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COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

"STATE OF TELEHEALTH: REMOVING BARRIERS TO ACCESS AND IMPROVING
PATIENT OUTCOMES"

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Chairman Luján, Ranking Member Thune, Chair Cantwell, Ranking Member Wicker, distinguished Members of the Subcommittee, thank you for the invitation to testify. It is a privilege to appear before you today.

I would like to begin by commending the Subcommittee for convening this hearing on telehealth and for its Members' leadership in supporting these vital services as well as the broadband connections that are necessary to power these offerings. Expanding Americans' access to telehealth services has been a top priority for me at the FCC, and I can say that it is an endeavor that has long benefited from broad and bipartisan support at the agency and here in Congress. In fact, for years, the FCC has supported the buildout of high-speed Internet services to health care facilities through the Universal Service Fund, which Congress authorized through the Telecommunications Act of 1996.

I have had a chance to see firsthand the benefits that these telehealth services can bring to communities across the country. New Mexico is just one example. On a visit to the mountainous Mescalero Apache Reservation last year, I met with the talented team at the Mescalero Indian Hospital. Thanks to a high-speed Internet connection, community members can now have one-on-one video sessions with world-class mental and behavioral health specialists that are located hundreds of miles away in Albuquerque. Without that connection, this type of mental and behavioral health care—care that we need to expand access to in this country—would be out of reach for many people in that community.

I have seen similar benefits in remote parts of South Dakota as well. In the southwest corner of the state, I visited Pine Ridge two years ago. That's where I toured a "smart emergency room" that connects via an Internet-powered video and audio feed all the way back to Sioux Falls, which is almost 400 miles away. A team of talented emergency room specialists located there at Avel eCare can walk the generalists at Pine Ridge through complicated, emergency procedures in cases where there is no time to transfer a patient to a larger or more specialized facility. The high-speed fiber enabling that connectivity was built with support from the FCC's Rural Health Care (RHC) Program.

This important type of telehealth—connecting one facility to another or what is often referred to as a hub and spoke model—is vital. With rural hospitals closing, a lack of specialists in many remote communities, and the challenges and costs of traveling long distances for care, we must continue to support this form of telehealth. The FCC is committed to doing just that.

At the same time, there is an emerging and complimentary trend in telehealth. The delivery of high-tech, high-quality care is no longer limited to the confines of connected, brick-and-mortar facilities. With remote patient monitoring and mobile health applications that can be accessed right on a smartphone

or tablet, health care workers now have the technology to deliver high-quality care directly to patients, regardless of where they are located.

I first learned about this new trend on a visit to the Mississippi Delta a few years ago. It's a part of the country with a deep and rich history. And it is not exempt from the many health care challenges that Americans face in communities around the country. Take Ruleville, Mississippi, which sees diabetes rates about twice the national average. It also has some of the highest poverty rates in the country, only adding to the difficulty in finding adequate health care.

In Ruleville, I met Miss Annie, a patient at the North Sunflower Medical Center. Miss Annie woke up one morning with blurred vision, and after seeing her doctor found out she had advanced diabetes. She tried treating it through traditional methods of care but didn't see much progress. She then signed up for a ground-breaking telehealth program being run in conjunction with the University of Mississippi Medical Center (UMMC). She was sent home with a tablet and a wireless-powered blood glucose monitor. Every morning, Miss Annie's tablet would chime as a reminder, she would prick her finger, and the tablet would then display her glucose number, which was reported back via a wireless connection to her doctors.

Based on that reading, an app on the tablet suggested appropriate actions—from a particular food or exercise, to watching a relevant video. If she forgot, she would get a call from a nurse. With this technology, her A1C levels went down, and Miss Annie says she has never felt better. I had the chance to visit Ruleville again just a few months ago with Senator Wicker and reconnect with Miss Annie. She is doing great and is a strong advocate for expanding telehealth.

After that first visit to the Mississippi Delta a few years ago, I started working with my FCC colleagues to create a nationwide, $100 million Connected Care Pilot Program that builds on the one UMMC pioneered. We were able to stand that program up in April of 2020. So far, we have awarded a total of $58 million to more than 50 entities in 30 states and the District of Columbia.

While there has long been value in telehealth, COVID-19 further underscored the importance of care at a distance. As stay at home recommendations spread across the country, everyday tasks that used to be carried out in person moved online. It became critically important that patients receive treatment remotely. In response, the FCC quickly waived certain telehealth rules and boosted funding to our RHC Program to make it easier for broadband providers to support telehealth during the pandemic.

Congress also came together and passed the CARES Act, which provided the FCC with an additional $200 million in emergency telehealth funding. Within days of Congress passing that law, we used that support to stand up a new COVID-19 Telehealth Program. We awarded all $200 million by July 2020, and at the end of that year, Congress provided the Commission with an additional $250 million for a second round of funding. So far, the agency has committed $80 million of that Round 2 funding.

I have had the chance to visit with many of the awardees and other health care providers that have greatly expanded their telehealth offerings, including in New Mexico, South Dakota, Washington, Mississippi, Florida, Kansas, Michigan, Ohio, and Pennsylvania.

