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WEBINAR

TELEHEALTH BEFORE AND AFTER COVID-19

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Remarks:

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Discussion:

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P R O C E E D I N G S

DR. TURNER LEE: Hello and good afternoon from Brookings. We are excited that everyone has chosen to spend your time with us for this next hour. My name is Dr. Nicol Turner Lee and I'm a fellow in the Center for Technology Innovation at the Brookings Institution.

And we're really excited because today I think we're going to pick up a topic that most of us have been seeing talked about on the news. And basically, it's something that we're wondering is going to be continued after we come out of this COVID-19 period.

And I'm very happy this afternoon to be joined by Chairman Ajit Pai, someone who I've known for a long time, who I know actually cares about telehealth. And as we were thinking about this topic, and we also have released a paper today that we hope that all of you will actually go to our website and get, I thought about the chairman because I know that the Federal Communications Commission has been busy accommodating some of the need to really transfer to a telehealth platform, a remote platform, in lieu of the fact that the more people that we have in hospitals and the more patients that we have going to doctors' offices, the more strain that we're seeing and the higher rates of infection.

And so, I don't know about you who's actually there out there today, but I've been talking about this issue for about 10 years now, from the very first time that I saw a telehealth demonstration in Anchorage, Alaska. And since then, it's been something that I think was useful before and it's obviously useful now.

So before I introduce the current chairman of the Federal Communications Commission, Ajit Pai, and have him give us remarks, I want to remind all of the viewers that you can submit questions for the panel that will follow, and I will introduce the panelists shortly, by emailing us at brookings.edu or via Twitter -- or events@brookings.edu, excuse me, or via Twitter at @BrookingsGov, which is the tag, or #Telehealth. So, again, submit your questions throughout the conversation and I will definitely take as many as I can within the time that we have.

Without further ado, I would like to welcome again the current Federal Communications Chairman Ajit Pai to open up this session with remarks around the topic of today, telehealth. Thank you,

chairman.

CHAIRMAN PAI: Well, thank you so much, Dr. Turner Lee, for that introduction. I really want to express my appreciation to Brookings for hosting this important conversation, and to Dana, Jordan, and Ross for sharing their expertise on the panel to come.

It's a special treat to be here with my good friend Dr. Nicol Turner Lee, and I feel like I'm with you again. A couple of weeks ago, Dr. Turner Lee participated in an online meeting of the FCC's critical Advisory Committee on Diversity and Digital Empowerment, where she serves as one of the directors of our working group. And it's a pleasure now to be a participant in one of the many important projects that she is helping to shepherd into the public discourse, which is, of course, telehealth.

Now, today's webinar, of course, is called "Telehealth Before and After COVID-19." And I thought I'd spend a minute talking about the "before" part of that equation.

Even before the pandemic, telehealth has been a very important component of the FCC's work and a personal interest of mine. When we talk about the digital revolution, I would argue that no area has seen greater potential for transformative change than healthcare.

When you talk about high-speed, low-latency connectivity, that can really accelerate the shift in healthcare from the point of care, such as a bricks-and-mortar clinic or hospital, to the point of need, such as a patient's home or wherever the patient happens to be. And with wireless sensors and ubiquitous connectivity, healthcare professionals can remotely monitor your health and data can be transmitted to your doctor immediately, so that problems don't manifest as emergencies that require an emergency room visit.

Now, I've seen the power of digital health for myself in some of my professional travels. For example, I cherish a visit to the Veterans Affairs Department's National TeleMental Health's hub in Salt Lake City, Utah, where I had a chance to speak with, among others, a patient who had been getting TeleMental Health services from the VA in Salt Lake even though he lived 1,000 miles away in Paradise, Texas. And he said this service, mental health delivered over telehealth, had added years to his life. It helped him lose 80 pounds, got him off blood pressure medication for the first time in 15 years, and gave

him a sense of optimism about the future.

The same thing with a visit I did earlier this year before the pandemic stopped our travel, where I visited Wind River Reservation in rural Ethete, Wyoming. And I heard from tribal leaders from the Northern Arapaho Tribe how a FCC funding recently enabled a fiber connection to one of the tribe's healthcare clinics there that was enabling tribal members to get care instead of having to drive several hours away, in some cases to another state all the way down to Denver. And that's been a huge difference in terms of the time saved and potentially the lives saved for tribal members in Wyoming.

And perhaps most memorably to me and I'm sure to Dr. Turner Lee, as well, we visited with Dominique Wilkins, the former Atlanta Hawks star, about a year ago. And we heard how he uses wireless sensors and other technology to monitor his diabetes and how he encourages others to think about technology as a friend as they help us ascertain better health outcomes. And I dare say, if it works for "The Human Highlight Film," it could work for any of us.

As I mentioned, it's not just a personal pursuit, it's also a -- professional pursuit, it's also a personal cause for me. I grew up as the son of two doctors who practiced for over 40 years in rural Kansas. And my father, in particular, was the only urologist in much of Southeast Kansas, and he would drive many hours every week to see people in even smaller towns than where we lived because that was the only way that you'd be able to see somebody without having to drive several hours to Wichita or Kansas City. And so, that's one of the reasons why I've tried to make telehealth an important cause for the FCC.

Speaking of the FCC, it wasn't just thinking about telehealth during -- or before COVID-19, we're doing something about it. For example, the Rural Healthcare Program, which has been on our books since 1997, for over two decades that program had a set budget of \$400 million. Had never been increased even though the demand had skyrocketed. Under my leadership, for the first time, in 2018, we increased that by 43 percent to \$571 million in 2018, and we indexed it for inflation to account for the growing need in the years to come.

Similarly, in 2019, we made major reforms to the Rural Healthcare Program, unanimously

I would add, that ensures that limited program funds will be used efficiently and effectively. We streamlined the process. We increased transparency and predictability, so that both healthcare providers, Congress, and everybody else can know exactly how the money is flowing and how it's being used. And we also strengthened safeguards against waste, fraud, and abuse. We want to make sure that every single dollar is going to a patient who needs it and a healthcare provider who can apply it very effectively.

