



Ensuring Medicare Beneficiary Access:
A Path to Telehealth

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Written Statement

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Chairman Senator Cardin, Ranking Member Senator Daines, and members of the Senate Committee on Finance, Subcommittee on Health Care, thank you for the opportunity to testify at today’s hearing: *“Ensuring Medicare Beneficiary Access: A Path to Telehealth”*. The views I am sharing today are my personal opinions and are not the views of the Health Resource Services Administration (HRSA), my employer the University of Utah, or the Northwest Regional Telehealth Resource Center (NRTRC).

I believe it is crucial to emphasize the significance importance telehealth services are for Medicare beneficiaries. It is my belief that leniencies around eliminating the geographical restrictions for originating and distant site telehealth providers, audio-only telehealth visits, and allowable provider types and payment parity have had and why they should remain permanent in Medicare coverage.

I am pleased that the subcommittee is exploring telehealth that delivers the right care, in the right place, at the right time to patients in ways that work for them, while providing appropriate payment to the practitioners and facilities providing those healthcare services. I am honored and humbled to testify alongside this seasoned panel of telehealth experts and want to note that in the absence of a patient witness, I will do my best to highlight the most important part of the equation, the benefits of telehealth for the patient.

I’d like to start with just a few facts about Montana, the fourth largest state by area, the eighth least populous state, and the third least, densely, populated state in the country.^{1,2} Low population density results in limited access to healthcare, most largely seen in specialty care, where providers are sparse. The population density by state underestimates the extremely rural nature of the Northwest region and Montana specifically.

The Native American/Alaskan Native populations living in the Northwest region make up a higher percentage than the total population in the rest of the nation, with 6.3% of the Native American and Alaska Native population residing in Montana per the 2019 ACS 1-Year Estimates.³

	Montana
Total Population	1,068,778
Area (Sq. Mi)	145,508
Rank of state by area	4th
Tribal lands (Sq. Mi)	145,555
Number of Tribes	7
Pop. Density	7.35
Rural % of Population	44%
MUA/MUPs	51
HPSA/ Primary Care	138
HPSA/Dental	123
HPSA/Mental Health	110

Historically, Americans residing in rural and frontier areas have faced disproportional challenges compared to their urban counterparts regarding access to clinical and behavioral healthcare





services. This disparity increased during the COVID-19 pandemic and stems from long-standing social inequities and systemic health conditions rural populations incur. Data indicates that rural communities experience higher blood pressure, obesity, diabetes, and higher incidence of tobacco consumption, putting individuals at higher risk of negative health outcomes from lack of access to quality, continuous disease management and mental health services. With the combination of increased comorbidities, decreased access to healthcare, and the decreased probability of health insurance coverage, rural community members are more likely to have a negative health outcome.⁴ Research also reveals that rural and frontier residents are more likely than their urban counterparts to experience a higher incidence of suicide, unintentional injuries, and premature death. These residents also tend to be uninsured or underinsured, have lower incomes or live in poverty, lack social support, and are without a regular source of healthcare. Results from the CDC “Mortality in the United States” report found that Montana, Alaska, and Wyoming have the highest suicide rates in the nation.⁵

I’d like to share why I am so passionate about telehealth. Following an internship at Craig Hospital, a neurorehabilitation and research hospital in Denver, Colorado, I began working as a critical care nurse in northwestern Montana; the patients I cared for included post-stroke patients. In 2010, the regional Montana hospital I was working for was awarded a Distance Learning and Telemedicine (DLT) grant through the United States Department of Agriculture (USDA). I was asked to lead the innovative telestroke program.

The telestroke program started by providing audio and video equipment to three critical access hospitals (CAHs) in northwest Montana, along with 24/7 neurologist coverage for patients suspected of suffering a stroke. Montana has 49 CAHs, and the majority of them are staffed with nurse practitioners, physician assistants, or family practice providers.⁶ Rural patients who are suspected of suffering an acute ischemic stroke, an embolism, or a clot that stops the blood supply to brain tissue, might be candidates for tissue Plasminogen Activator(t-PA) which should be administered within four and a half hours of the onset of stroke symptoms. This is where the telestroke program becomes so valuable. A neurologist can assess the patient over video alongside a local practitioner and can decide whether or not to administer tPA. At that point, the patient is transferred via flight to a qualified stroke center in a larger city.

