AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

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Senate Committee on Finance

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Good morning Chairman Wyden, Ranking Member Crapo, and members of the committee. My name is Dr. Narayana Murali, and I serve as the Executive Vice President of Care Delivery & Chief Strategy Officer of the Marshfield Clinic Health System. I also serve as the Executive Director of Marshfield Clinic, headquartered in Marshfield, WI. It is my honor to be here today to discuss this important topic.

It is my privilege to testify on behalf of America's Physician Groups and myself. APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care to nearly 45 million patients. It is the vision of APG's member organizations to transition from the fee-for-service (FFS) reimbursement system to a value-based system where physician groups are held accountable for the cost and quality of care they provide to their patients. APG's preferred model of capitated, delegated, and coordinated care, eliminates incentives for waste associated with Fee for Service reimbursement. I am here to make the case for permanently supporting the telehealth flexibilities created in during the PHE, with some refinements.

Since the outset of the pandemic, APG members in all 50 states have risen to the challenge presented by COVID-19. Our members have been at the forefront of caring for patients, as well as the communities we serve from coast to coast. The challenges have been immense, and the risks associated with COVID-19 remain serious today. However, the lessons and experiences we have gained – as difficult as it has been at times – can serve as opportunities to embrace changes, so we can continually improve services we provide to our patients and communities. This is especially true when it comes to the waivers and flexibilities made available to address the nation's current public health emergency (PHE). The widespread adoption and utilization of telehealth services in a variety of healthcare settings have been lifelines to patients, ensuring access and continuity of care during some of the darkest days of the pandemic when alternatives were non-existent. This is particularly true for those physician groups that have moved away from FFS (*where earnings are tied to volume of services rendered*) and are participating in models of care where the provider takes partial or full financial risk for quality, outcomes and total cost of care (*degree of risk may be shared with a health plan or fully absorbed by the provider - globally capitated contracts*).

I joined the Marshfield Clinic in 2006 as a nephrologist, having practiced and furthered my education in India, Australia and the United States. I did an internal medicine residency at Mayo School of Graduate Medical Education, a National Institutes of Health-sponsored Clinician Investigator Training Program and fellowship in kidney disease at the Mayo Clinic College of Medicine, Rochester, Minnesota. I serve as the prime site principal investigator of the Wisconsin Consortium for the *All of Us* Research Program, a historic effort to gather data from one million or more people living in the United States to accelerate research, improve health, and deliver precision medicine. In addition, I serve as the Secretary of American Physicians Group, the Vice Chair, of the Governing Council of Integrated Physician and Practice Section of the American Medical Association and on several other not-for-profit Boards. As a physician

with decades of experience treating patients and navigating the healthcare system, I would like to especially commend Congress and the various relevant federal agencies for their efforts to address the struggles healthcare providers and organizations have alike faced during the COVID-19 pandemic. Yes, we have all come a long way and yet much work remains to be done.

Marshfield Clinic Health System (MCHS), which Marshfield Clinic is a part of, is an integrated health system serving northern, central, and western Wisconsin. We are one of the nation's largest fully integrated systems serving a predominantly rural population. Our 1,400 physicians and providers accommodate 3.5 million patient encounters each year across our 10 hospitals and over 60 ambulatory clinical sites. Our primary service area encompasses over 80 percent of the rural population of the state of Wisconsin. In fact, over half of our 60+ facilities are located in communities of less than 2,000 people. We are the largest provider of primary and specialty care in our region. As stewards of our communities and to what we call home along with our patients, we have been committed to community engagement activities that support the rural and underserved communities. We are a teaching health system, providing over 1,300 students with over 2,300 educational experiences throughout our system. The Marshfield Clinic Research Institute is the largest not for profit, private medical research institute in Wisconsin with more than 30 Ph.D. and M.D. scientists and 150 physicians engaged in medical research.

As a fully integrated health system, MCHS has a rich legacy of over 104 years and a long history of providing accessible, affordable and high quality, compassionate healthcare. A third of the counties we serve have less than two workers per Medicare beneficiary, and our patients are older, sicker and poorer than average in the state of Wisconsin and the nation. Forty two percent of the children in our primary service area are eligible for reduced or free school lunches.

