



Statement for the Record

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U.S. House Committee on Energy and Commerce Subcommittee on Health
“The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care”

March 2, 2021

Chair Eshoo, Ranking Member Guthrie and members of the Subcommittee, I appreciate the opportunity to submit a statement for the record and share with you one institution’s experience and reflections on the role telehealth has played as a lifeline for millions of patients during the pandemic. As you consider the future state of health care, I offer five recommendations for policy changes needed to support telemedicine in a post-pandemic environment and one bill you should pass as soon as possible to help support access to care for the duration of the pandemic.

As a practicing physician, I lead digital health strategy and the Office of Telemedicine for Johns Hopkins Medicine (JHM), an integrated system of six academic and community hospitals, four suburban health care and surgery centers, a home care group, and numerous patient care locations in the Baltimore-Washington region and Florida that collectively serve nearly 4 million patients annually.

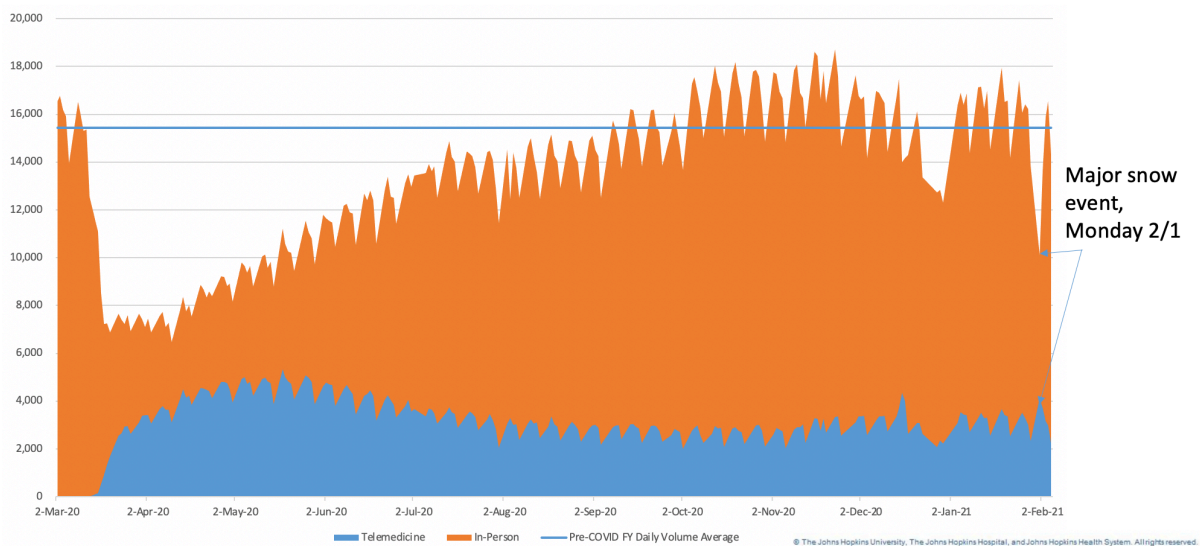
One year ago, in March 2020, Johns Hopkins recorded its first confirmed case of COVID-19. There is no question that during the course of the last 12 months, telehealth helped reduce the spread of the virus and saved lives. The critical flexibilities Congress and the Administration granted during the COVID-19 pandemic allowed providers, like those at Johns Hopkins, to be nimble and rapidly transform how we delivered care. Like other systems nationwide, JHM quickly scaled remote services to maintain vital connections to patients who otherwise would have delayed or skipped needed treatment.

JHM has been at the forefront of creating new and better ways to connect patients with providers for decades. Johns Hopkins also has embraced telehealth as a benefit within its managed care products where possible, including its Medicare Advantage offerings. While we will continue to do our part to leverage the benefits of technology-enabled care, we recognize that the most challenging work lies ahead as we strive to promote policies that will result in more equitable telemedicine delivery to patients already at risk of limited access to health care.

Telehealth Utilization During the Pandemic has been Substitutive, not Additive

Since March 2020, Johns Hopkins Medicine has conducted over 790,000 telehealth visits, or on average ~69,000 telehealth visits per month; before the pandemic hit, that number was fewer than 100 per month. When in-person visits fell precipitously in March 2020 due to a surge in COVID-19 cases in our region, Johns Hopkins providers were able to replace some of that care using telehealth modalities. Clinician and patient response to the new modality was impressive, given the relatively infrequent use before the pandemic. Initially, after a dramatic decline in healthcare engagement by patients, telemedicine has been a replacement option for many patients who prefer this modality, bringing our total volume back to our pre-COVID averages.