Importantly, we also adopted a \$100 million Connected Care Pilot Program. That Rural Healthcare Program I just talked about? Under the law it's limited to rural healthcare facilities, but we wanted to extend that care outside the bricks-and-mortar context. So, we set up a Connected Care Pilot Program that enables connectivity to travel with the patient. We're really excited to see how that enables connectivity for healthcare providers in the time to come.

Now, as for the "after" part of the equation, telehealth after COVID-19, I would say that the coronavirus pandemic has had many negative impacts, but one of the silver linings, I hope, is that this becomes a so-called hinge moment for telehealth. One of the most notable facts about our Rural Healthcare Program is that, you know, it's been on the books for, as I said, for over a couple of decades and two decades later, we have exponentially better technology. You're going to hear about this from some of the great panelists in the next panel. But we need doctors and patients to make that leap of faith towards telehealth. And the coronavirus pandemic can be a catalyzing event to help make that happen.

There have been polls out, for example, that show that more than one in eight Americans have used a video chat to consult with a healthcare professional just in the last month alone. A separate analysis found a 50 percent increase in telehealth visits in March. There are many other studies. I'll just give you the one anecdote. I'm married to a physician and she's used telehealth in her own practice, which has been great for her and great for the patients she sees. The patients might be nervous about coming into a facility and exposing themselves or exposing her, and it's been one way for her to provide care safely even on a virtual platform.

And so the FCC is trying to take advantage of this hinge moment to work with others. In

particular, about two months ago, I wrote to Congress and asked them for authority and funding to set up a telehealth program. And gratefully, they did that in the CARES Act. They gave \$200 million of funding to set up a telehealth program. That bill was signed on a Friday; on Monday, I proposed to my colleagues a program to make it happen; and on Tuesday, the FCC voted on it officially. In fact, just today, we've already doled out the fifth set of grants to providers across the country, \$11 million, and I believe it's over 30 million in total that we've now stood up.

And thanks to the work of the FCC's remarkable staff, this funding is going to help everybody from New York City to Yuba City, California, who have innovative ways of employing telehealth to keep themselves and their patients, both coronavirus and non-coronavirus patients, safe.

Now, the other piece of it I would want to mention very briefly, it's not specifically a healthcare initiative, but this is going to be a massive game-changer for telehealth in the years to come. And one of them is the massive increase in spectrum that we've recently adopted.

For example, just last month, the FCC voted unanimously to approve my plan to devote a massive 1,200 megahertz of spectrum in the 6 gigahertz band for unlicensed operations, essentially turbocharging WiFi, a fivefold increase in the amount of spectrum available for WiFi, which will enable very high bandwidth, high-speed, low-latency connectivity that could be used for anything, whether it's a wearable device for a patient, a super high-resolution scan that a doctor can use to conduct surgeries or do dermatological analysis and the like. I mean, this is just the tip of the iceberg and we really look forward to seeing how telehealth innovators use that spectrum.

Similarly, we're in the process of setting up the Rural Digital Opportunity Fund, a \$20 billion program to get high-speed fixed broadband into homes, up to 6 million homes, especially in rural, remote, and tribal parts of this country; parts of this country that for too long have been on the wrong side of the digital divide. We want to change that equation and the Rural Digital Opportunity Fund is going to be one big way of doing that.

Of course, one of the key things that we want this broadband connectivity to leverage is telehealth innovation. So, we really look forward to seeing more of those Wind River Reservation clinics

sprouting up across the country to take advantage of rural broadband connectivity.

And the final thing I'll mention very quickly is the 5G FAST Plan, 5G, of course, being the next generation of wireless connectivity. And this has been a major effort for the Commission over the last several years. We want to make sure that all parts of this country benefit from 5G, not just for faster speeds, of course, that everyone can appreciate on their smartphone, but for some of those telehealth-related applications and services they're going to require very high-speed, reliable wireless connections. And in the years to come, you're going to see even more companies using some of the spectrum, deploying some of the wireless infrastructure, and laying some of the optical fiber that's necessary to make 5G telehealth a reality across this country.

Of course, there are other things beyond the FCC's bailiwick that we don't have power over, but I have been speaking about it nonetheless. For example, the need to reform some of the interstate licensing rules that I've heard everywhere I visit has stood in the way of really determined and dedicated healthcare providers not being able to access people across state lines. That's something that HHS and others have been doing great work on.

Same thing with reimbursement. CMS has broadened its formula for reimbursement, as I understand it. And Administrator Verma and others I think have our full encouragement as they continue that process.

I think it's an all of government and all of the private sector approach. We need to think very creatively and forwardly about how telehealth is going to be delivered in the time to come. And I can't wait to work on that with Brookings, with Dr. Turner Lee, with the panelists, and with anyone else who's out there. I think the future is very bright for telehealth.

And if we can take one silver lining out of this dismal time, I think it is that we are finally at the point where technology can deliver better outcomes for healthcare patients across this country and a more effective healthcare system for everybody.

So thanks again for the opportunity to speak today and look forward to gleaning much wisdom from the panelists and from Dr. Turner Lee in the time to come.

DR. TURNER LEE: You know what, Chairman Pai? Thank you for that. I mean, as you can tell from our layout today, the infrastructure part of it is really important. And the access to broadband is pretty much the game-changer as to who will benefit from this technology and who will not. So, I'm very appreciative of you actually coming today because I don't have to ask any of those questions of the panelists, for one.

And for two, you sort of laid out I think the large-scale plan of how we have to keep moving forward. And I echo your sentiment that this has been a decades-long conversation. So, thank you again for joining us and we look forward to more of the FCC.

And, folks, you know, I want us to really put that conversation in the context of the panel discussion that we're going to have right now. The individuals that are joining us, you know, come from the medical profession. They are doctors or they work with doctors. They're health policy analysts, like my dear friend Jordan Roberts, who I'll introduce in a moment. And it's really important that we sort of blend these two conversations to figure out what we are really going to do post pandemic to make sure that we can all benefit from this service.

I want to remind you again that please send questions to events@brookings.edu or via Twitter using the Brookings tag or #Telehealth.

With that, I've got three folks today with me that I will introduce in no particular order, but I want to make sure that you know who they are. Ross Friedberg is the chief and legal business affairs officer at the Doctors on Demand organization, which he'll talk a little bit more about. Dana Lichtenberg is assistant director of congressional affairs for the American Medical Association. And last but certainly not least is actually Jordan Roberts, who's a health policy analyst at the John Locke Foundation, with whom Brookings co-partnered with to co-author a report that is actually online within the last 30 minutes around regulating telehealth before and after COVID-19. So with that, I want to jump right into this discussion.