As part of the telestroke program, a vascular neurologist (who happened to have grown up in Montana and was at that time, the only vascular neurologist in the state) and the stroke nurse (me) would travel to the remote CAHs and provide education on the administration and monitoring of tPA. We formed a relationship and trust between the clinicians at the rural site and our telestroke team. During my time with this program, it grew to 13 CAHs in Montana and to offer specialties such as teleNeonatology, and telepediatrics. We also created originating sites in rural communities for patients to go to have a





telehealth visit with their specialist in Kalispell. These types of visits allowed a patient to stay in their community, not travel long distances in inclement weather, over mountain passes, alleviate risks of collisions with wildlife, preventing the removal of students from school, allowing parents to avoid taking time off from work. Monetarily, this allowed families to save money on gas, lodging, and food. The telestroke program is still in operation today, and the neurologists authorized their 100th dose of tPA via telehealth this past summer, potentially saving the lives of 100 patients. To note, those patients, most likely will not need long-term care or therapies, providing cost savings to the patient and the healthcare system. I can honestly say this was made possible by access to telehealth, when this program started, not one of the CAHs had administered tPA.

Due to the success of this program, the hospital created a “Virtual Health Department”, and I served as the virtual health manager, supporting the growth of telehealth in northwest Montana. I saw first-hand the benefits of telehealth. For instance, one cardiac specialist shared gratitude after “seeing” a congestive heart failure patient via telehealth and having the opportunity to look into the patient’s kitchen where he recognized that the patient’s diet was contributing to repeated trips to the ICU.

There have been frustrations. The city of Great Falls, population 60,400, did not have a nephrologist for patients with kidney diseases, but because the city was deemed urban, patients were not able to go to their local clinic as an originating spot to connect with a nephrologist via telehealth. So, patients had to drive at least 90 miles to Helena to see a nephrologist.

In my current role at the NRTRC, I provide technical assistance to practitioners wanting to implement, improve, or sustain telehealth services. I provide telehealth education to medical and nursing students. Based on my experiences, the four key areas I would like to see be made permanent are:

1. Eliminating the geographical requirements for originating site
2. Preserving audio-only telehealth visits
3. Expanding provider types for telehealth services
4. Ensuring payment parity

1. Eliminating the geographical requirements for originating site

The origination site, is defined as the location where a patient is located when receiving healthcare services by telehealth.⁸ Before the pandemic, Medicare would reimburse for a telehealth visit if the patient was at an address that did not fall in a metropolitan statistical area or if the address was located in a metropolitan statistical area, the address must be in a rural area and be in a primary care or mental health geographic health professional shortage area (HPSA). In 2020, the Federal Administration





removed these restrictions, allowing patients to receive the care they needed, no matter where they were located, when they needed it, and health care practitioners and facilities received payment equal to that of an in-person visit.

It would be a disservice to limit the originating site to a patient's home or a clinical location. Locations such as public libraries, community centers, fire stations, and even a patient's parked vehicle in a place where they can access the internet have provided disadvantaged populations access to practitioners via telehealth. By adhering to the geographic limitations, we are contributing to the digital divide and health inequities. Many patients living in urban areas benefit from telehealth as well. Many caregivers don't have the ability to take their patients to an in-person doctor visit, which might delay preventive care or access to mental health services. Take the case of the wife of a man with frontotemporal dementia (FTD) who cannot attend in-person appointments because his particular manifestation of FTD does not allow him to be cared for by someone else, and his behavior is too disruptive in a waiting room. The man's wife commented, "Telehealth is literally a lifesaver for me."

My colleagues and I have been working to develop a resource that identifies [Telehealth Access Points](#) (TAPs), which are dedicated public spaces where patients can access telehealth appointments. These spaces have a private space for a telehealth visit, an adequate internet connection, along with a device with video, speaker, and microphone capabilities. It is imperative to ensure that all patients have access to telehealth, including those who may not have a private space or have limited broadband access at home.

2. Preserving audio-only telehealth visits:

Telehealth was a vital tool during the COVID-19 pandemic, ensuring continuity of care, reducing healthcare disparities, and enhancing overall patient outcomes. Medicare's population of adults over age 60 account for 25% of physician office visits in the United States, and often have multiple morbidities and disabilities. Thirteen million older adults may have trouble accessing telemedical services that requires both audio and video; a disproportionate number of those are already disadvantaged in terms of accessing healthcare. Telephone visits may improve access for the estimated 6.3 million older adults who are inexperienced with technology or have visual impairments.⁹

Audio-only telehealth is important to reduce barriers to Medicare beneficiaries' access to care because it does not require proficiency in using a smart device, having a webcam, or broadband connection. There are certain populations that are not quite comfortable with using the internet and video technology.





Broadband is not yet ubiquitous and can be expensive in rural areas. Medicare rules should preserve an audio-only option for those patients who don't have other means to seek medical services. A healthcare provider can provide qualified advice whether seeing the patient in person, via video, or listening over the phone. It is necessary for audio only to be an option for those individuals who don't have connectivity or any other way to seek medical services. If audio-only telehealth is not made permanent, it is possible that certain individuals might not be able to access these services.