Total Ambulatory Volume (Video vs. In-Person Visits)



Note: Telemedicine and In-Person volumes are stacked (not overlapping).

Over time, as public health limitations lifted and patients began to feel more comfortable entering facilities for non-emergent care, we have seen a natural decline and leveling out in the use of telehealth, although it remains an important option for a number of our patients.

Ultimately, when selected as a clinically appropriate tool, telehealth requires similar skills, level of effort and training, history taking, and medical decision making as in-person care, and should be reimbursed similarly.

Audio-Only as a Tool for Promoting Health Equity

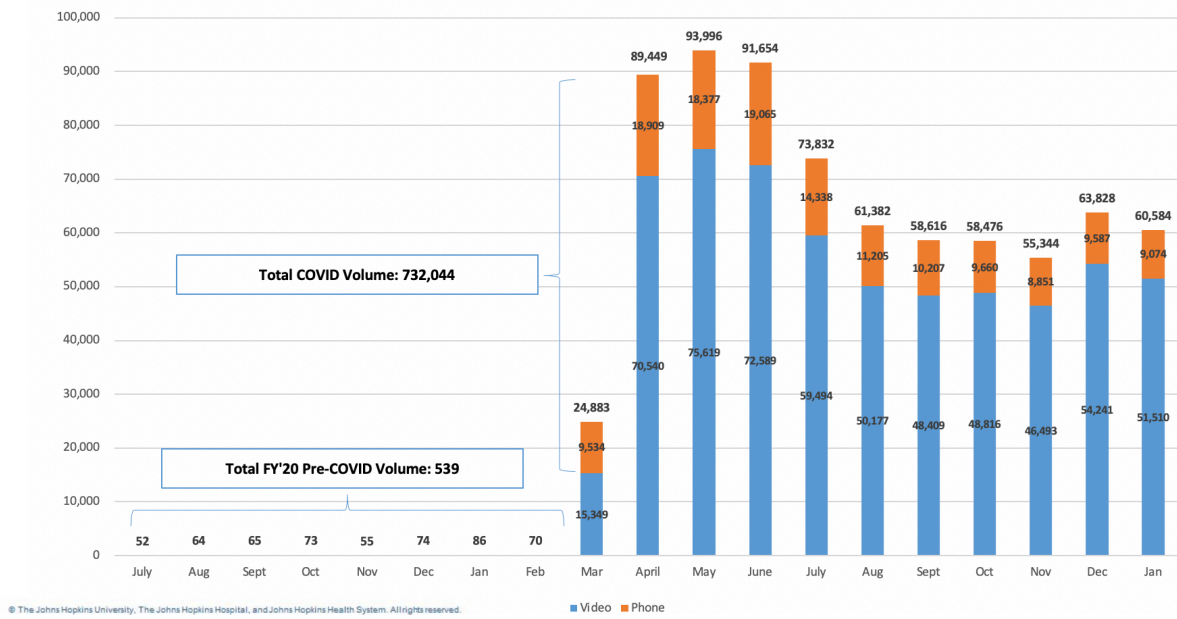
Researchers at Johns Hopkins have begun to explore how virtual care could be used to mitigate persistent disparities in U.S. health care. To best serve vulnerable patients, providers need to be able to continue to leverage all available tools, including audio-only care, after the expiration of the public health emergency (PHE). This will help ensure that telehealth's rapid expansion during the pandemic doesn't exacerbate inequities for some disadvantaged groups. Lawmakers should keep equitable access at the forefront of the discussion about permanent telehealth policy, particularly for patients enrolled in public insurance programs.

Telemedicine has played a key role in increasing access to care during the pandemic, but certain urban communities, like the neighborhoods that surround Johns Hopkins Hospital in downtown Baltimore, lack access to the broadband infrastructure to allow for video-based care. Compared to other cities, Baltimore has a higher proportion of households lacking both the hardware (laptop or desktop computer) and the wireline broadband for getting online.¹ The digital divide has adversely impacted disease monitoring and made it more difficult to fully evaluate the intersecting forces that contribute to racial disparities, including the underlying conditions and poverty that affect how the virus spreads across certain communities.