Jordan, I'm going to actually start with you because in my years of actually doing this, and I date back to -- my conversations in telehealth and telemedicine back to 2009, when a congressman by the name of G.K. Butterfield, who still is there, asked this question about how to bring remote services

to Wilson, North Carolina.

So, I'd like to actually get from you before we get started, you know, these definitions, and we laid them out very eloquently in the paper, between telehealth, telemedicine, and digital health, just so we start the conversation on the same page. They're often conflated, so if you could provide a definition of each, that would be very helpful.

MR. ROBERTS: Yeah, thanks, Nicol. And yes, that was one of the first things that we wanted to do when we started to write the paper was to come up with some definitions that we could agree on, so we're all talking the same language here as we move forward and as more people learn about this.

So, to start off, telehealth, this is going to be one of the most broad terms to describe all different types of technology and telecommunications in healthcare. And this can be such things as health education, remote monitoring of vitals, physicians virtually connecting with one another. It's the broadest term to describe all of this. And the most important thing about telehealth is that it includes a wide array of healthcare providers that may not work in a clinical setting. So, it's the broadest of all these terms.

And then when we move to telemedicine, this is going to be a more narrow term that is limited to the -- it describes the care that is going to be delivered in a clinical setting, but is now delivered through telecommunications at a distance. So, this could be, you know, video consultations with a specialist or you send a photo of a rash or a burn to your doctor to have him check out.

And the way I like to think about this, it's sort of like the relationship between squares and rectangles in that all squares are a type of rectangle, but not all rectangles are a type of square. And so if you apply that to telemedicine and telehealth we would say that telemedicine is considered a type of telehealth, but not all telehealth is a type of telemedicine. And so, those are the main differences between the two.

And then we have another term, digital health. And, you know, this is going to describe more software applications or consumer-facing hardware, such things as Fitbit, an Apple watch, or other

mobile devices where the patient is really at the helm and they're more in control of the use of the technology.

And so, in the paper what we wanted to do is to agree on one term to kind of use broadly and so we decided on telehealth because in the paper we take a 10,000-foot view of some of these barriers to just broad technology in healthcare. And so, telehealth is the one that describes most a broad sense of what we're talking about there.

So, those are the differences. And so, it's important to know those as we start to talk about the future.

DR. TURNER LEE: Thank you, Jordan, for that. And again, the paper is available online and we'll refer back to that throughout the conversation. But this is clearly not a conversation just about the paper, it's about telehealth.

Dana, I want to switch over to you because I started this and I think one of the reasons why we found this topic to be relevant, we sort of were working on this paper before the coronavirus outbreak and now, you know, it's very neatly placed I think within the conversations that are going to happen.

You know, one, hospitals were in distress, right, when it came to actually seeing patients. And on the other hand, we needed symptomatic people or potentially asymptomatic people to stay away from large gatherings of others. And so telehealth, with the stroke of a pen, and I know you've been doing this as long as -- longer than myself. It's been decades since we've actually been talking about this, right, as the Chairman insinuated. It came in and sort of helped with some of that social distancing.

My question to you is, you know, was it helpful? I mean, we're hearing it from a nice to know. And, you know, I think a couple of us on this call have probably had these scenarios play out. But was it helpful generally in the mitigation of risk of the pandemic? So let's start there and then I'll turn to Ross and then we'll start having more of a conversation.

MS. LICHTENBERG: Yes. So, the AMA's been working on telehealth, as you noted, for quite a long time. And it's been frustrating on how slow it's going.

This is -- the policy changes that just happened, allowing for telehealth and paying for telehealth, specifically the two-way interactive video, has turned out to be a linchpin sea change moment. It turns out it's a modality. It's not the practice of medicine. It's a medicine done via technology and it has allowed this incredible explosion of services across the breadth of medicine and an explosion in the uses of other digital tools.

So, it appears that we were right that telehealth, the policies that were limiting the two-way interactive video specifically, the geographic restrictions and the site restrictions and the lack of payment were really the biggest areas writ large. Telehealth has been absolutely essential, both for the response to COVID and managing both in the home and at hospitals, in fact. But it has also been absolutely essential to provide continued access to healthcare for non-COVID patients.

We've seen enthusiastic, innovative, and aggressive rollout in about three to five weeks of telehealth and telemedicine and digital health that we expected would probably take three to five years if we got coverage. So, it turns out those things were absolutely essential. It's the fact that we had artificial restrictions, as the Chairman just said, you know, after two decades of working on this, we have an exponentially better technology, but we're still limiting the basic platform, which is interactive two-way live video, as if it was a satellite Rural Health Program from the '80s.

So, I think we've seen it's just amazing what has just happened. And I think we have a lot of lessons to learn from this about how to go forward. But, yes, this has been essential.

We are now asking for coverage through the ERISA plans. We have legislation that would do that. We've asked the states to require the commercial plans to follow Medicare and Medicaid programs have also been following Medicare. And it's been absolutely essential, including the phones. And I don't want to -- that is a COVID response that phone services are also being covered and CMS just increased the payment for that to match, similar to the complexity of what you would pay for similarly complex in-person or via telehealth.

DR. TURNER LEE: Yeah. No, Dana, I mean, you're completely right and we're going to come back to some of these issues, but you're completely right. You know, again, three weeks versus

decades of sort of figuring out what works and now we're seeing again, like you always mentioned, this national pilot or this improvisation around it.

Now, Ross, you actually work with doctors, right? I mean, you're a doctor. You work with doctors. There's been a lot of regulatory barriers at the state and federal levels to actually implement this, so I'm very curious about what your opinion has been after seeing these immediate waivers that really relaxed certain barriers when it came to payments and coverage and application.

DR. FRIEDBERG: Yeah, absolutely. And just to provide a brief bit of context, Doctor on Demand is a national provider of primary care telemedicine, which we define as including mental health with psychiatrists and psychologists and social workers and also chronic care. And we operate in all 50 states, and so there's a lot of multistate complexity with telemedicine.

