerous awards for innovation, leadership, and advocacy in the field of stroke and digital health, and served on multiple editorial boards, including as the digital health section editor for *Stroke*, and the international advisory board for *Lancet Digital Health*. I conduct research on digital literacy and serve on the board of directors of Tech Goes Home, a Boston-based non-profit dedicated to improving digital literacy among underserved populations.

Today I am pleased to testify about the ways in which telehealth improves patients' access to quality health care and why failing to make permanent the COVID-era telehealth waivers will result in a tragic loss of access to care for Medicare beneficiaries.

I can speak personally to the tremendous benefit that telehealth has provided for me as a physician caring for patients with complex stroke conditions. It has given me the ability to evaluate how my patients are recovering in their home environment, to determine the safety of that home and the need for additional services, the opportunity to meet many family members I could not otherwise have met—even the occasional favorite dog, cat or parakeet—and to truly “meet my patients where they are.” So often we give lip service to providing “patient-centered” care, but rarely do we deliver on that promise. Telehealth allows us to live up to that promise, especially when a medical condition or social circumstance makes travel to the doctor's office a

physical, emotional, or financial ordeal. When asked about his preference for in-person vs telehealth visits, one of my long-term patients replied along the lines of, “Doctor, I love seeing you in person and shaking your hand, but if I am being honest when I come to an in person visit, I spend 4-6 hours roundtrip and see you for about 30 minutes. But when I do a telehealth visit, I spend 40 minutes of which I see you for about 30 minutes and there isn’t much difference in what we do together in that exam room. I’m so grateful you make yourself available for virtual visits.” At Massachusetts General Hospital, telehealth visits were lifechanging for our adolescent patients with autism spectrum disorders for whom time spent in a waiting room with a lot of other people could cause severe emotional distress. They took to virtual visits immediately and benefitted enormously from this method of care delivery.

The Growth and Value of Telehealth as a Result of Improved Payment Policies

The payment flexibilities for telehealth that accompanied the COVID-19 pandemic dramatically impacted the way that telehealth services were delivered across the country. Prior to the pandemic, because of variable and uncertain payment policies around the country, telehealth was most frequently developed and delivered as standalone services for discrete, simple conditions, targeted toward patients who could pay out of pocket, and largely ignoring disadvantaged and underserved populations. While rural communities were potentially eligible sites of service for reimbursable telehealth care, the patients were required to be located at a hospital or approved clinic which dramatically limited access. Research on telehealth was largely limited to specific specialty services such as telestroke and tele-mental health. As a result, only a minority of patients had experience receiving telehealth and an even smaller minority of health care providers had experience providing telehealth services.

With the payment and eligibility flexibilities accompanying the pandemic, and in subsequent years since that consistent payment environment has persisted, established health care providers have been able to count on reimbursement for services provided via telehealth largely in parity with in-person services. As a result, those services have merged with in-person care into a hybrid integrated care model, delivered via established health care providers, and targeted toward more chronic and complex conditions. The certainty of payment for such services has also led established health care providers to target telehealth services toward those who could benefit most—patients with chronic and complex conditions, who require frequent visits, whose conditions can effectively be managed with telehealth encounters, and those who live in rural and underserved areas. And indeed, current research points to patients with chronic disease utilizing telehealth at higher rates than those in most other disease categories.¹ The assurance of payment has also led health care providers and technology vendors to target expanding access by adding support and services for non-English speaking populations, patients with disabilities, and those with lower digital health literacy, thus narrowing the gaps in health equity and access to care.

A major result of the increased provision of telehealth services by academic medical centers was a substantial proliferation of research into integrated telehealth services across a broad variety of

¹ Alyssa Shell Tilhou, Jain, A, DeLeire, T. *Telehealth Expansion, Internet Speed, and Primary Care Access Before and During COVID-19*. January 5, 2024. Journal of the American Medical Association. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813612>

specialties, conditions, and patient populations. There is now substantial research demonstrating improved outcomes and access across numerous specialties and a vast array of health care services published in recent years.² These studies clearly demonstrate the value of well-designed telehealth programs integrated into the everyday practice of traditional health care.

Low Risk of Fraud and Abuse Associated with Integrated/Hybrid Telehealth Models

I am aware there are concerns about fraud, abuse, overutilization, and lower quality of care when it comes to telehealth-enabled care.