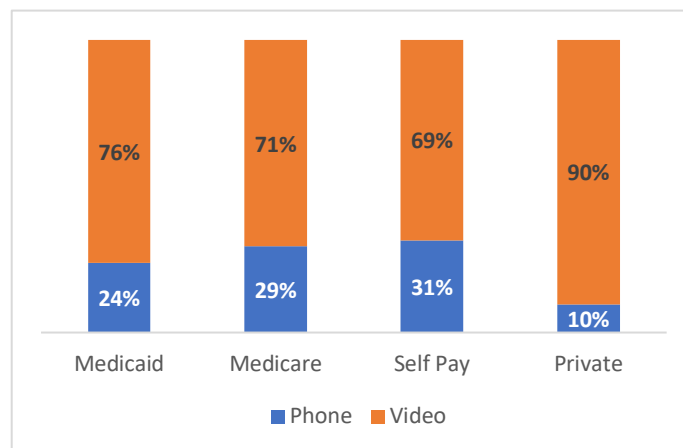
¹ "Baltimore's Digital Divide: Gaps in Internet Connectivity and the Impact on Low-Income City Residents," Abell Foundation, May 2020.
[https://abell.org/sites/default/files/files/2020_Abell_digital%20divide_full%20report_FINAL_web%20\(dr\).pdf](https://abell.org/sites/default/files/files/2020_Abell_digital%20divide_full%20report_FINAL_web%20(dr).pdf)

JHM’s experience demonstrates that clinically appropriate audio-only care can materially help health systems better meet the needs of underserved patients. On average, approximately 20 percent of JHM telemedicine visits systemwide used audio-only modalities, however, use of audio-only care is not distributed equally. JHM patients insured through Medicaid and Medicare relied on audio-only technology two and three times as often as commercially insured patients, and these trends remain little changed in 2021 compared to early in the pandemic.

Video and Phone Visit Volume Trends (Monthly)



Addressing Access Disparities: Audio-Only Care by Payor



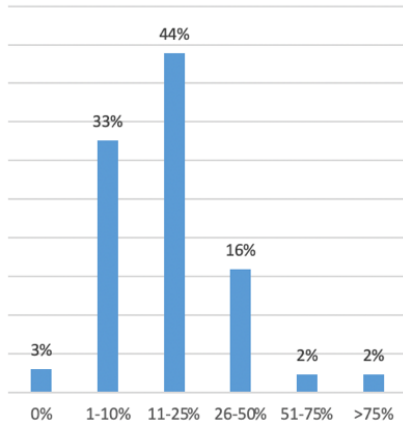
Some may argue that audio only care may not be as good as video care and so accepting audio only care for the vulnerable may worsen disparities. I encourage the committee to view audio only care as an option to promote more equitable healthcare access in the short term while long term access solutions are solidified. The long-term goal is that the digital divide will narrow and more people will have access to video-based care. But in the meantime, audio-only coverage is an essential stop gap measure to prevent a two-tiered system. Can you imagine, as a provider, if a video visit fails and having to say “sorry I can’t help you today”? Often times, patients and providers may choose audio care because it is the only viable option given real world constraints (child care, time off work, transportation and parking, language and technology literacy); it is certainly preferable to no care at all.

Being able to schedule audio only care for those who don’t have video access, or convert to audio only in the moment for those who have unanticipated technical failure are important flexibilities to ensure providers can deliver care in this imperfect digital world. With appropriate rules to guard against improper use, audio-only should remain a critical tool to help address equity and access issues in a post-pandemic world.

Survey of Patients and Providers: Post-COVID

The Johns Hopkins Office of Telemedicine recently conducted a survey of patients’ experience with, and providers expectations around, telemedicine. Out of 1,935 patients surveyed, 88 percent said having a video visit option would be very or extremely important for future care; 9 out of 10 respondents would recommend telemedicine to friends or family. In testimonials, patients expressed appreciation for the unique flexibility and efficiency of virtual care.

What % of total visits after COVID ideally telemedicine?



In a survey of 221 Johns Hopkins primary care providers, 64 percent stated that 11 percent or more of their total visits would ideally be conducted via telemedicine after the pandemic. Only 3 percent stated that they would conduct no telemedicine. Importantly, providers also note that telemedicine has increased their joy and satisfaction at work, pointing to flexible hours and the ability to work from home as major benefits of telemedicine.

