The New Normal of Care Delivery

How COVID-19 Accelerated the Adoption and Use of Virtual Care and What's Next

Health IT Leadership Roundtable
July 2020

Executive Summary

The U.S. health care delivery system is continually evolving, as new evidence, medical breakthroughs, and technology advance our capabilities to improve health and transform the practice of medicine.

Virtual care has long been touted as a key way to expand access to care and to improve efficiency, coordination, and flexibility of care. Virtual care tools such as telehealth and remote patient monitoring allow clinicians to furnish care and monitor patients' status more consistently and conveniently today. Meanwhile, new types of virtual care tools and services are being piloted, such as chat bots, electronic triage (e-triage), behavioral nudges, machine learning and artificial intelligence. These tools can also provide patients with quick answers, help to appropriately direct care, improve medication adherence and health behaviors, and apply advanced analytics to inform clinical decision making.

This future vision of virtual care can be informed by our collective experience the past few months with the 2019 novel coronavirus (COVID-19) public health emergency (PHE). The PHE required substantial changes in the way health care is delivered, to ensure the patients can continue to access care safely amid substantial challenges for the health care system and for the country. These changes have resulted in the rapid adoption and greatly increased use of virtual care – prompting a "new normal" of care delivery that is expected to persist and continue to evolve.

However, successfully integrating virtual care into care delivery requires building patient and clinician trust, alongside other critical elements, such as data and technology infrastructure and interoperability. Putting these pieces into place over the long run will require investment, education, and policymaking.

With this in mind, in July 2020, a wide range of organizations representing clinicians, hospitals, payers, technology companies, and patient advocates came together to jointly host a *Health IT Leadership Roundtable on The New Normal of Care Delivery.*[1] The Roundtable sought to provide an opportunity for a diverse set of patients, policymakers, and organizations to find common ground in assessing the future of virtual care and what steps are needed to enable its success.

This White Paper summarizes many of the key conversations and perspectives raised during the Roundtable event, as well as recommendations for moving forward. The White Paper: (1) describes the role of virtual care in the healthcare delivery system, the growth in use and application during the PHE, and predictions for its continued evolution; (2) lists several of the key foundational elements of virtual care, such as infrastructure, interoperability, and authority; and (3) outlines actions needed to maintain the new normal in the future.

HEALTH IT LEADERSHIP ROUNDTABLE HOST COMMITTEE

Alliance for Connected Care | American Academy of Family Physicians | American College of Physicians | American Health Information Management Association | American Heart Association | American Hospital Association | American Medical Informatics Association | Blue Cross Blue Shield Association | College of Healthcare Information Management Executives | Consumer Technology Association | Federation of American Hospitals | National Partnership for Women & Families | Premier Healthcare Alliance

[1] See Appendix A for the agenda for the *Health IT Leadership Roundtable: The New Normal of Care Delivery*.

Key Recommendations resulting from the Roundtable discussions include:

Access, Efficiency, & Flexibility

- **Infrastructure** / Equity – Congress should provide additional funding to the FCC and to HRSA to expand the reach of, and eligibility for, the Rural Healthcare Program, the Telehealth Network and Telehealth Resource Centers, and the Telehealth Network Grant Program.
- **Interoperability** – HHS should continue to work with stakeholders to promote interoperability and patient access/sharing ability to health care information.
- **Authority** – HHS and Congress should permanently lift many of the current barriers to the use of virtual care in the Medicare FFS program with focus on increased access, value and flexibility, including site of service restrictions, modality restrictions, and supervisory requirements. Additionally, States should consider what flexibilities should be maintained post-COVID-19, based on the unique circumstances and characteristics of their state populations.