Just as with traditional care providers, telehealth providers also have the potential to provide lower quality services, commit fraud, or promote overutilization. Such abuse is rare, and there is **no evidence** that such abuse is any more prevalent for telehealth services provided by established health care providers than for traditional in-person care. In July 2022, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) published a Special Fraud Alert providing guidance on suspect characteristics of telehealth that may pose a higher risk for such abuse³, and those characteristics clearly point to higher risk associated with standalone telehealth services that are poorly integrated into in-person care services. This by no means indicates that all standalone telehealth services are fraudulent or at risk of promoting over-utilization, but it does provide clear guidance demonstrating that telehealth services delivered via established health care providers as part of a continuum of care for health care delivery do not pose an increased risk of fraud and abuse relative to in-person health care service delivery. Regulations and auditing are already in place to reduce the risk of fraud and abuse in the delivery of in-person care, and providers are required to submit a level of service commensurate with the services rendered. Together they provide a framework that should be equally effective for telehealth-enabled care. Since providers must still be fully engaged with the patient encounter, whether it occurs via a screen or in person, there should be no difference in reimbursement for this activity or opportunity for fraud.

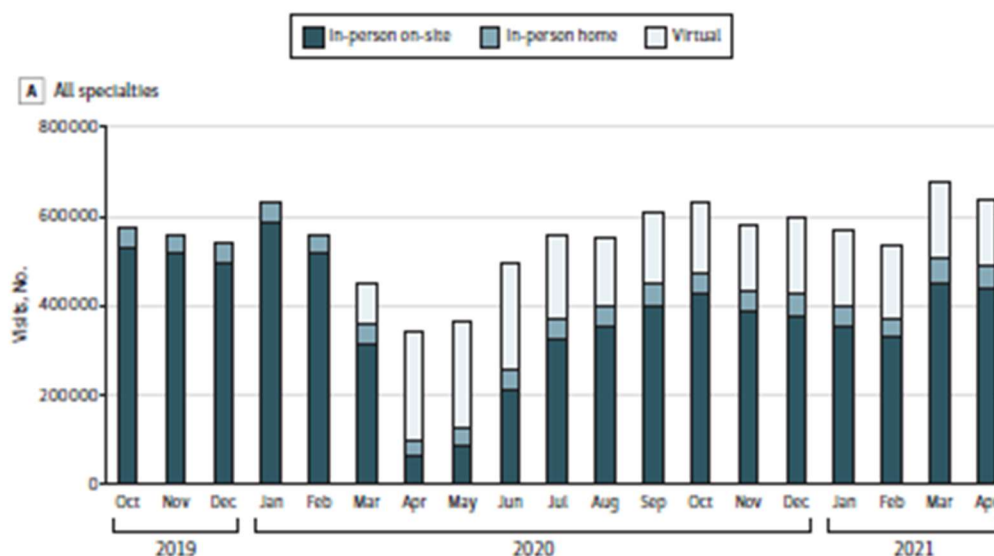
While audio-only virtual visits pose the greatest risk for low value care, they also were a lifeline during COVID and beyond for many patients with low digital literacy, limited English proficiency, and social drivers of health. Strong oversight of audio-only visits, including a requirement for documenting why video was unable to be performed, could preserve this vital delivery modality while limiting risk of fraud or abuse.

As to the issue of churn or overutilization, published data suggest that telehealth visits were largely substitutive rather than additive and lend strength to the argument that these visits consume time from a limited pool of physicians and other providers in the same manner as in-person care and do not lead to overuse.

² Kevin K Wiley, Johnson J, Coleman C, Olson C, Chuo J, McSwain SD. Translating Value Across Telehealth Stakeholders: A Rapid Review of Telehealth Measurement Evidence and a New Policy Framework to Guide Telehealth Researchers. *Telemedicine and e-Health*. April 2, 2024. [tps://doi.org/10.1089/tmj.2023.0211](https://doi.org/10.1089/tmj.2023.0211)

³³ HHS, Office of the Inspector General. Special Fraud Alert: OIG Alerts Practitioners to Exercise Caution When Entering Into Arrangements With Purported Telemedicine Companies. July 20, 2022. [Special Fraud Alert--Telefraud \(hhs.gov\)](https://www.hhs.gov/telefraud)

Figure. Monthly Total Ambulatory Visit Volume by Visit Type (In-Person Plus Virtual) from October 1, 2019, to April 30, 2021



