Written Testimony before the U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health

Hearing Concerning the Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care

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March 2, 2021

Good morning Chairwoman Eshoo, Ranking Member Guthrie and members of the Subcommittee. I am Dr. Megan Mahoney, a family physician for over 20 years, the Chief of Staff at Stanford Health Care, and a Clinical Professor in the Department of Medicine at Stanford University.

Thank you for the opportunity to appear before you to discuss the impact of telehealth on our practice and patients and share recommendations to ensure we can continue to provide safe, effective, patient-centered care beyond the public health emergency (PHE).

The COVID-19 pandemic illuminated important gaps and vulnerabilities in the healthcare delivery system, most visibly the lack of existing infrastructure and preparation needed to provide care to patients remotely and limit the risk of infection. Health systems around the nation made tremendous investments to rapidly develop virtual care capabilities and are now hardwiring that change into their clinical practice. At Stanford Health Care, this system-wide transition to virtual enabled all of our 2000+ physicians with telehealth capabilities and over 225,000 of our patients to complete their first video visit. The depth and breadth of this transformation highlights the changing dynamics and fundamental expectations of our delivery system, as well as patients' receptivity to accessing care through telehealth. Over 90% of our patients **surveyed have said the likelihood they would schedule another video visit is either 'good' or 'very good'.** Patients will demand the option for virtual care going forward, and it is now our collective responsibility to make the system sustainable, efficient and accountable to patients and payors.

The transformation from in-person care to telehealth may have been catalyzed by COVID-19 and the shelter-in-place orders, but it **would not have been possible to achieve without the lifting of legislative and regulatory barriers including:**

1. The waiving of Section 1834(m) geographic, originating site and provider type restrictions
2. The ability to see both new and established patients via telehealth, without any requirement for a prior in-person visit
3. Equivalent provider reimbursement for clinically equivalent services provided via telehealth and in-person
4. State medical licensure waivers creating a path for physicians to provide video visits to patients across state lines

Based on experience and what we have learned to-date, these policy changes should be made permanent. They have dramatically improved access to patient-centered care without increasing overall healthcare utilization. Addressing the 1834(m) restrictions is of particular importance to avoid the inadvertent creation of a **donut hole for Medicare Fee for Service (FFS)** patients, who are among the most vulnerable. The existing statute puts Stanford Health Care and other providers in a position to offer telehealth to everyone *except* Medicare FFS patients because of antiquated restrictions that do not reflect the way healthcare is delivered today. The remainder of this testimony describes what we have learned through our experience with telehealth, what we still need to study, and recommendations for sustainability.

1. **Virtual Care is appropriate and broadly adopted across all clinical specialties and provider types**. 87% of all providers at Stanford Health Care have completed at least one video visit during the pandemic. This includes many non-physician healthcare practitioners that are critical to patients' well-being, including physical therapists, speech language pathologists and occupational therapists [Fig. 1]. These provider types are eligible to bill Medicare independently for all in-person services yet are statutorily excluded from offering those same services via telehealth under Section 1834(m) of the Social Security Act. At the initial peak of the pandemic (April 2020), our Stanford **ambulatory telehealth visits grew from 1% to over 70% of our total outpatient volumes**. With the phased reopening of all our clinics to in-person care, we are now **largely stabilized at 30-40% virtual visits across Stanford** and believe this will be our new normal going forward. We learned that virtual care is a clinically effective, critical tool across all specialties, not just those previously thought to be primed for telehealth such as psychiatry and low complexity urgent care [Fig. 2].

