

# Congress of the United States

U.S. House of Representatives  
Committee on Small Business: Subcommittees on Agriculture, Energy, and Trade and  
Technology

## 21<sup>st</sup> Century Medicine: How Telemedicine Can Help Rural Communities

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Honorable Steve Chabot, Chairman and other Members of the Subcommittee:

I am Barb Johnston, testifying as a private citizen who has been working in Telemedicine for many years including more recently as a Co-Founder and CEO of a small business Telepsychiatry company. Prior to this I was Executive Director of the Medical Board of California. I am a former Board Member of the American Telemedicine Association where I am also a Fellow. I have served since 2006 as a Founding and current Board Member of the California Emerging Technology Fund whose mission is to deploy broadband to rural and underserved communities across California. Having worked in Telemedicine since 1995, I offer these comments as lessons learned from the public we serve, healthcare providers, regulatory bodies, government agencies, and colleagues in our industry. Although my comments are meant to focus on the economic effect of Telemedicine in rural communities, many of these remarks will also relate to non-rural environments.

**The core problem in rural medicine is that the 15% of Americans who live in rural areas are serviced by only 10% of the nation's physicians.** To maintain and improve the Economic Vitality of Rural America it is essential that rural people are kept healthy and that rural communities are supported by a full range of medical services, delivered both in person, and increasingly, by telemedicine.

**Telemedicine has demonstrated its effectiveness over the past 50 years and already benefits Rural America by:**

- a. Keeping rural dollars in rural communities, and providing access to much needed and more timely Healthcare services
- b. Supporting Rural Primary Care providers and clinics and ensuring local health facilities, including hospitals, remain open
- c. Encouraging the recruitment and retention of local physicians and other healthcare providers who can be supported by telemedicine providers
- d. Lowering the overall costs of care and avoiding unnecessary ambulance transportations, emergency visits and hospitalizations
- e. Avoiding small businesses closing down each day that an owner or worker has to travel for healthcare, and also preventing rural people losing work days because they have to travel for healthcare

- f. Supporting health IT workforce development for rural healthcare workers

### **Economic Impact of Telemedicine**

The potential economic impact of widespread implementation of TM across Rural America will be significant and holds promise to create a more efficient and effective healthcare system, lower overall costs and improve economic vitality of Rural America.

*“According to statistics from the Organization for Economic Cooperation and Development (OECD), the United States spends more on health care than any other OECD nation, both in absolute terms and as a percentage of gross domestic product (GDP). In 2015, the United States spent \$9,450 per capita on healthcare, representing 16.9% of GDP. That represents an inflation-adjusted increase of nearly 23% since 2005.<sup>1</sup> Forecasts show these expenditures continuing to grow.<sup>1</sup> The Centers for Medicare & Medicaid Services, for example, forecasts total U.S. health expenditures to grow by 5.6% per year between 2016 and 2025, and to outpace GDP growth by 1.2% per year over that period.”<sup>2</sup>*

TM has been expanding in both urban and rural America and patients have begun asking for this convenience. People, especially rural people, can't afford to drive hundreds of miles to urban clinics, losing wages and paying for eating out if appropriate care can be provided via TM in their own community. There are over 200 TM identified networks in the United States. More hospitals and health systems are implementing TM services to improve access to care, lower healthcare costs, recruit and retain providers and more and more people are expecting the benefits of TM. Americans use their computers (cellphones/laptops/desktops) for everyday life: education, banking, shopping, news, and communications and they now expect to access some healthcare services via TM.

Brian Whitacre, an associate professor and extension economist in the department of Agricultural Economics at Oklahoma State University, researched TM travel cost and lost wages (for rural Arkansas, Kansas, Oklahoma, and Texas) and projected annual travel costs savings based on mileage from \$2,303 to \$109,080 with a mean of \$24,210. He estimated annual lost wages between \$4,188 to \$68,269 and a mean of \$19,761. Dollars not spent on unnecessary travel can stay in rural communities. Rural America can simply not afford to lose wages when TM could prevent it.

### **Telemedicine Laws and regulations needed to support Rural America**

With changes to regulations and laws as suggested below specific high demand telemedicine services will be possible, and will lead to extra clinical and economic benefits accruing to rural communities.

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<sup>1</sup> Schadelbauer, Rick, “Anticipating Economic Returns of Rural Telehealth  
NTCA-The Rural Broadband Association, March 2017 (1).