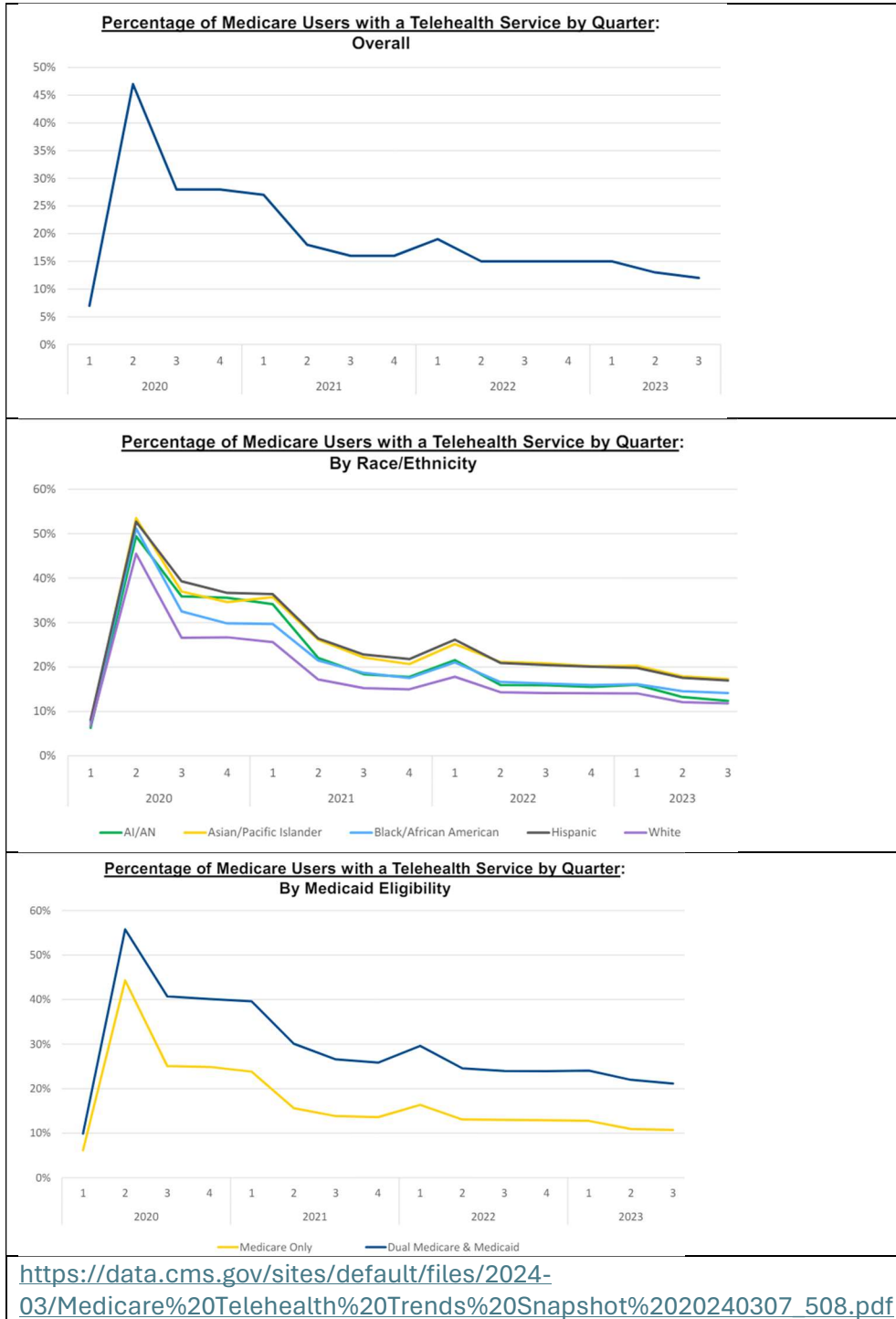
JAMA Network Open. 2021;4(10):e2129973. doi:10.1001/jamanetworkopen.2021.29973

Negative Consequences for Lack of Payment on Integration, Quality, and Equity

It is important to note that failure to continue payment for telehealth services provided by established health care providers will not decrease the risk of low-quality care or inappropriate utilization. On the contrary, it will simply cause a reversion to the telehealth environment prior to the pandemic, when uncertainty and inconsistency around payment led to fragmented services targeted toward consumers who could pay out of pocket. Without certainty of payment for telehealth services, those health care providers who *can* offer in-person services will only offer in-person services, while those who can only offer telehealth services will continue to offer telehealth services but will target those services only to those who can pay out of pocket. Services will be targeted toward simple conditions and likely provided with lower quality and consistency, with the goal of driving heavy utilization, therefore increasing the risk of fraud and abuse, and diverting health care resources from addressing chronic and complex disease, thus increasing the overall cost of care. It is likely that uncertainty around the future reimbursement framework when the waivers expire has contributed substantially to the reduction in telehealth service claims as health systems gear up for a return to mostly in-person care. Medicare beneficiary utilization of telehealth went from a peak of 48 percent in 2020, to 29 percent in 2022, down to a steady state of about 13-15 percent in 2023 (Medicare Telehealth Trends Report) with greater utilization among Asians and Hispanic vs. Black vs. white patients.⁴ In addition, Dual Medicare and Medicaid eligible patients used far more telehealth than Medicare-only patients. These data demonstrate the tremendous value of increased telehealth access for Medicare beneficiaries from communities that face substantial social drivers of health and who