Figure 1. Virtual Uptake by Provider Type*

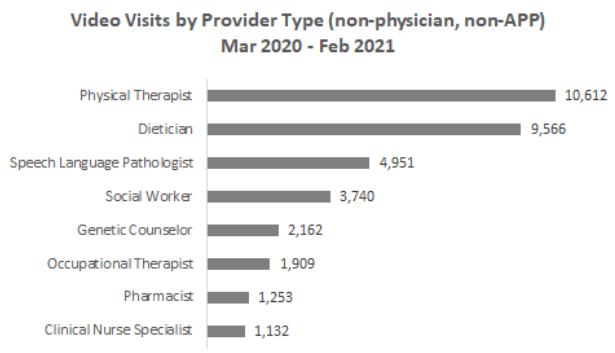
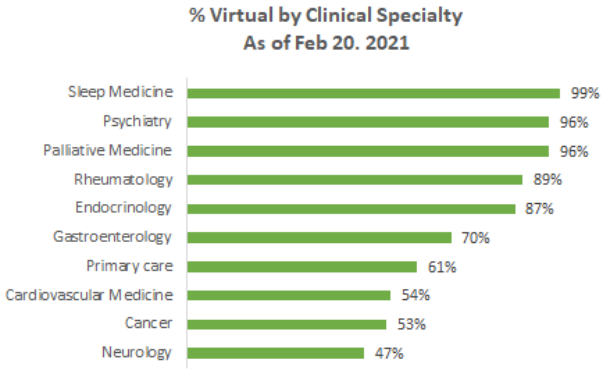


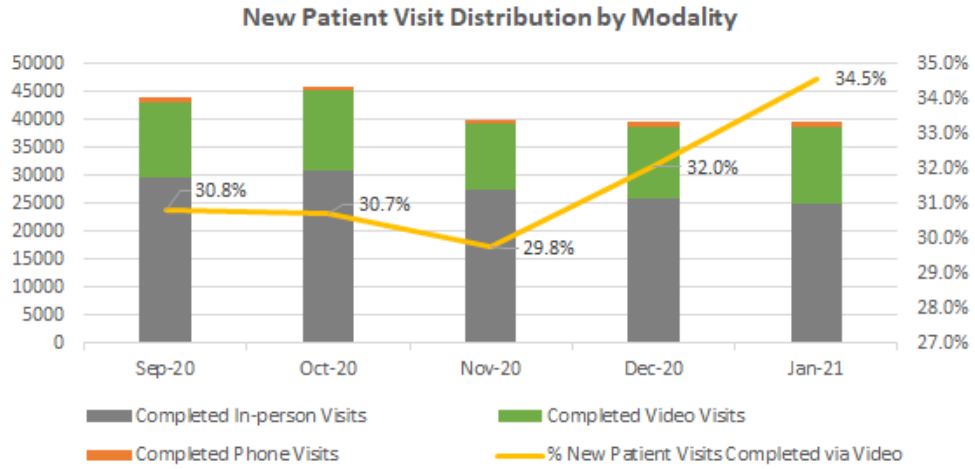
Figure 2. % Virtual by Clinical Specialty*



*Demonstrative sample, list not exhaustive

2. **Virtual care is an important healthcare access point for both new and established patients.** Patients are offered video visits based on clinical appropriateness first and are then able to choose whether they prefer to be seen remotely or in person based on their preference. Depending on the patient's clinical need, a physical exam is often not required in the first visit – in fact, over **30% of patients now initiate care with a Stanford provider via telehealth** [Fig. 3].

Figure 3. New Patient Visit Distribution by Modality



Concerns about Medicare program integrity have perpetuated the perception that requiring a patient to come in-person for an appointment before they can be seen virtually guards against fraud. Our experience in practice is that this requirement adds no clinical value and only limits access to care for patients who do not have an in-person provider. Such in-person requirements can even create safety risks – consider the elderly patient with difficulty walking who could fall unnecessarily, or the many patients receiving care from our sleep medicine clinic who are unsafe to drive. Why should we require these patients to travel to our clinic when it is not clinically necessary or safe to do so? We should do everything in our power to respect patient preference and never limit providers from delivering the most clinically appropriate care.

Additionally, these technologies can increase opportunities for personalization of care and may be particularly well-suited for patients who face barriers around transportation, inflexible work hours, and childcare needs that make it difficult to attend in-person visits. It is important to note, however, that virtual care requires reliable internet access, a smartphone or computer, digital literacy, and insurance coverage of services, which need to be considered to prevent exacerbating existing health disparities.