You know, as we all know, medicine is still very much a locally regulated animal and telehealth transcends borders. Right? A physician can see a patient across the world quite easily in a virtual visit.

You know, we operate across multiple different payers. So, you can pay cash for Doctor on Demand, you can use insurance, and most recently now you can use Medicare and Medicaid. And I'd say there's a few things we've seen over the last few weeks in terms of regulation that's been really great to see.

I mean, the first is just a huge barrier for telehealth forever has been inconsistency across payers. Right? Some payers cover, some payers don't. Some payers cover under certain situations only and then Medicare had broad restrictions on coverage with geographies and limited use of codes and other things.

And with the Medicare waiver, we now have 38 million Medicare lives that can use Doctor on Demand for the first time ever.

With the Medicaid waives, which often I think are not spoken about as much, we are able to serve a lot of Medicaid populations very quickly that we weren't before. So, for example, we have a partnership with Mass Health to serve and provide zero co-pay telemedicine to everybody in the state of

Massachusetts with Medicaid.

And previously, before the pandemic and the waivers, there would have been a cumbersome, potentially full-year process to enroll and get set up to do a program like that. But as a result of the waivers, we were able to stand up telemedicine for a Medicaid population within seven days, which is just extraordinary.

And I would also just add on the state issue, you know, there's -- the way I think about it is if there's a hurricane, right, and we like to bring utility companies from other states into help out, right, because there's usually a need for more utility workers. And I think the same is true with healthcare and this pandemic. Certain areas of the country are in greater need than others at different times. And the ability to use licensure waivers to flood that area with telemedicine providers to help out where there's great need, like New York City a few weeks ago, it was just incredibly helpful.

See, the challenge is there's still inconsistencies, right? So, some -- each state kind of handles the waiver authority differently. They have different processes, you know, for how you get a licensure waiver, and so you have to work through some of that. Medicare, the waivers are great, the Medicare coverage waivers, but they're temporary. And so, that does create some uncertainty about how much should you invest in creating an awesome experience for Medicare beneficiaries when you don't know if it's going to be around in three months, five months, six months. Right?

So there is that uncertainty, but I'd say on the whole, it's been an extraordinary few months, an extraordinary few months of progress in telemedicine. And really just the time is now for virtual care. I mean, we're just seeing incredible interest from both the public at large and the provider community in embracing this new telemedicine that we have today.

DR. TURNER LEE: And I just want to make sure because there may be people who are not following, you know, just healthcare in general that are watching today. Ross, can you just tell us the licensure thing, how the licensure barrier actually plays out so it's clear with folks?

DR. FRIEDBERG: Yeah. So, a physician in the United States typically has to be licensed where the patient resides and where the physician resides. And the same is true with most other

provider types, as well: psychologists, psychiatrists. And so a physician who lives in New York, who wants to see a patient in Pennsylvania or New Jersey or Ohio, would need to be licensed in each of those states under the laws today.

What the waivers allow is a physician who's duly licensed in one state to practice in some of these other states without having to go through a separate license requirement, almost like what we have with driver's licenses today. I don't need a separate driver's license in every state as long as I have one. The waivers give us some of that in the states that have opted into a waiver, and that's making it a lot easier for us to use physicians where they're in most need.

And as you noted, Nicol, earlier, I mean, an example of that is just rural. Right? So, in Texas right now I think one-fifth of counties have major shortages of primary care. I think no primary care in many of those counties. Right? And so the ability to bring physicians into those counties from all over is really helpful.

DR. TURNER LEE: Yeah. No, and, I mean, I think part of what we tried to do in the paper, again, is like sort of break down I think what has been these, and Dana sort of insinuated, as well, like these longstanding federal barriers: licensure, reimbursement, interoperability, what the Chairman alluded to in terms of interstate coordination.

And at the end of the day, you know, what we found in this exploration, and our other co-author Jack Karsten, who is a senior research assistant here at Brookings, is that all healthcare in many respects is somewhat local. And states actually play a huge role in sort of defining what those parameters are.

Jordan, I want to come back to you because one of the arguments that we make in the paper, which, you know, may be contested by some, but it's really important, particularly since it was utilized during the pandemic, is state parity laws. Can you explain a little bit of what that means in terms of state parity laws and the extent to which they were helping telehealth before or they were, you know, sort of hindering it prior to the pandemic and prior to what we've actually been talking about in terms of its adoption and use?

MR. ROBERTS: Yeah, sure. And so, you know, when we're talking about barriers to telehealth adoption and usage, one of the main ones discusses reimbursement. And what that means is how a provider gets reimbursed for providing care virtually.

And so, what parity laws -- parity essentially means equal, and so parity laws mandate that insurers and payers need to reimburse providers at an equal rate for care provided virtually as it would be care provided in person. And, you know, the thinking behind these laws is to incentivize providers to adopt them more because of the equal reimbursement.

but, you know, my organization, the John Locke Foundation, the origins of the paper that we co-wrote with the Brookings Institution was a report by Katherine Restrepo, our former director of health studies here. And basically, she made the case against private payer parity laws and the main takeaway is that these laws are contradictory to telehealth's cost-effective nature by mandating equal payment. And what she lays out in the report is that in North Carolina, we don't have any private payer parity laws and we had a fairly robust telehealth market already operating without these laws. And so, when we think about how telemedicine and telehealth can supplement and, you know, buttress the healthcare system right now, we need to think about cost savings and increasing access. And so, you know, when we talk about paying for healthcare virtually, it doesn't really make sense to myself and some others to pay for it on an equal ground because it just costs a lot less to deliver.

But what we saw during the pandemic was that a lot -- CMS and a lot of other payers, either through mandates or choice of their own, decided to reimburse providers at parity. And, you know, I think this makes sense during this time where primary care doctors and a lot of other healthcare providers, they have their supply of patients artificially suppressed because of these stay at home orders and just general angst about going outside or going to the doctor's office. So, you know, a lot of these payers stepped up to pay providers at parity during this time, which makes sense.

But I think, you know, as we look towards the future and see how telemedicine can just aid the healthcare system in general by reducing costs, reducing waste, and increasing access, I think we need to leave it up to the insurers and the providers to come together and freely negotiate what seems to

be a rate that makes sense where we can incentivize cost saving, incentivize better health outcomes, and do that without a bunch of mandates on insurers.