Telehealth at MCHS did not have its genesis in the pandemic. It has been a foundational element in our clinical delivery of care for rural Wisconsin. In fact, we have used telehealth services since 1997, and it has become an important resource to care for patients in often remote and distant locations throughout our service area, which is approximately 45,000 square miles, just bigger than the state of Maine. In 2019, by our estimates use of telehealth saved our patients over 1.2 million driving miles. For older and sicker patients who cannot transport themselves, this is very impactful. To this, add the inclement weather and the challenges of harsh and cold winters. Additionally, in rural areas few, if any, public transportation systems serve as safety net for our patients. A critical lever we have leveraged to manage the cost of care for our patients and communities is our full risk, globally capitated arrangements with our not for profit Security Health Plan, and other models of risk based arrangements with payers in the private and governmental markets. Capitated arrangements have allowed us to innovate, invest and implement effective systems of care for our patients while also passing on the benefits in terms of lower premiums and additional benefits such as hearing aids and spectacles. These programs have improved outcomes, reduced costs and waste, and ensured high quality and accessible healthcare. Presently, Marshfield serves 68,224 patients in a globally capitated, full risk arrangement. We also serve another 51,131 patients on value-based contracts.

Relying on the knowledge gleaned from our several decades' long history of utilizing telehealth services in our clinical care models, and our present experience of responding to COVID-19, I would like to share the following perspectives and substantiate why these are relevant for your consideration.

1. Telehealth adoption has increased exponentially. With the federal waivers and commercial insurance coverage expansion during the PHE, almost 20% of ambulatory care can be safely provided through telehealth.
2. Expanded utilization of telehealth by baby boomers and senior citizens has resulted in improved patient access, increased convenience, and appropriate care albeit with less than robust,

integrated platforms. Creating such platforms within the framework of existing health care and EHR systems can reduce overall cost of health care.

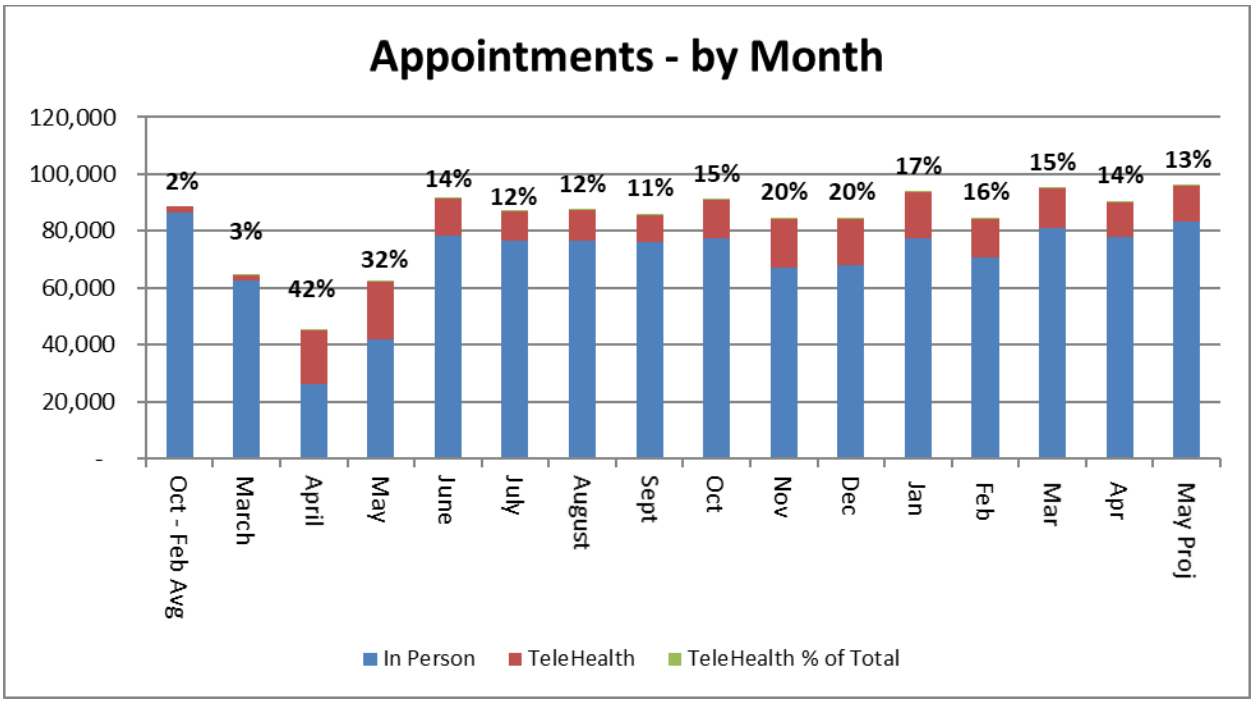
3. Blanket telehealth waivers issued in response to the pandemic have enabled the industry to continue its population health and health promotion initiatives and provide innovative programs such as Hospital Without Walls.