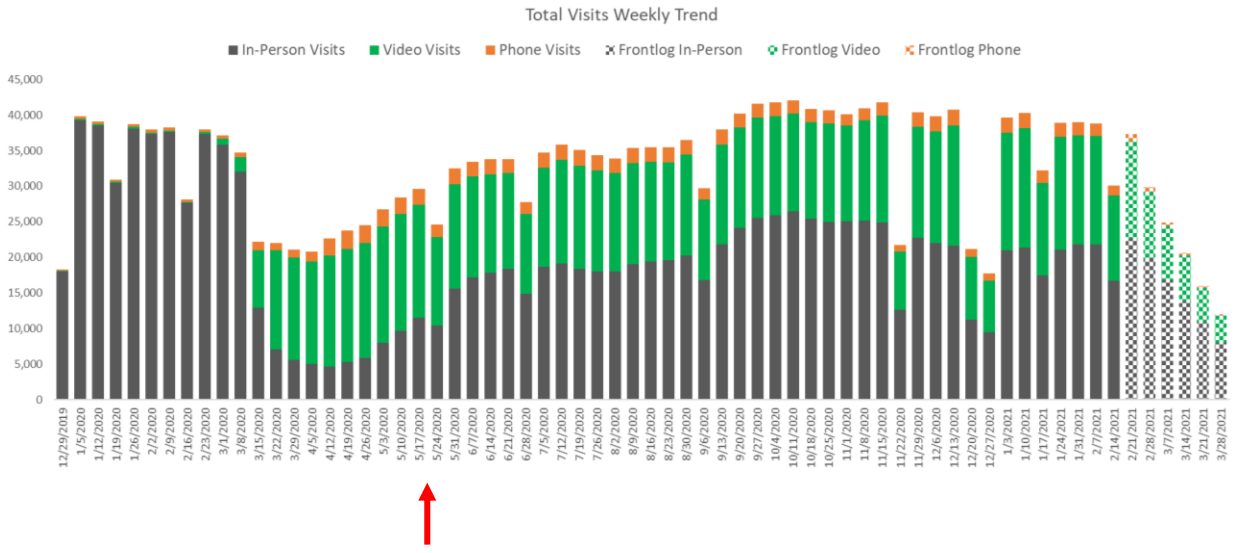
3. **Telehealth has proven clinically effective. It requires equivalent effort and medical decision making (MDM) by providers and should be reimbursed accordingly.** Remote care is one of our most effective tools for combating the spread of communicable diseases and ensuring continuity of care. Going forward, telehealth will provide critical access to care for many patients who are unable to travel, or who cannot take time off work or personal responsibilities to attend an in-person appointment. In many ways, telehealth improves the care experience harkening back to days when the doctor would make house calls – as a family physician, it has been incredibly valuable for me to see my patients' home environments. Among other use cases, we have learned we can actually complete a more valuable medication reconciliation visit with the patient at home, where they can easily access all of their medications and supplements, without having to memorize their doses or risk forgetting a prescription. From a provider billing and reimbursement perspective, the

complexity and clinical effort of the visit is already captured in the level of service coding and does not further vary whether the service was provided via video or in-person.

We encourage the application of standard quality measures for in-person and virtual care, which ensure the same yardstick is used to compare these modalities. The past twelve months have produced the first real-world dataset of scaled telehealth in the United States. Additional time and data collection are needed to complete peer reviewed research to quantify the clinical quality, cost and outcomes of telehealth as compared to in-person. To that end, the Stanford School of Medicine is collaborating with MedStar Health and Intermountain Health to develop one of the nation's largest cumulative data sets of primary care video visit longitudinal outcomes, funded through the Agency for Healthcare Research and Quality (AHRQ). In order for large scale studies like this to produce a meaningful analysis of impacts in a post-pandemic environment, telehealth access and data collection would need to continue past the end of the public health emergency (PHE).