So, that's kind of what has happened. And, you know, a lot of these parity laws will revert back to what they were before the emergency order as soon as that's over. But we don't know when that will be, so it's an important discussion to have as we move forward to a post COVID world.

DR. TURNER LEE: And, I mean --

MS. LICHTENBERG: Can I jump in on that?

DR. TURNER LEE: Yeah, yeah, Dana. Because I was going to say it's interesting, it's sort of like these artificially suppressed numbers, I'm curious, too, how that's going to be affecting going forward.

MS. LICHTENBERG: Well, we look at this as a discrimination issue when we talk about parity, much more akin to the mental health parity situation in that, historically, telehealth services have been underpaid or not covered at all.

DR. TURNER LEE: Right, right.

MS. LICHTENBERG: Which is barrier, clearly is a barrier, because, as we've seen, telehealth has exploded in the last five weeks because we finally got coverage.

DR. TURNER LEE: Right.

MS. LICHTENBERG: You know, and payment is part of that discussion. Some telehealth -- telehealth is just a modality.

DR. TURNER LEE: Yes.

MS. LICHTENBERG: So, if you're a physician or another provider who's using the same time, energy, and skills to provide the same complexity of services via telehealth, they should be getting the same payment. Their overhead costs are fixed. They have to pay for their staff, they have to pay for their office. The fact that they're also providing some of their services via telehealth, which also comes with its own expenses, that the decisions on how much money you should pay for that should be calculated of what goes into that service just like any other service. But we don't want to start from the

position that telehealth is always less costly. That's not always the case. Sometimes it's more expensive.

And if you're putting the same time, skills, and expertise into it and from your office, you should be paid the same. Otherwise, you're discriminating against doing the service via that modality and that in itself will stop deployment.

DR. TURNER LEE: So, that's interesting. So, I had a telehealth visit for the first time the other day, Dana, where I had an allergic reaction to shellfish. And I didn't eat it, but I was so tired of cooking the same stuff for my kids that I decided to make shrimp without, you know, touching it, but it ended up getting in my system anyway. And so, it was interesting because I had a reaction, it didn't go away, and I had to set up a telehealth visit. It literally took like five minutes.

MS. LICHTENBERG: Right.

DR. TURNER LEE: And it wasn't with the doctor, it was with a physician assistant. And I think one of the things that we should talk about going forward, and I agree with you that doctors -- and, Ross, I'll have you jump in, as well -- you know, doctors should be paid at the same type of parity. The question, though, becomes is there are some parts of this that may incentivize doctors and patients to use it more simply because it's a five-minute visit versus me getting in the car, driving to the office, sitting down, and getting checked in. It literally was something much more convenient for me as a patient.

And we'll get to the equity question in just a moment. But I think going forward, and, Ross, kind of swinging (phonetic) to you as a telemedicine provider, this whole conversation of whether a doctor should weigh an in-person visit versus telemedicine has sort of been caught up in the fact that we couldn't get it right in terms of paying it. But with these artificially suppressed numbers, Ross, I want to go back to you, I mean, this environment that we're in, obviously the volume is online, how will that affect your business if the volume goes back to in-person?

DR. FRIEDBERG: Yeah. I just want to make a few quick comments first on the bigger debate about parity and then I'll jump right into that narrow question, Nicol.

So, you know, there's different ways to look at this issue of parity. And one way that we look at it at Doctor on Demand is through the lens of primary care. And even before the pandemic, you

know, well before the pandemic, we were seeing declining utilization of primary care in America, and a shortage of primary care physicians and medical students going into primary care. And we know from decades of research that nations that have strong primary care foundations tend to have lower costs overall. Right?

Now, fast forward to the pandemic and we're seeing an even greater crisis. Right? A lot of physician practices are in severe financial stress right now. Many are going out of business. And so even with telehealth as something they can use to make up some of that shortfall in revenue, they're still struggling across the country. And we run this risk in many parts, especially rural areas, of independent practice going out of business entirely. Right?

So, I think we have an opportunity right now thinking longer term than just this immediate crisis to look at how can we use technologies like virtual care to, you know, reinvigorate primary care in this country? Right? I actually believe, and we believe at Doctor on Demand and are building toward this and have a number of programs around this, that the future of primary care will be virtual. Right? You will be in your home, the physician will be remote, and there may be devices and other connections that help support the care, but it will be primarily a virtual experience.

The challenge is a lot of the care that goes on in a primary care medical home environment does not necessarily go on within the visit itself. Right? Like you can imagine a world of digital health where, and this world exists today at Doctor on Demand, where a lot of the care is between visits through an app, through devices, through remote monitoring. Right? And I think the fundamental challenge we have is that the traditional systems of reimbursement are visit-based, traditional visit-based systems of reimbursement. But now we have a technology that transcends visits. What's a phone call? What's a text message? What's a visit? What's this remote monitoring?

We need to think about, holistically, how do we design reimbursement programs for primary care that promote that kind of activity within practices, where they're not just pushing everyone into a visit, right, because that's the only mode of reimbursement? But they are yet reimbursed for those visits, right? We need to think about it more holistically if we're going to get to a place in medicine where

primary care is again like the foundational component where you go for your care initially, where there is care coordination, and where there is chronic care management, and all of that.

I don't even know if I hit your main question.

DR. TURNER LEE: No, no. I mean, I think you're hitting it, I mean, and I think everybody's hitting it. I mean, this is how complex this debate is.

When I first was introduced to telehealth, I was in Anchorage, Alaska, and we watched a dermatological remote care from Anchorage to one of the remote islands. Dr. Karen Rheuban of the University of Virginia was the lead doctor that actually took us on this tour. And at that time, you know, we knew it was good. This is almost -- I'm not going to tell people my age, but this was almost 15, 20 years ago that I actually saw this demo.

And, you know, fast forward to today, I agree with both you, Dana, and Jordan that we're going to have this conversation around whether or not we want to apply very stringent, you know, reimbursement, licensure, and other regulatory boundaries to something that we know could actually be helpful both on the primary care side of it versus, you know, the secondary care, dermatological services or other clinical services that are ancillary to the consumer experience.