As we look forward to the next phases of the pandemic response and the return to whatever our new paradigm will be, embracing telehealth and stopping its backslide is critical. I urge you and your colleagues to fully support and implement effective and responsible policy that ensures continued accessibility to high-quality telehealth services that benefits patients, and their overall health.

Patient Behavior and Preferences, a MCHS snapshot and an APG view:

Since COVID 19, patient preferences on how they choose to engage with physicians and Health systems has forever changed. In MCHS, we serve around 100,000 outpatients a month with some cyclical drop in Wisconsin winters. Those appointments have declined to about 90,000 outpatients a month during the PHE. In entire year of 2019, we registered about 12,500 telehealth encounters, with about 200 clinicians providing telehealth services in any given month.

In 2020, across all demographies, telehealth visits skyrocketed from a pre-pandemic average of about 2 % visits a month, by 21 fold in April 2020. Within 4-weeks of the pandemic, MCHS was averaging 3000 telehealth visits per week, and by week 8, we were delivering over 6500 telehealth and phone care visits per week. During the time our centers were closed, telehealth and phone care services were able to provide access to 22% of our normally expected patient volume. **Overall, in 2020, MCHS provided 240,000 telehealth and telephone encounters. All 1400 physicians have been trained to provide this service.**



In the last 4 months, telehealth visits have plateaued to an average of 15.5%. In certain specialties, such as Behavioral health, 30 to 32% of our patients use telehealth or "phone only" visits.

In discussions with my APG colleagues and several health system leaders across the nations, we all agree there has been a decline in telehealth numbers. **Observational evidence suggests this 15-16 % fraction of "telehealth and phone visits" over all appointments per month are a reflection of a new steady state for consumer behavior across the nation.** Baby boomers have increasingly adopted telehealth visits, as have many of our octogenarian parents.

Patient Experience, Loyalty and Direct to Consumer Models

Patients seem to be willing to switch to telehealth as tolerance to waiting for appointments decreases. With increased access to convenient care, patient satisfaction in the care they receive from their physicians has also increased. In a survey of our patient population, Marshfield Clinic found that 68% percent of respondents reported being "highly satisfied" or "satisfied" with their virtual visit. **The most common reason given by patients for frustration with their telehealth visit was poor quality of internet connection.**

Removal of geographic site origination and other burdensome regulatory burden would improve access to care. Our Child Psychologist in Lake Hallie, WI had to move to Colorado because of family commitments. With the low availability of skilled providers to cover these patients we worked with the State of Wisconsin for approval of telehealth services and invested in a telehealth room in Lake Hallie. Patients were offered the option to continue or switch to new provider. In two years, only one patient opted for a different provider. He sees about 1200 encounters annually.

Digital Divide (Lack of Broadband access)

Phone-only telehealth services have been critical to delivering healthcare to the underserved, rural and racial minorities. *Even a year into the pandemic, meeting the regulatory expectations of audio-video visits for risk adjustment in rural Wisconsin has been challenging*. In April 2021, 57.6% of the 12,299 telehealth/phone patient appointments used "Phone Only "care. Our patients, who are old, have chronic illness sit in the parking lots of our schools and clinics to access broadband Wi-Fi that they lack at home for telehealth services. It is sad how little we, as one of the most developed nations in the world, are able to support our old, poor, needy and sick.

According to the Federal Communications Commission, 19 million Americans lack access to fixed broadband service at threshold speeds – and 14.5 million of those residents are reside in rural settings.[1] According to one study, during the pandemic, federally qualified health center audio-only ("phone")visits accounted for 65.4% for all primary care visits and 71.6% of behavior health visits[2] . Centers for Medicare and Medicaid Services (CMS) estimates up to 30% of visits during the pandemic have been audio-only[3]. Rural residents should not be disadvantaged in accessing telehealth just because of where they live.