One thing these visits have brought home is the unprecedented spike in telehealth visits over the past two years. In Parsons, Kansas, I recently met with a health care provider that saw telehealth visits jump from close to zero before the pandemic to about 1,200 each month. At the University of Michigan, I met with doctors that saw a 75-fold increase in telehealth visits per month—increasing from 400 a month pre-pandemic to more than 30,000 at its height. Near Miami, Florida, one provider went from zero telehealth visits in 2019 to 90,000 in 2020. All of these facilities said that they were able to ramp up their

technology infrastructure to meet this surge in demand thanks to the FCC's congressionally-funded COVID-19 Telehealth Program.

More broadly, the data on telehealth and remote patient monitoring show significant benefits too—both in terms of health outcomes and a reduction in costs. For instance, the Veterans Health Administration's remote patient monitoring program resulted in a 25% reduction in days of inpatient care and a 19% reduction in hospital admission for more than 43,000 veterans. It also cost $1,600 per patient compared to more than $13,000 per patient for VHA's home-based primary services. Another remote patient monitoring initiative showed a 46% reduction in ER visits, a 53% reduction in hospital admissions, and a 25% shorter length of stay. Analysts estimate that the widespread use of remote patient technology and virtual doctor visits could save the American health care system $305 billion annually.

While the benefits of telehealth are clear, barriers remain—from legal and regulatory to connectivity challenges. For instance, there have long been a range of licensing and reimbursement issues that held back telehealth. In early 2020, the Department of Health and Human Services (HHS), with urging from Members of this Subcommittee, helped facilitate greater access to telehealth services through the issuance of key waivers. For example, HHS has allowed more types of providers to bill Medicare for telehealth services and granted waivers for the reimbursement of audio-only telehealth services. While these waivers are set to expire at the end of the COVID-19 public health emergency declaration, we cannot afford a return to the status quo once the pandemic ends. We have made too much progress to move backwards.

For this reason, I fully support the bipartisan CONNECT for Health Act reintroduced this year by Senator Schatz, Ranking Member Wicker, and many other Members of this Subcommittee. This important legislation would take a number of steps to ensure that more people have access to telehealth, including by removing geographic restrictions on telehealth services, allowing health centers and rural health clinics to provide telehealth services on a continued basis after the pandemic ends, and giving the Secretary of Health and Human Services additional authority to waive telehealth restrictions after the pandemic ends. Similarly, the Telehealth Modernization Act and the Protecting Rural Telehealth Access Act—championed by Members of this Subcommittee—are valuable pieces of legislation that would extend many of these same waivers.

Ranking Member Thune's bipartisan RUSH Act of 2021 would also take important steps to facilitate greater use of telehealth in skilled nursing facilities, like the one I visited in Lennox, South Dakota. This legislation would reduce unnecessary hospitals visits and stays and, in turn, decrease the risk of COVID-19 or other virus transmission.

There's more the FCC can and should do, as well. For starters, connectivity is key to telehealth. And on this front, we have made significant progress towards the goal of ensuring that every American has access to an affordable, high-speed connection over the past few years. Since 2016, Internet speeds have more than tripled. Competition has increased too, with the percentage of Americans with more than two options for high-speed service jumping by 52% between 2016 and 2018 alone. And the digital divide has been cut significantly as both new cell sites and high-speed fiber builds accelerated over the past few years.

Yet there remain too many Americans without access to affordable, high-speed connections. And this prevents them from realizing the benefits that telehealth and other online services can deliver. So the FCC must continue to deliver results.

On the spectrum front, we must keep moving the airwaves needed for 5G and other high-speed connections into the commercial marketplace. On infrastructure, we need to build on the reforms we put in place over the past few years and continue to modernize and streamline our regulations.

And there is more the FCC can do to ensure that our telehealth programs deliver on their important goals. For one, we should quickly finalize the award of the remaining portions of the COVID-19 Telehealth Program and the Connected Care Pilot Program funding. We are taking another good step in that direction later this month when we will vote on a new round of awardees at our October Open Meeting. So I want to thank Acting Chair Rosenworcel for moving that forward. For another, we need to work with stakeholders on a long-term solution to funding these types of initiatives. The Connected Care Pilot Program for instance is a three-year initiative. One goal for the program is to provide additional evidence regarding the value that flows from connected care technologies. In my view, the portions of the health care industry that benefit from these technologies and their associated reductions in health care costs should be the ones that support them in the long run. Now is the time to work towards that transition.

Finally, the FCC needs to take additional steps to ensure that our RHC Program provides the sufficient and predictable level of support necessary to meet the needs of rural health care providers. I have worked with my FCC colleagues towards this goal over the past few years, including on the issuance of a January 2021 waiver that addressed anomalies in a rates database—anomalies that would likely have contributed to an inadequate and inconsistent level of support for Alaskan health care providers. I also worked with my colleagues to add additional rates into that database and otherwise on relief that ensures greater flexibility. There are additional steps we can take to improve the administration of the FCC's initiatives, including by imposing firmer deadlines on funding decisions, and I look forward to continuing to work with my FCC colleagues and stakeholders on those improvements.

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In closing, I want to thank you again Chairman Luján, Ranking Member Thune, Chair Cantwell, Ranking Member Wicker, and Members of the Subcommittee for holding this hearing and for the opportunity to testify. I look forward to continuing to work with the Subcommittee to accelerate the buildout of broadband networks to facilitate the greater use of telehealth services. I welcome the chance to answer your questions.