⁴ Centers for Medicare and Medicaid Services. *Medicare Telehealth Trends*. March 21, 2024. <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-telehealth-trends>

were so disproportionately impacted by COVID. And as goes Medicare, so goes US health care. Commercial and self-insured employer plans largely follow the lead of Medicare policy, and thus elimination of the COVID telehealth waivers and reversion to the status quo where home is no longer an eligible site of service will have enormous ripples across the US health care system.



This will likely lead to a less integrated telehealth service model, less variety of services available for fewer patients, fewer options for chronic disease management, decreased access to care for disadvantaged and underserved populations, higher costs, and lower quality of care.

Rather than contemplating termination of payment for telehealth services, Congress should focus on facilitating improved access to high-quality, integrated telehealth services by strengthening broadband access for disadvantaged and rural populations, establishing digital health literacy programs, conducting research to demonstrate the value of telehealth services (particularly hybrid telehealth modalities), and promoting payment models that increase adoption of well-integrated telehealth services focused on chronic disease management, longitudinal care, and service for disadvantaged populations. Lastly, the legal precedent that health care is considered to be delivered where the patient is located exacerbates the disparities in access to specialized expertise which is often lacking outside of large urban communities where health care specialists tend to practice. This leads to the need for provider multi-state licensure, complex licensure compacts that do not address many of the burdensome requirements of maintain licensure or practice, ambiguities in the nature of prescribing vs dispensing of medications, uncertainty as to the applicable geographically adjusted rates, and all results in greatly restricted access to specialty care for patients with complex disease. For example, of the approximately 1 million physicians in the United States, only 13,000 have used the compact pathway, demonstrating that it is of limited utility currently.⁵ A simple solution to this quandary is to redefine the location of health care delivery as where the provider is located, while ensuring that patients will still have the right and standing to bring complaints or legal actions against health care providers in the state where the provider practices. This maintains states' rights to regulate medical practice while preserving the simplicity of determining where the care is actually rendered. This may be a more practical method than universal federal medical licensure or multi-state licensure exceptions, both of which have their detractors. Without addressing the interstate access to care issues, it is unlikely that telehealth can achieve its full value.

Resiliency of the US Health Care System

When COVID emerged in the United States, nearly all in-person ambulatory health care delivery ground to a halt. Telehealth emerged as a vital safety net, a method of care delivery that could take up the slack created by the need for pandemic induced social isolation. Much like a backup generator in a power failure, this modality allowed health systems to “keep the lights on” for ambulatory care and avert a secondary health care disaster caused by lack of access to care. All major industries include capabilities for business continuity and disaster recovery, and health care should be no different. All major US industries also have expanded access to their services via digital methods that no longer require the consumer to be physically present to receive services, and in many cases the majority of their products and services are delivered as a digital first experience. Health care has lagged behind other industries in this regard, and it would be a tragic failure if we were to abandon the gains we have realized through telehealth technology and engaging disadvantaged communities, and were to revert back to covering only in-person care. At a time of crisis in the US health care workforce and diminishing numbers of health care

⁵ Interstate Medical Licensure Compact Commission. FY2022 annual report. Accessed October 20, 2023. https://www.imlcc.org/wp-content/uploads/2022/10/IMLCC_AnnualReport_2022_FINAL_WEB.pdf

workers, preserving this resilient care delivery modality and its capacity to surge in times of need should be a major national priority. Making the COVID telehealth waivers permanent is a critical component of preserving this capacity and baking it into routine health care operations.

Conclusion

It is in the best interest of all Medicare beneficiaries that a permanent extension of the pandemic-era telehealth flexibilities be enacted. I urge Congress to take action to protect this vital piece of our health care system and not to let us lose the hard-earned momentum we have gained during the tumultuous time of the pandemic. I thank you for the opportunity to offer my perspective today, and for your continued leadership to improve the health and wellbeing for all people in America regardless of wealth, geography, race, ability, literacy, or age. I look forward to your questions.