With this background as context, the following are policy recommendations I offer on behalf of JHM as consideration for the Health Subcommittee.

JHM Telehealth Policy Recommendations

- 1. Lift geographic and originating site requirements.** Section 1834(m) of the Social Security Act restricts the delivery of telehealth services to certain rural areas (geographic site restrictions) and certain physical locations, such as hospitals and physicians' offices (originating site restrictions). These outdated restrictions are the product of another era and should be modernized to keep pace with the future of health care. As we have seen in the pandemic, where restrictions were rapidly lifted, easing access in this space did not generally result in an overall increase in utilization. I urge Congress to permanently remove these restrictions from statute.
- 2. Make provider enrollment flexibilities permanent.** Under 42 CFR 424.516, providers rendering services from a site other than their clinical practice must add each address to their CMS enrollment file. Fortunately, this requirement was waived during the PHE, permitting flexibility in provider location when delivering telehealth services. I urge Congress to ensure these flexibilities become permanent, thus permitting increased workforce efficiency in delivering care to patients.

- 3. Permit telehealth services via audio-only communication.** CMS has interpreted statutory description of “services that are furnished via a telecommunications system” to mean that Medicare telehealth services must be furnished using video technology. Legislation is needed to permanently codify that telecommunications services can, in certain instances, include audio-only communication. It is vital that audio-only services remain available as an option to ensure access to services for the most vulnerable patients and prevent further exacerbating the digital divide.
- 4. Reimburse for chronic disease management and monitoring in the home.** CMS established flexibility to allow professionals that provide home health and hospice services to do so via telehealth and bill accordingly during the PHE. Congress should create new statutory authority to allow all physician-ordered, clinically-appropriate home health services to be provided via telehealth. In addition, Congress should permit individuals to self-monitor (collect and document) their health and securely share the data with their providers, and permit inclusion of this information in important quality and outcome reporting.
- 5. Encourage mutual recognition of state licensure post-COVID.** We have seen licensure limits substantially restrict access during this unprecedented COVID-19 emergency period. To maximize the utility of telehealth options and ensure provider accountability, state regulatory entities and officials (e.g., governors, state legislatures, medical boards and licensing agencies) should work together to implement durable solutions to facilitate and promote mutual recognition of health professional licensure, reduce duplicative paperwork and processes, and allow patients to see the provider of their choice regardless of their location.

Finally, as soon as possible, **I urge Congress to enact emergency legislation to establish temporary state licensing reciprocity as proposed in the Temporary Reciprocity to Ensure Access to Treatment Act (TREAT Act, S. 168/H.R. 708).** The TREAT Act is narrowly tailored to address a critical need during the pandemic by maintaining access to care when travel is ill-advised and

facilitating efficient deployment of health care personnel where they are needed most. The bill enables providers licensed in good standing in one state (and not barred in any other state) to treat patients in any state. This short-term patch retains state-based licensing, but ensures uniform reciprocity to ease access during the crisis. Swift action on this important legislation is needed so that Americans can make the best use of telehealth technology and reduce exposure risk for patients and providers. For Johns Hopkins, this need became quickly apparent last Spring after students were abruptly sent home to other states and when patients from across our health system were suddenly unable to travel for cancer treatments and care for other rare conditions. Moreover, newly diagnosed patients were prevented from seeking second opinions or starting treatment with preeminent experts at Johns Hopkins and other leading institutions. Many of the needed services could be done remotely, but only if the clinician is licensed in the patient's state. After the pandemic, some patients will again be able to drive or fly across state lines to see their chosen provider but current recommendations to stay at home as much as possible highlight why the TREAT Act is desperately needed today.

Conclusion: Telehealth is an important tool in the toolbox

In my clinical practice and as a senior executive tasked with executing our institution's telehealth strategy in the midst of a pandemic, I have seen the intangible, un-"score"able benefits of telehealth. For my pediatric patient with poorly controlled asthma, I can spot home triggers such as pets, carpets, and tobacco via telemedicine, providing insight I would not gain in an office visit. My adult patient with the ever-changing medication regimen no longer has to worry about forgetting their long list of prescriptions at home. It is the modern equivalent of a "home visit" and another tool in the toolkit to enhance and facilitate care for my patients. I look forward to working with you to fulfill the promise of telemedicine in a thoughtful manner, and would be happy to make myself available for questions or follow up.