Maryland
Hospital Association

February 17, 2021

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Support- Senate Bill 567 – Telehealth Services – Expansion

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 567.

Telehealth has long improved access to care and health outcomes. As COVID-19 led many Marylanders to stay home, health care providers rushed to use telehealth—delivering care remotely to keep patients and caregivers safe. From Western Maryland, to Baltimore City, to the Eastern Shore, patients used telehealth to maintain continuity of care. Emergency federal and state waivers allowed health care providers to ramp up telehealth quickly. These services were universally supported by patients and by hospital caregivers. In many ways, telehealth is the "silver lining" of the COVID-19 pandemic. All see first-hand what health care and policy experts have known: telehealth broadens access to care, improves patient outcomes and satisfaction, and chips away at health inequities. **Quite simply, telehealth <u>works</u> for Marylanders.**

MHA worked with a coalition of providers to introduce SB 3, the Preserve Telehealth Access Act, which has been before this committee this session. SB 3's provisions would expand access to telehealth in the same ways as SB 567 proposes to do. Maryland hospitals therefore offer strong support for SB 567 as well.

I. History of Telehealth Adoption and Shift to Telehealth Services During COVID-19 Pandemic

During the 2020 General Assembly session, legislators introduced two bills to ease barriers and expand access to telehealth. From the outset of COVID-19, it was clear these measures would be instrumental to promote access to care. Over the past year, federal and state waivers allowed more access to care via telehealth and ensured continuity of care during this unprecedented public health crisis.

As in-person visits declined, telehealth visits emerged as a viable, safe, and effective way to provide care. About five times more Marylanders used telehealth in 2020 than in 2017. **At one Maryland hospital, telehealth visits boomed from 11 per week to 4,500 per week (410% increase).** National data show telehealth services to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries rose 2,600% between March and June 2020, compared to the same period in 2019.

Data show care patterns have and will continue to change as telehealth becomes mainstream. That is why reimposing barriers to telehealth will not be a return to normal. It would be an undeniable step backwards for Marylanders—particularly the most vulnerable.

II. Fundamental Components of SB 567

A. Remove Originating and Distant Site Restrictions

The distinction of "originating sites" (where the patient is located) and "distant sites" (where the treating provider is located) is maintained by Medicare and Medicaid. During COVID-19, federal and state laws restricting what could be considered an originating or distant site were relaxed to keep patients and providers safe.[1] These flexibilities expanded access to care, as patients no longer have to surmount transportation, childcare, leave, and other barriers to medical appointments. Maryland's hospitals support the removal of restrictions on originating site and distant site, so that providers can continue to meet patients where they are.

B. Coverage and Reimbursement for Audio-Only Health Care Services

To fully address health equity in telehealth use, however, the value of audio-only health care services cannot be understated. The digital divide in Maryland between households with high-speed internet and corresponding devices with audio-visual capabilities is significant and cuts across traditional rural/urban lines. Generally, urban areas have more broadband access, as is the case across most densely populated areas in Maryland. Yet, even in Baltimore City—Maryland's most populated city—more than 40% of households lack high-speed internet needed for audio-visual services.[2] Roughly 30% of households also lack a computer, laptop, or tablet to conduct an audio-visual visit.[3] In Maryland's rural areas—particularly with median incomes below the state average—over 30% of households do not subscribe to high-speed internet, and over 25% do not have connective devices. **For urban *and* rural areas, audio-only health services may be the only modality a significant portion of their population can access.** To restrict coverage and reimbursement for audio-only health services would essentially isolate these Marylanders from necessary health care, especially in the aftermath of a pandemic.

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[1] Centers for Medicare & Medicaid Services (CMS). "Medicare Telemedicine Health Care Provider Fact Sheet" www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (accessed Jan. 25, 2021); CMS. "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers" www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (accessed Jan. 25, 2021); CMS. "Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic" www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid (accessed Jan. 25, 2021)

[2] "In 2020, many Marylanders still lack high-speed internet. And that's a problem for work and school." The Baltimore Sun. Aug. 7, 2020. baltimoresun.com/coronavirus/bs-md-pandemic-broadband-access-20200807-6ugb7j7dkneyvntm7dyvjgydmm-story.html

[3] Horrigan, John B. "Disconnected in Maryland: Statewide Data Show the Racial and Economic Underpinnings of the Digital Divide" The Abell Report, Volume 34, Number 1 (Jan. 2021) abell.org/sites/default/files/files/2020_Abell_digital%20inclusion_full%20report_FINAL-web.pdf