You know, I had this question later, but I want to bring it up first. You know, the main population we should also be looking at as we go through COVID-19 are the medically marginalized. I mean, there were -- years ago, I used to say with so many people of color and disproportionately low-income people carrying a cellphone, instead of building a clinic, why can't we virtualize a clinic, right, for people to use that? And now we're seeing that access being supported through this pandemic.

You heard what Chairman Pai said. I mean, are we still going to have, Dana, an equity problem when it comes to serving people who are medically marginalized with this?

MS. LICHTENBERG: I think so. I mean, we -- clearly, this pandemic has shown that we need a federal investment in broadband infrastructure, period. Clearly, it's an essential just like a phone or electrical grid is and that is something that has to happen. It's a huge problem.

We had already noted that we saw a growing gap in that we were slowly going to a more

digital health and that a lot of communities didn't have access because they didn't have broadband. So, you know, you could already say we already have and AMA just stood up its first health equity (inaudible) and this is one of our top priorities is how do we address health disparities?

All the new digital technologies -- telehealth, telemedicine, whatever you like, and we're now just calling it digital health in general -- are essentially infrastructure for value-based care. They're also linchpins to getting access to people who have not had equal access in the past.

So, you know, we think that one of the reasons why the focus has been at the AMA on trying to lift the barrier, the policy barriers that don't make any sense and lifting certainly the geographic and site restrictions on telehealth to an audiovisual that don't even apply to other digital health applications, like (inaudible) monitoring the acute care management remotely. You know, that just needs to happen.

But we also have to tie it into broadband access, including access to the devices. Otherwise, we're going to have whole swaths of populations who don't have equal access to healthcare. They don't have it today and it's going to get worse because things are going to move to virtual modalities as part of the reach that doctors use, as part of the tool set that they're be using in the future, and a whole bunch of people won't have access to it.

I don't want a continuation it's great that we got phone service covered for the emergency, but that was a patch. We shouldn't have that. You know, the phone's great for some things, but really, we need to have access as a medical community to all the tools available to do the best job for the patient, and we just don't have that right now.

DR. TURNER LEE: No, and, I mean, that's one of the things that we're seeing in this pandemic, right, that disproportionately the rates of infections are higher among groups that generally just have poor access to quality healthcare to start with, right? And so giving telehealth and opportunity requires, I think, this fundamental premise of ubiquitous broadband access and access for all in addition to the devices.

MS. LICHTENBERG: Yeah, and then you mentioned value-based care. I think that

we've also seen that as we move to alternative pay models that these tools are essential. We can't actually do alternative pay models as people would like us to do or more value-based care is like, say -- which are not fee-for-service models, they're other models. We really can't do it without health IT, without digital tools, without broadband. Those are all essential components. And the fact that we weren't getting coverage and paid for and policies that were actually actively stopping physicians from using their tools they need to use has stalled out the entire move to value-based care in a realistic manner.

DR. TURNER LEE: And before I start going into what we should be telling Congress, I want to go back to Jordan, though. Because that's a premise we make in the paper, right, that where we are today, Jordan, is not where we're going to be in the future, right? The modalities are going to change over time. And I want to go back again to like the regulatory frameworks that we embrace around this, and just have you share a little bit about, you know, even where Dana's talking about digital health, how we even frame that in terms of some of the restrictions that have been placed around this whole area.

MR. ROBERTS: Yeah. And, you know, I talk about this in the context of I'm from North Carolina, and we have one of the largest rural populaces in the entire country. And so, extending healthcare to these people, these medical deserts where, you know, we have a serious maldistribution of physician -- or medical professionals in the state. And so, when we look to, you know, the title of our paper is, "Twenty-First Century Barriers to Telehealth Adoption," and what we look for is what are ways that we can simply change regulatory language, like Dana talked about? Simple changes in Medicare policies, what they can cover, just to expand and include as much different technology as we can in the future. And getting these barriers out of the way and letting, you know, the market dictate who gets these services, we can really make a lot of progress.

And we know that rural populaces, they just don't look like they did, you know, 20, 30 years ago. We have less population there, less economic activity there. And so, we need to look at and realize that and kind of accept it. You know, the traditional hospital and the traditional emergency room and things like that may not work in these more rural communities, so where can we remove barriers, remove regulatory barriers that just allow these different innovations to even take place in the first place in

places like rural North Carolina?

So, it's looking to where we can knock down barriers and allow that the medical geniuses we have in this country to really take their expertise and apply it to these traditionally underserved populations.

DR. TURNER LEE: Yeah, and that brings me back to, I mean, this bigger question of, you know, we're talking nationally about reopening states. Many of the improvisation in terms of, you know, drive-through testing centers and trying to figure out how to get 53 million kids back online for school. I mean, we've all been part of this creative process, I think, to figure out how to both address the consequences of this virus, but, at the same time, there's been a lot of discussions around what lessons have we learned.

So, I want to start with you, Ross, in terms of getting Congress' ear. You know, the obvious -- I mean, there's a couple things happening here. Right? Healthcare has always been one of those contentious areas that has ebbs and flows with political leadership. We already know that, right? But we also know that Congress has this great opportunity to sort of look at the lessons learned and to do something different, so that we can actually benefit from it generally and get it down to where Jordan said, the medically underserved.

So, if you were to give Congress some advice on how to actually continue with the adoption and use of telehealth -- and I'm just going to say this, Ross, because you had a big smile on your face when you said these last (inaudible) weeks have been great -- so that the next 3 weeks, the next 3 years, the next 30 years are great, what would be the advice to Congress who may want to come back and just put everything back the way it was?

DR. FRIEDBERG: Yeah. I think, you know, it might sound little bit like -- a little redundant here, but I think Congress has to look at what's happening with primary care right now. It's a major crisis. If we don't fix that, we're not going to have a lot of telehealth even with the technology and some of these very specific barriers removed around coverage. Right? Like we need a strong, functioning primary care backbone that then leverages telehealth. Right? And telehealth can help the

economics of primary care in a big way if we get the policies right on how to reimburse for those services, both fee-for-service and otherwise. Right?

There's some interesting pilots going on at CMMI around innovative primary care models. They exclude virtual care companies like ours from participating. Right? We need to change that. We need to do experiments right now on how we can create the virtual house call; the virtual primary care physician, your regular doctor who can see you on a regular basis if you need to wherever you happen to be, rural, urban, or otherwise; send devices into your home. How that's going to be funded and how that's going to be structured needs to be I think front and center long term if we're going to rebuild our healthcare system.