<sup>2</sup> Centers for Medicare & Medicaid, National Expenditures Projections, 2016-2025  
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Natioanl/HealthExpenddata/Downloads/proj2016.pdf>

The changes I recommend are;

1. **Modify DEA rules to allow physicians to prescribe controlled substances by telemedicine.** This will benefit the following 3 specific sets of patients who need treatment with controlled substances that cannot currently be prescribed by telemedicine.
  - i. Opiate Addicts who need medication assisted treatment,
  - ii. Veterans with PTSD and TBI, and
  - iii. Children with ADHD
2. **Change the CMS rural rule to enable Medicare patients despite geographic location to receive telemedicine services.** This will open up more rural telemedicine services, especially for seniors in nursing homes.
3. **Simplify national credentialing and state reciprocal medical licensing processes to enable telemedicine psychiatric and specialist medical services to be increasingly linked into rural primary care clinics.** This will give rural communities better access to medical experts.

The following are details of my recommendations:

- I. **Change the DEA rules to allow physicians to prescribe controlled substances for patients who receive their care via telemedicine.** This will especially benefit the following 3 specific sets of patients who need treatment with controlled substances that cannot currently be prescribed by telemedicine.
  - Opiate Addicts who need medication assisted treatment,
  - Veterans with PTSD and Traumatic Brain Injury (TBI), and
  - Children with ADHD

The DEA has not followed through on required rulemaking regarding the **Ryan Haight Act** of 2008 which inadvertently affected the TM industry making it impractical to prescribe controlled substances by TM. Although DEA was meant to make this correction in October 2015 it has not and has no announced plans to modify the Act. The three groups of patients most adversely affected by this ruling are prevalent in rural regions, are of great political sensitivity and importance, and lack of treatment for all leads to considerable costs, both clinical and economic. The continuing inability to properly treat these patients adversely impacts rural economic vitality in a major way. These patients are forced to travel to urban centers for care or to suffer with lack of care.

I recommend that either Congress or the DEA should make emergency rules to allow providers to prescribe controlled substances, as recommended by the American Telemedicine Association, at least initially for mental health and psychiatric services, including addiction treatment.

- II. **Change the CMS rural rule to enable Medicare patients despite geographic location to receive telemedicine services.** This will open up more rural telemedicine services, especially for seniors in nursing homes. Medicare's narrow definition of rural as relates to reimbursement of healthcare provided via TM prevents most Medicare beneficiaries from access to healthcare via TM. Medicaid does not have this

“rural” limitation. Medicare constituents should have the same benefits that Medicaid constituents enjoy.

Changing this rule is especially important for patients in Skilled Nursing Facilities (SNF), primarily seniors with some rehabilitation and disabled patients. As Executive Director of the California Telemedicine and eHealth Center (CTEC) 2003-2007, I travelled across urban and rural California to fund Telemedicine (TM) programs primarily targeting underserved communities. Despite efforts to fund skilled nursing facilities not one SNF determined to accept the funds or assistance to pilot TM. As Principle Director of the CMS funded Patient-Centered Medical Home for Mental Health program 2012-2015 SNF patients were able to access much needed Telepsychiatry services. Unfortunately after that award funding ended the program could not continue in large part because of the Medicare rural rule. What I found was:

- Rural SNFs have a severe lack of access to specialists including but not limited to psychiatrists, dermatologist, cardiologists, etc. Patients are commonly behaviorally disturbed and at times receive excessive amounts of tranquilizers except when reviewed by psychiatrists and geriatricians, both of which are in very limited supply in-person in rural communities.
- Studies have shown that SNF patients do clinically much better when reviewed by psychiatrists and/or geriatricians, are less sedated, have less medications and have less expensive transfers out of the SNF
- Most SNFs do not meet the “rural rule” for Medicare reimbursement and therefore are not able to use Telemedicine so that patients can access health services via TM.
- Because CMS will not reimburse for TM unless the location is in a narrowly defined “rural” location many health facilities refuse any TM programs because of concern over billing problems, being perceived as providing preferential services to the non-Medicare patients.
- **Medicare is the only health insurance payor who limits access to healthcare via TM related to geography.**
- Rural SNF’s have difficulty recruiting and retaining General Practitioners (GP). TM can provide a vehicle for a GP, and other specialists, to support an onsite Nurse Practitioner at the SNF.
- Physician shortages can lead to closure of a SNF which can lead to local unemployment, and the move of patients to other regions away from their families.
- The implementation of TM usually relies on existing staff, upskills those staff and frequently leads to job satisfaction and employee retention.
- Lack of specialists available for a SNF, such as psychiatrists, requires patients to be transferred usually by ambulance to a hospital many miles away to then be held in an emergency department for several days waiting for a psychiatrist or other specialist to evaluate the patient. This scenario is cost prohibitive and usually involves payment from either Medicare or Medicaid. Costs include the ambulance each way, the emergency department stay and the specialist. The rural SNF also loses revenue each day the patient is away and they cannot “give away” the patient’s bed. Because the specialist is so far away, the patient may require follow up ambulance transportations to and from the emergency department or

clinic office with the loss to local rural economy growing and bills to CMS escalating.