Moreover, telehealth use during COVID-19 highlighted the disproportionate effects the digital divide has on already underserved and disadvantaged communities. Black and Latinx communities, who have long-standing disparities in access to care, more often rely on audio-only health services.[4] Areas with lower median household incomes, and older residents, including many with impaired eyesight or motor skills, relied on audio-only health services due to lack of internet and audio-visual capable devices.[5] Similarly, MHA's members experienced this firsthand, with hospitals sharing that patients with Medicaid were leveraging audio-only services at high rates. For example, one hospital reported 29% of Medicaid patients using audio-only services. Continued coverage and reimbursement for audio-only services safeguards this access for Marylanders.

C. Reimbursement Parity for Telehealth Services Compared to In-Person Services

Commercial and public payers started to systematically reimburse for telehealth services for the first time during the pandemic. This allows providers to sustainably deliver the services. Yet, as virtual visits became the safest, and often only, form of health care delivery during the pandemic, hospitals rapidly scaled up technology (software and hardware), connectivity infrastructure, staffing and IT support—in some cases purchasing devices for patients to use in their own homes. The original investment in and continued maintenance of those components will require adequate reimbursement if providers are to continue offering those services. It would be a severe disservice to Marylanders to indirectly dissuade telehealth use by paying providers less for a vital, valuable, and equivalent service. Creating reimbursement parity for telehealth services allows to sustainably continue delivering telehealth services across the state.

D. Expansion of Remote Patient Monitoring (RPM) Services

RPM services most often refer to decentralized monitoring, meaning a patient uses a device in their home to give clinical information to a provider at their office. This means the practitioner can monitor the patient's condition without requiring a formal visit and immediately respond if needed. Although most RPM devices are designed to monitor specific physiologic conditions or processes, recent studies found even ubiquitous devices, such as smartwatches with clinical apps installed, could detect pre-symptomatic COVID-19 or other respiratory illnesses.[6] [7] RPM can

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[4] Eberly, Lauren A., et al. "Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic" *JAMA Network Open* (Dec. 29, 2020) jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488

[5] Darrat, Illaaf, et al. "Socioeconomic Disparities in Patient Use of Telehealth During the Coronavirus Disease 2019 Surge" *JAMA Otolaryngology-Head & Neck Surgery* (Jan. 14, 2021) jamanetwork.com/journals/jamaotolaryngology/fullarticle/2775067

[6] Mishra, Tejaswini, et al. "Pre-symptomatic detection of COVID-19 from smartwatch data" *Nature Biomedical Engineering*, Vol. 4 (2020) www.nature.com/articles/s41551-020-00640-6

[7] Radin, Jennifer M., et al. "Harnessing wearable device data to improve state-level real-time surveillance of influence-like illness in the USA" *The Lancet Digital Health* (Feb. 1, 2020) thelancet.com/journals/landig/article/PIIS2589-7500(19)30222-5/fulltext

prevent conditions for worsening, which could lower health care costs for emergency visits and save precious lives in the process. Removing restrictions around RPM ensures that these services are accessible to all Marylanders.

III. The Future of Telehealth

The rise in telehealth during COVID-19 offers a substantial opportunity to improve health care access for millions of Marylanders—particularly those with geographic and socio-economic barriers to care. Legislators, policymakers, and federal and state agencies in the U.S. are making telehealth coverage and reimbursement permanent because they recognize the power of telehealth to advance health and health care. [8] [9]

For these reasons, we urge a ***favorable*** report.

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[8] CMS. "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021" www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1 (accessed Jan. 25, 2021); Sullivan, Thomas. "FCC Chair Ajit Pai Issues Call to Expand Telehealth." *Policy & Medicine* Jul. 15, 2020. www.policymed.com/2020/07/fcc-chair-ajit-pai-issues-call-to-expand-telehealth.html; "The Doctor Will Zoom You Now." *The Wall Street Journal* Apr. 26, 2020 www.wsj.com/articles/the-doctor-will-zoom-you-now-11587935588

[9] "Virginia Expands Telehealth Coverage During COVID-19 Emergency." mHealth Intelligence. Nov. 20, 2020. mhealthintelligence.com/news/virginia-expands-telehealth-coverage-during-covid-19-emergency?eid=CXTEL000000520230&elqCampaignId=16927&