You know, at Doctor on Demand one of the interesting things that happened is I get calls pretty regularly from other countries, right, looking at how they're going to respond to the pandemic and just their healthcare systems more broadly, including countries in Africa. And recently, one country reached out to us and said, you know, we're a poor African country and we're looking at telehealth and we're realizing that we can potentially leapfrog 20 years of healthcare infrastructure investment by just making a bigger bet on primary care medicine that's telehealth-based. Right?

They're thinking very big over there and we should be, too. Like how can we take this and make it a moment of reinvention in terms of how we get healthcare in America? Just doing these surgical changes to like the Medicare Part B coverage rules and licensure waivers, that's an important first step and it's been really helpful in this pandemic, but it's not going to get us to the kind of healthcare system we want. So, we need to just think more holistically about the kind of care.

And the last thing I'll just say on that is we've really got to think beyond visits, right? Or if we're thinking about visits, we have to realize like a visit in the future includes things like a device that may be in your home and remote monitoring and using software and technology between visits to get preventive care information and other information. Right? So, just the way we even think about what these services deliver is different. And that has to inform Congress and others who are making decisions on how to pay for it. It's not just apples-to-apples with like traditional care models.

DR. TURNER LEE: Mm-hmm. So, you're actually suggesting that we have a paradigm shift, right? That we come out of this -- which is tough. I mean, I think your first point of your response is the healthcare system is very complex and it's very fragmented right now, right? So, we may have the opportunity to actually see that the can -- the lid of the can has been taken off and let's try to do something differently. So, I think that's really interesting.

Dana, what would you tell Congress if you had the opportunity to sort of lay on to what Ross said, that it's okay to be respectfully different in terms of your views, but what does Congress need to do when we come out of this pandemic if we're going to make telehealth much more continuous?

MS. LICHTENBERG: They've got to stop treating telehealth as special. It's a modality. Two-way interactive video shouldn't be treated different than remote patient monitoring. The fact that we have restrictions on geographic, the geographic and site restrictions need to be removed immediately. We just got proof that they were completely nonsensical and were artificially limiting the use of technology probably for the last several decades. You know, they need to let them just lift it.

I know we've had problems with the CBO score to lift the 1834(m) restrictions on Medicare coverage, which everybody else has been copying. So, like a virus, we have a remnant of a law from the '80s that was based on satellite uplinks that is restricting the use of technology that has been used in every other economic sector in the United States. Completely ridiculous.

We're just like that's it. Congress needs to lift the restriction. No more piecemeal we're going to cover this, but not that. We're going to cover TeleMental Health, but we're not going to cover providing critical care to a skilled nursing facility. They're picking and choosing winners and losers at this point in the market and limiting what doctors and the medical community and the patient community knew for years. That'd be our number one request is just get rid of 1834 restrictions.

We're going to ask the states the same thing. Don't go backwards on that. Those restrictions need to be gone.

In addition to that, you know, we have just had pilot projects. As I said, the national pilot - - huge, nationwide pilot partnered in every sector of the medical world on how do you use these tools.

That data is going to be in the claims databases. It is going to be coded because most of these are services that are the exact same. The modality is different, but the service -- they're using the same service codes. And we know which ones are virtual or which ones are in person because we have them code -- put a site of service modifier on the code. So, the claims databases are going to have a massive amount of information.

In addition to that, AMA was doing a telehealth initiative already. We were working with Texas, Florida, and Massachusetts state societies to do a Telehealth Initiative. That was working with 25 practices to see could we build evidence for clinical practice and, like, coverage and payment for telehealth? Well, that just exploded.

So, we'll be doing a lot of qualitative survey work moving forward of the practices we were already working with and comparing the three states and how things worked; all the state policies and comparing state by state what policy changes were made and what the response was. How do patients and physicians experience using telehealth? What were the clinical outcomes? What supports do we need to have in place to support clinical -- you know, the best clinical practice moving forward? What policies worked and which ones didn't?

Well, it turned out that, for example, quite a few commercial carriers were putting prior (inaudible) and documentation requirements on telehealth services that didn't apply to other services. It's like that's interesting. Why were you doing that?

So, we're going to have a lot of mop-up.

DR. TURNER LEE: Yeah, yeah.

MS. LICHTENBERG: We're having a cross-enterprise discussion right now about practically what do we need to do? That will include additional work. We had pushed out coding guides and practical advice to doctors on how to implement telehealth, which was well-received and I think was copied pretty much by everybody. We had insurers borrowing it, everybody has borrowed it. We've identified some coding gaps.

DR. TURNER LEE: So, Dana, data will be key. I think you're so right. And, Jordan, I'll

have you answer this. And we've got tons of questions, so I'm going to try to figure out how to ask at least two of them before we run out of time.

But, Jordan, I'll ask you the same thing. I mean, we put a lot of -- a roadmap within the paper not just for Congress, but for the healthcare community in general to look at. What would you say would be your number one pushout to Congress to sort of keep this conversation going?

MR. ROBERTS: I think I'd just echo what Dana said, don't restrict anything. You know, we want to allow for as much usage of this, allow providers and patients to become more comfortable with it, allow insurers to work with providers figuring out the proper way to reimburse and use this. So, just don't restrict, don't limit it. We know that the technology is going to move quicker than the regulations, so let's set up a regulatory framework that allows, you know, a robust future for telehealth and as much use of it as we possibly can.

DR. TURNER LEE: And then for states, I mean, we're talking about federal, but a lot of what we make in the paper is for states. What advice would you give to states, Jordan, as well?

MR. ROBERTS: I think you should just look at, you know, where the need in your state is and look at how the laws are set up. And look at, like we identify in the paper, if there's any barriers to allowing patients or providers to adopt this and just allow them to make those decisions, what's best for their practice, what's best for their healthcare needs. So, just look for any barriers, anything that gets in the way of more free usage of this.

DR. TURNER LEE: That's right. So, I have a question from Christy (phonetic) that I think I want to ask to you, Ross. She asks, how will the anticipated increase in telemedicine affect small provider groups or solo practices who might not have the technological resources to get in the telemedicine game?