- Even if a physician begins a practice in a rural community where he/she has a solo practice which requires 365/days a year and 24/7 call coverage it usually can't last long. Time off, let alone vacations, become difficult to impossible. This work load inevitably leads to burnout or losing that one provider. Support from telemedicine providers is known to markedly improve in-person physician retention.

**III. Telemedicine should be routinely integrated into Rural Primary Care:** CMS through its Center for Medicare Medicaid Innovation (CMMI) Initiative awarded \$7.7million to a small business Telepsychiatry company between 2012 and 2015 to develop and implement a new model of care where a Telepsychiatry network was integrated into over 80 Primary Care clinics across Wyoming, Montana and Washington State. Patients were followed up after their psychiatric consultations by virtual care navigators who checked on medication and lab work compliance. The goals were to prove this model would improve access to health care, assure patient satisfaction and reduce the per capita cost of care. These goals were achieved. Patient satisfaction data collected by an independent third party reported that the 96% of patients who had received care via this Telepsychiatry program would recommend Telepsychiatry to friends and family and **81% preferred Telepsychiatry to in person** psychiatry. Significant cost savings were also achieved.

Poor adherence to medication regime for patients suffering mental illness often leads to a choice between suicide, homicide, drugs/alcohol, poverty, and emergency department visits/hospitalizations. Adherence to medication was monitored for the schizophrenic patients in this program at 99% which is extremely high. Patients with all other mental illnesses (depression, anxiety, bipolar, etc.) in our project had a 96% adherence to medication regime. Key factors to this outcome included the fact that patients received care in the clinics they normally went to-their rural primary care (PCP) doctor's office. Stigma was reduced as no one knew they were seeking mental health care via their PCP. Patients and families didn't have to drive miles away with the cost of gas and eating out so money stayed locally and less time was lost from work.

Key findings of the cost effectiveness of this Telepsychiatry model of care as reported to CMS include the following;

- NIH reported in 2006 that the average cost of outpatient mental health for adults was \$1,551/year and for children \$1,931. Mental illness accounts for \$193B in lost earnings per year. (<http://www.nimh.nih.gov/health/statistics/cost/mental-healthcare-cost-data-for-all-americans-2006.shtml>)
- Over 50% of US counties have no psychiatrist and psychiatrists practicing now are retiring in large numbers with no one to replace them.
- In this Telepsychiatry integrated into Primary Care model the average costs of care was \$390/patient/year. Patients were seen by a psychiatrist via TM, who made a diagnosis and developed a treatment plan which were given directly to the patient and their own PCP in their rural community. In most cases the patients were able

to be followed by their PCP since the Telepsychiatrists had established the diagnosis and the treatment plan.

#### **IV. Regulatory barriers to the entire Telemedicine Industry**

1. **Credentialing** requirements delay onboarding physicians both in person and as TM providers. Credentialing requires massive amounts of information to assure physicians are in good standing and qualified. Credentialing in itself is appropriate but the problem is that every health facility requires the physician to be credentialed over and over again. Each credentialing process takes between 2 to 6 months, and is often repeated every 2-3 years, with new references required each time. For TM providers who may be required to care for patients in many small rural hospitals or clinics because the rural populations are small and scattered across one or more states the credentialing process is onerous and time wasting. A national credentialing process would improve efficiencies. Some insurance companies already use one national credentialing agency to solve this problem. Delayed credentialing often leads physicians to take jobs in urban areas because they need to work and pay their bills.
2. **Licensing physicians** by individual State licensing Boards is slow and inefficient. Physicians in the USA are more mobile than ever before. They move State to State due to changing their own jobs or they relocate because of a spouse/partner. TM physicians are hit hard by having to go through licensing in each individual State which can take 3 to 9 months. Most TM providers have to be licensed in multiple states and have to re-license every two years with new letters of reference, and proof of continuing medical education activities which are different for every state. The costs are significant and are a barrier to physicians working in TM. Australia established a National Registration and Accreditation physician system in 2010 to solve this problem. In the United States, The Federation of State Medical Boards (FSMB) established the Federation Credentialing Verification (FCVS) system to streamline physician licensing. Thirteen States already require FCVS but five State's won't accept FCVS physician packets. A more comprehensive national licensing system would improve access to healthcare, encourage more physicians to care for rural patients via TM and would lower health system costs. In 2015 the FSMB launched the Interstate Medical License "Compact" which seeks to facilitate a streamlined system for licensing physicians. This has potential to save time but unfortunately physicians still have to go through all the individual State licensing process and pay all the individual State licensing fees which for physicians who work across State lines (TM or in person) is very time consuming and expensive.

In closing, I thank the committee for its attention to this significant issue and for allowing me to present my thoughts on the potential impact of Telemedicine on economic vitality of Rural America.