Telehealth is substitutive, not additive to in-person care. Because telehealth at a national scale is still relatively new, there is the perception that it may be over-used and lead to increased health care costs. This has not been our experience. Even as Stanford Health Care reopened all our clinics to in-person care, we have not seen an increase in overall healthcare utilization [Fig. 4]. The past several months have provided the real-world test case for a return to regular practice providing both telehealth and in-person care. We have analyzed our own data and found that office visit utilization has remained largely flat regardless of specialty. Practically speaking, we find the physicians' time is the rate limiting factor for visits per day, and this has not changed with the transition to video. In my own clinic, I can confirm that my number of scheduled appointments per day has remained the same, with a portion of my patients simply joining their visits virtually versus in-person.

Figure 4. Office Visit Volumes by Modality



Clinics reopen to in-person care broadly across Stanford Health Care

4. **Telehealth improves access to care. Patients from all 50 states have sought care at Stanford Medicine** during the pandemic because we provide subspecialty services that simply do not exist elsewhere. This is a unique feature of AMCs. Under the existing federated medical licensure system, physicians are required to be licensed in the state where the patient is physically located at the time of the visit. This structure has worked well and served its purpose. A strong, thorough and transparent physician licensure system is paramount to patient care and accountability but needs to be re-evaluated with the emergence of telehealth. We support the TREAT Act and are also looking beyond the end of the current pandemic to contemplate this new paradigm of care. The medical licensure system must take in to account unintended and undue administrative burdens to facilitate nationwide access to specialty care. For example, tertiary and quaternary care centers like Stanford receive patient requests from all over the country for specific subspecialists, but it would be nearly impossible for the specialist to predict the patient's location far enough in advance to pursue licensure in that state. Nor would it make practical sense to do so -- the licensure process is labor intensive and requires upkeep, including individual applications, background checks, fingerprinting, and continuing medical education (CME) requirements that differ in every state. The provider community will have strong opinions on this, but let us consider the patient perspective, such as this letter from a patient's daughter,

"My father has recently been diagnosed with an aggressive form of cancer, and both his local physicians and the consulting... physician strongly recommend a referral to Stanford in particular, for additional input on his urgently needed therapy. Unfortunately, ***he is too ill to travel to the consulting facility at Stanford****, and in addition to his fragile state making travel extremely risky, he would be at extraordinary high risk of developing severe disease if he were to acquire COVID-19 during the trip.* ***The safest and most logical course would be a video or telephone visit with the Stanford team, though it appears this approach would be prohibited under... [state] law."***

We receive letters like this every day from patients who cannot travel to us, and yet regulatory barriers prevent us from bringing the care to them. Our faculty at Stanford Children's receive many requests for consultation into Nevada because there is no pediatric rheumatologist in the entire state. This example is not unique, these access challenges existed before the pandemic and will persist after, disproportionately impacting those who do not have the resources to travel across state lines for specialty care. For the first time, telehealth creates an opportunity to open access to patients who historically have been geographically isolated in states with little to no specialty or subspecialty providers.

It is critical to the health, safety and equitable access of our patients to ensure we can continue to provide telehealth services after the end of the public health emergency. In order to do so, providers and patients will need:

1. The antiquated restrictions of 1834(m) to be addressed to conserve Medicare beneficiary access to telehealth:
    - The ability to provide video visits to patients **regardless of location** – non-rural and rural settings, and whether the patient is at home, work, or another private location of their choosing.
    - The ability for **all provider types** that are enrolled to independently bill Medicare for in-person services, to also provide clinically appropriate telehealth services – including occupational therapists, physical therapists, and speech language pathologists.
2. Continued expansion of covered telehealth services by CMS in the annual Physician Fee Schedule (PFS).
3. Recognition that the visit provided via video and in-person should be reimbursed equally as it is clinically equivalent and **requires the same effort and medical decision-making by the provider**. The complexity and clinical effort of the visit is already captured in the level of service coding and does not further vary whether the service was provided via video or in-person.
4. A national view of medical licensure that allows physicians to **care for patients across state lines**.

Thank you for this opportunity to share our experience and learnings with the Subcommittee. We deeply appreciate the rapid actions you and your colleagues in Congress took at the start of the pandemic to open access to virtual care for millions of Americans. We look forward to discussing the continued role of telehealth in providing high quality, sustainable, equitable access to care for the people of the United States.