Travel for Health Care and its Economic Impact

The economic impact on patient families of saved miles and time cannot be lost upon us. Our three pediatric neurologists are the only physicians with the subspecialty skills to see complicated neurological patients across a 45,000 square mile service area. In order for a child with well controlled epilepsy, the parent or parents are compelled to take time off from work, often for a whole day, all for a 30-minute physician visit that can be done over telehealth or telephone. *This is a wasteful exercise of time, money and resources. This child is an example of the 20% of medical care that is well suited for virtual care.*

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[1] *https://www.fcc.gov/reports-research/reports/broadband-progress-reports/eighth-broadband-progress-report*

[2] Uscher-Pines L, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. 2021;325(11):1106-1107.

[3] *Verma, S. Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. Health Affairs Blog 2020. https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/*

Other such visits that are well suited for telehealth include follow up visits, tele-dermatology, provider to provider consulting in subspecialty care, second opinions for highly specialized counseling and radiology opinions. The benefits of reducing unnecessary travel, lost days of production for the family, and improved access to care alongwith downstream reduction in urgent and emergency care utilization are all important drivers of reducing cost of care and improving patient experience.

Geographic Limitation and Improving Access to Appropriate Healthcare in Rural America:

Overcoming geographic isolation through telehealth in rural America has critical relevance. There is limited access to public transportation, and long drive times to avail medical care. This is further compounded in winter when the roads are treacherous with black ice or travel is blinded by blowing winds and snow.

A story that tugs at my heart is that of a 67 year old diabetic woman who traveled 200 miles to see me, 4 times a year to titrate medications and optimize her health. In 2007, MCHS provided me the ability to provide virtual care, do a heart and lung and physical exam over video, review her vital signs with the assistance of a nurse, review her lab tests and arrange for diuretic infusions when her heart failure worsened. For 13 years, every year she has sent me Christmas card and even now, when I no longer see her.

Incent Investments for Increased Physician Adoption

In the wake of the pandemic, physicians have rapidly adapted to the new paradigm of care. The additional waivers and regulatory changes surrounding telehealth services have been vital in creating pathways for organizations facing financial peril to be creative and expand access to care.

The present state involves working simultaneously with an Electronic Health Record (EHR), a video platform, a chat function with their medical teams to coordinate scheduling, lab tests and diagnostics, educating patients how to switch on their cameras, educating themselves in performing a good virtual physical exam and good "web side" manners.

Substantial investments in infrastructure are needed to ensure physicians can provide high quality, cost-effective, increased access to care through telehealth services. As patients become increasingly adroit with technology and physicians with telehealth workflows, access to critically needed services such as behavioral health, primary and specialty care would also increase.

Acute Care without Walls

Since 2016, MCHS has provided, hospital-level care in patients' homes **through use of telehealth, in-home nursing visits, and virtual visits by hospitalists**. We treat over 100 acute care conditions such as asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease (COPD) safely at home with proper monitoring and treatment protocols.[4]

Our research highlighted in the August 15, 2019, New England Journal of Medicine Catalyst[5] and those of others have demonstrated high rates of patient satisfaction and improved outcomes, and meaningful

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[4] *Centers for Medicare and Medicaid Services. (2020, November 25). CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge [Press Release]. Retrieved from: https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge*

[53] *NEJM Catalyst, No Place Like Home: Bringing Inpatient Care to the Patient, Narayana Murali & Travis Messina. https://catalyst.nejm.org/no-place-home-recovery-care.*

reductions in costs. As an author of this study, I will be the first to admit that the best place for a patient to recover is where they are most comfortable – and that is not in a hospital room in many instances.

► Our patients had 44% fewer 30-day readmissions, and 50% reduction in Emergency Department Visits than Security Health Plan members within the same group of DRGs who were treated in the hospital.
► HRC patients had 37% shorter length of stay, compared with historical data from SHP members within our diagnosis-related groups. (Length of stay for HRC patients was measured as number of days in the "acute" phase.)
► Patient satisfaction was greater than 90%, based on the number of top-box responses for all questions administered via the HRC program patient satisfaction survey.
► The health plan saved approximately 15–30% per episode, when compared to our historical baseline costs.