DR. FRIEDBERG: So, I think that telemedicine could an incredible support for small independent practices because it enables a physician in a rural area to see patients perhaps in ways they couldn't afford. Right? Like for their patients that live 30, 40, 50 miles away, they no longer have to travel. Telehealth provides interesting solutions through companies like Doctor on Demand to get easier

coverage for afterhours and on-call care, so we can provide support to independent physicians who need it.

Also, we have programs at Doctor on Demand to provide specialists who are available for small independent providers. Right? So if you need access to a psychiatrist or a psychologist either for a provider-to-provider consult or, you know, a place to refer your patient for mental health, telehealth is a great resource for you and it can be more coordinated than just the traditional models.

So, I think there's quite a bit of support that telehealth can offer to an independent physician. Also, some of the software tools now -- I mean, I would just end with this key point. The biggest thing we hear from our doctors at Doctor on Demand about what they love about working with us, and we have a very high retention and satisfaction, is that our platform removes the administrative burdens of medicine. In fact, the number one reason providers join Doctor on Demand is because they're exasperated by the administrative aspects of running a practice. Right?

The platforms that exist today, like Doctor on Demand and others, many of them are very good at removing and taking over some of that administrative stuff, so that the physician can focus more on the patient, which provides all sorts of benefits with respect to morale, productivity, economics for the physician. And so, when we think about a telehealth platform it's not just the video between the patient and the doctor, but also all of those supports around it that, if designed right, make it easier to practice medicine.

DR. TURNER LEE: Mm-hmm, mm-hmm. Jordan, this question is for you.

MS. LICHTENBERG: Could --

DR. TURNER LEE: Oh, I'm sorry.

MS. LICHTENBERG: I'm sorry. No, I just said I just wanted to add a little bit to that. You know, our Digital Medicine Advisory Payment Group, which advises the AMA internally about our -- you know, working on telehealth policy, we did a survey of our academic members because we have several academic centers. And what we found out and what they told us was that telehealth programs, that they support the locals. So, if you're a local physician, you're providing this -- it's like doing rounds. You have

this incredible access to expertise and consultations and quick answers that you didn't have before.

DR. TURNER LEE: Yeah.

MS. LICHTENBERG: And it actually creates a new practice of medicine and it helps keep the care at -- local. So, not just for the independent practicing, but the health centers, for the local hospitals. They found that they were actually doing more services locally because of the help that they could get via telehealth meant that they weren't referring people on as much. It actually reduced the need to, for example, transfer people to the regional hospital centers.

DR. TURNER LEE: Yeah.

MS. LICHTENBERG: Very interesting.

DR. TURNER LEE: This question came from Evan, but I don't know if I have enough time to answer it because I want to get to a couple other questions, but I think if we were to go to Congress, you know, in the next few months, we want to make sure whatever system that we set up has the ability to pay providers for the technology in some way, right, so that it's a reimbursable expense. And that's sort of also been the hang-up. I think that question that Christy had is right on, that, you know, sometimes it has not always been accessible to a variety of providers.

Jordan, I would be remiss if I didn't have this question about data security. You know, it's been asked and I changed my screen, so I'm going to go back because I try to say everybody's name. One of the viewers asked a question around how to do we ensure data security of these new telehealth -- what role -- okay, how do you anticipate security concerns to impact the role telehealth will play in the technological advancement in healthcare? And that comes from Marie.

So, we talked a little bit about that, but why don't you share areas of opportunity and areas of concern?

MR. ROBERTS: Yeah. So I think the biggest thing to remember is that health data and personal health data is just so important to keep private and to make sure that the right people have access to that. So, as we move forward, you know, I'm advocating for a lot more use of this technology and a lot more different modalities, so we can figure out ways that technology can best supplement the

traditional delivery of care. But that's also going to require that we have, you know, privacy measures in place, so that this data cannot get out.

You and I, Nicol, just wrote a piece about some of the concerns we had with some of the widespread tracing with relation to COVID-19 and how there's so much potential for abuse, discrimination, and just misuse of health data. So, as we increase the types of technology and increase usage of technology, patients and providers need to, you know, keep in mind how precious and how important healthcare data can be to ensure that it's used just for treating the patient and it doesn't get into the wrong hands to where it can be used against a patient in employment or things like that.

So, you know, it just can't be understated how important it's going to be to ensure that we're using devices that are protected and that people place a higher emphasis on keeping their own health data private.

DR. TURNER LEE: Yeah. And that's why I think it's so important, I mean, we put in the paper conversations around encryption without back doors and making sure that, you know, digital health tools had the ability to have privacy by design embedded into wearables and other things. I mean, those are really important pieces in addition to respecting, I think, the profession overall.

And for all of you that have been watching us, and we are -- I cannot take any more questions because we're about to wrap up, but all the questions were great. And I think the question I'd like to answer for myself in my closing comments is around disparity.

You know, equity is obviously one of the major driving forces that we need to continue to place into every conversation that we have. I said yesterday on another webinar, my colleague Elaine Kamarck is -- you know, this has also surfaced is that equity *[sic]* is real and it's persistent. Inequities have to be addressed going forward and that should be part of every conversation that we have.

But this conversation today, and we urge you to go to the Brookings website, grab the paper, talk about it, give us comments and feedback. Follow Ross and Dana and particularly as the AMA is putting out a new guidebook on digital health, as well as some framework around data collection during this period.

At the end of the day --

MS. LICHTENBERG: And cybersecurity, which (inaudible).

DR. TURNER LEE: And cybersecurity, yep. At the end of the day, what Brookings and the John Locke Foundation really found out is that we need to have, and I think Ross put it so eloquently, some flexibility as to the placement and the use of these telehealth visits, the modalities that will be introduced into the healthcare scheme. But more generally, we need to go back, and I think I heard from everybody, sort of retool and recalibrate what healthcare means in American society. And that is something that many of you have tried for decades, but guess what. What this pandemic has demonstrated that with a little ingenuity and creativity we don't have to wait decades anymore. We can actually start having conversations that have pragmatic use.

So, with that, I would say to all of you thank you for attending today. Become part of the conversation. We will try to answer as many questions that are on the Twitter feed. And I want to thank you all again for attending. And thank you to all the panelists, as well as the Chairman, for being part of this very timely dialogue. Thanks again.

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