According to a study published in the *American Journal of Medical Services*, audio-only telehealth services provided similar benefits and were not inferior to video-based virtual visits. Many study participants shared that they would recommend an audio-only telehealth visit to others and that their medical concerns were addressed appropriately. Audio-only telehealth services promote health equity for people who are economically disadvantaged, live in rural areas, are racial or ethnic minorities, lack access to reliable broadband or internet access, or do not have access to devices with video capabilities.¹⁰

I recommend that the same allowances for audio-only that are made for mental health visits are extended to clinical visits with provider discretion on whether an in-person, audio and video communication or audio-only communication is the best option for the health issue(s) and the patient. As a reminder, those allowances are when beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio-video interaction for the purposes of diagnosis, evaluation of treatment of a mental health disorder.

3. Expanding provider types for telehealth services

Federally Qualified Health Centers (FQHCs) provide primary care, behavioral health services, dental, pharmacy, and a myriad of wraparound services to underserved communities. The use of telehealth during COVID was the first time that FQHCs were able to consistently bill for services that they provided using telehealth for Medicare beneficiaries. The conversation around telehealth expansion has long centered around increasing access for patients, which FQHCs were able to do through the COVID waivers. It's important that these COVID-driven changes be made permanent, and that we also continue to adopt virtual health technologies to assist with provider recruitment and retention and finding ways to optimize staffing and workflows. For years FQHCs in many states have been able to provide telehealth services for Medicaid beneficiaries, making the more stringent requirements for Medicare patients and reimbursement a source of health inequity.





Speech language pathologists, physical therapists, and occupational therapists were able to provide telehealth services during COVID and be reimbursed, demonstrating that those services could be provided safely and effectively and that a large amount of Medicare patients needed to use those services. To not have these services available could potentially hinder a patient's recovery from healthcare episodes, such as stroke or post-orthopedic surgery or a pediatric patient born prematurely. During my time at the hospital, we would discharge pediatric patients after their neonatal intensive care with a prescription for speech therapy, even though there were no speech language pathologists within a 200-mile range.

4. Payment Parity

Providers who use their expertise and cognitive skills can attest that they do not give a lower quality of service for patients that they see via telehealth, over those who they see in-person, and this should be reflected in reimbursement so telehealth is not disincentivized. To note, the CMS Final Rule for CY 2024 Fee Schedule recognized that there are still practice expenses providers and clinics incur when the practitioner is in their home and have agreed to pay the non-facility rate, which is higher than the facility rate. Practitioners are expected to bill for certain things and if the service can meet the definition of the code they are billing for they should be reimbursed the same amount regardless of whether or not the visit was in-person or via telehealth.

A common barrier to the adoption of telehealth has been state-specific laws and regulations governing reimbursement and professional licensing requirements. When the administration declared a Public Health Emergency (PHE) on March 13, 2020, and put waivers in place to remove regulations around telehealth, patients were seen virtually, keeping not only immunocompromised patients safe, but practitioners safe, and were paid for these services. The [Office of Inspector General is monitoring potential fraud through use of telehealth](#), and there have not been any announcements thereof.

It is important to acknowledge that delivery of telehealth includes myriad regulatory requirements, preferences, and challenges: and coordination of allowable services per Medicare, state Medicaid agencies, and other insurers, providers, locations, modalities, billing, payers, reimbursement, technology, provider preference, patient preference, to name a few. Now is the time to seize the opportunity to streamline and improve telehealth service delivery for everyone involved. The Office of Inspector General performed an audit of 440,003 Montana Medicaid telehealth paid claim lines totaling \$43.2 million from March 1 through December 31, 2020, analyzing the procedure codes paid as telehealth and identifying which were allowable for billing as telehealth. The audit found that 99.9% of the lines reviewed were compliant with federal and state requirements, and Medicaid providers





generally complied with federal and state requirements when claiming Medicaid reimbursement for telehealth services during that period of the COVID-19 pandemic.¹¹

In closing, telehealth plays a critical role in improving access to timely and regular health services with highly qualified healthcare providers, especially for patients with challenges that affect access and care coordination. By addressing the outlined recommendations, Medicare beneficiaries will have consistent access to telehealth services, promoting their overall health and well-being. Making the telehealth leniencies discussed earlier a permanent fixture in Medicare coverage is a significant step toward improving the lives of American citizens.

Thank you for your attention to this critical matter. I appreciate the committee's dedication to enhancing healthcare access for all Americans, and I am hopeful that you and your colleagues will continue to champion the cause of telehealth for Medicare beneficiaries.

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