In late 2020, MCHS with bipartisan support from the congressional delegation that represents our service territory was granted a Section 1135 waiver from CMS to more broadly implement the Acute Hospital Care at Home program. MCHS, was one of the first nine, health care institutions in the country granted this waiver by CMS. MCHS was approved four hospital sites by CMS for Acute Care at Home, during the COVID pandemic. This waiver allowed us to expand our Hospital at Home, and has increased our capacity for the care of patients during the COVID-19 pandemic, providing greater flexibility and reducing the burden on providers caring for the most acutely sick patients.

Recommendations
In response to the committee's request below are our recommendations

I. Allow Acute Care without Walls flexibilities to extend beyond the PHE waiver
Even in rural areas, this model has successfully improved access and outcomes. While the CMS allowed a blanket waiver to permit the expanded use of this program for the duration of the PHE, we continue to gain data and experience to improve the program. We hope and strongly urge that Congress recognize the success of these programs, and ensure these programs can continue to grow and increase access beyond the PHE.

II. Eliminate Origination Site and Geographic Limitations
a. These limitations are outdated based on our experience with the present waivers and can no longer be justified as guardrails to protect against fraud, waste and abuse.
b. By creating certainty that telehealth will continue to be reimbursed by federal healthcare programs, Congress will give providers the certainty they need, to invest in the technology infrastructure, software and practice redesigns necessary to make telehealth part of their standard business operations. A lack of certainty could create new disparities among providers, and result in uneven access for patients.

III. Support and Ensure Access to Reliable Broadband
It is imperative to invest in broadband technology to close the digital divide and ensure living in rural communities is not a barrier to accessing telehealth.

IV. Allow Phone only telehealth services for Medicare Advantage Risk adjustment until we overcome the challenges of internet access
The disparities in broadband access are exacerbated in rural, underserved and minorities. In fact, over half of our telehealth visits with our patients have been phone-only because of limited access to broadband, smart phones or tablets. Medicare Advantage has allowed both audio and audio/video

telehealth services. Audio-only (phone) has not been allowed for risk adjustment, which impairs appropriate funding for health care delivery to the most vulnerable - an impact that will ultimately affect future Medicare member benefits and premium, given restrictions to formally document real risks is not true reflection of no risk. Our APG members agree that barriers that discourage patient participation through phone, when access to broadband is unavailable, prevent patients from receiving necessary care and ultimately expose organizations that are in the capitated, value based models to greater financial peril.

V. Ensure Payment Parity

In order to guarantee that clinicians and systems have the appropriate incentives to invest in telehealth services and capabilities, Congress must ensure payment parity between in-person and virtual visits. Allowing for expanded telehealth without the guarantee of payment parity will create another barrier to adoption, limit overall uptake by providers, and stagnate access to this important treatment mechanism for patients. Congressional action on this front will also send an important message to commercial payers to guarantee parity across insurance markets.

VI. Reduce Administrative Burden on Providers

First off, every effort possible should be made to harmonize statutes and regulations at the federal, state and local levels to promote the continued adoption and utilization of telehealth. For example, Congress should explore the establishment of a form of blanket patient consent to facilitate the provider connecting with them via the 2-way video method that the patient is most comfortable with. Congress must also work in concert with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to reduce burdensome regulations that inhibit the expansion of telehealth to smaller physician practices that reduce the ability of clinicians to focus on their most important task: serving their patients.

VII. Protect Patient Data While Fostering Innovation and Access

As patient satisfaction rises with the increased usage of telehealth services, creating a care environment that best serves patients and their needs is paramount. HIPAA waivers have been helpful in providing care and allowing patients (senior patients especially) to use compliant platforms they are familiar with. However, I am aware that some of these non-HIPAA compliant applications and platforms may compromise security and thus, it will be important to weigh the benefits of expanding access via the use of consumer-based technology versus potential privacy and security risks. All payers should be encouraged to align payment policies and coding requirements in order to ensure a seamless system of care that works in a coordinated manner across all providers and organizations.

VIII. Support integrating telehealth in EHR platforms

Congress should consider supporting regulations and incentives for integrating telehealth in Electronic Health Record Platforms.

I would again like to thank Chairman Wyden, Ranking Member Crapo, and the rest of the committee for granting me this opportunity to share these observations and recommendations with you during this hearing. We look forward to continuing to work with you on this very important issue and advancing America's healthcare system.