Patient Experience and Trust

- **Digital Literacy** – HHS and health care stakeholders should provide funding and promote targeted outreach and education campaigns to help patients understand the types and benefits of virtual care tools and services that might be available to them and how they integrate with the rest of the health care delivery system.
- **Quality and Program Integrity** – HHS and health care stakeholders should work together to identify the key goals and desired outcomes, in order to modify current program oversight, quality and performance programs to ensure they can appropriately measure care delivered virtually.
- **High-Quality, Equitable Care** - More research is needed on how to effectively engage and communicate with patients through virtual care, in ways that improve patient experience and advance health equity.
- **Privacy and Security** – Congress should establish a data privacy structure that ensures health data is protected regardless of whether it is covered by HIPAA, aligning privacy and security rules where possible.

Introduction: The New Normal

Virtual care services, such as chat-boxes, remote monitoring, and telehealth, had been growing in recognition and use prior to the beginning of the COVID-19 PHE, but the crisis has greatly accelerated their availability and uptake across markets and populations. Virtual care has become a critical tool for communicating with patients about the virus and how they can keep themselves and their family members safe; screening and triaging patients that need to be seen in person; and resolving lower acuity needs remotely - thus limiting potential transmission of COVID-19 and maintaining needed capacity in critical care centers.

For example, telehealth has primarily been used to-date to provide access to care in areas where there was a shortage of specialty physicians, or for on-demand virtual urgent care; it is now also increasingly supplementing other types of care and services, such as virtual office visits, home health services, or for home medication administration.

FAIR Health analyzed millions of commercial insurance claims from April 2020, and found that the types of telehealth services provided differed than those provided in April 2019. In April 2020, 34.10 percent of all telehealth claims were for mental health services, 5.83 percent were for joint/soft tissue diseases and issues, 3.71 percent were for hypertension, and 3.08 percent were for acute respiratory diseases and infections. Previously, there were higher rates of telehealth claims for treating minor infections, such as urinary tract infections, or skin conditions.[2]

While mental health has traditionally been a mainstay of telehealth visits, the technology has been especially important as the PHE has added stress, isolation, and uncertainty. According to Blue Cross Blue Shield of Massachusetts, nearly half of the telehealth visits it has covered since the beginning of COVID-19 have been for mental health services, including psychotherapy.[3]

BY THE NUMBERS: GROWTH IN VIRTUAL CARE

FAIR Health's Monthly Telehealth Regional Tracker found that telehealth utilization increased by over 8300 percent from April 2019 to April 2020, increasing from 0.15 to 13.00 percent of commercial claims.

A McKinsey study found that patient adoption of telehealth has skyrocketed from 11 percent of U.S. individuals in 2019 to 46 percent in 2020.

CMS Administrator Verma noted in early June that virtual visits in the Medicare program grew from 11,000-12,000 a week in early March to about one million per week in mid-April, an increase of almost 12,000 percent.

Blue Cross Blue Shield Association's (BCBSA) COVID-19 National Pulse Survey found that virtual care use grew 1.6 times since the summer of 2019.

With respect to clinician adoption, a survey by the College of Healthcare Information Management Executives finds that 73 percent of organizations surveyed had conducted less than 25 virtual visits per day prior to COVID-19, while 84 percent of organizations were conducting more than 50 visits per day, and over one-third were scheduling over 250 visits per day, post-COVID.[1] McKinsey also found that clinicians are now seeing 50-175 times the number of patients via telehealth.

[2] FAIR Health, "Monthly Telehealth Regional Tracker, April. 2020." Available here: https://bit.ly/31MRPPb

[3] Blue Cross Blue Shield of Massachusetts, "Blue Cross Blue Shield of Massachusetts Processes 1 Million Telehealth Claims in 9 Weeks: Health plan adds more than 400 mental health clinicians to network to help meet demand." May 21, 2020. Available here: https://bit.ly/38cWz1z

COVID-19 has also accelerated innovation and utilization of remote monitoring devices. Remote devices such as miniature electrocardiograms and electronic blood pressure cuffs are increasingly being used to help monitor and report patients' status, helping clinicians to continually assess their patients' health and elevate care as needed. These tools have also been used to help monitor COVID-19 patients to reduce the amount of staff exposure and to reduce other patients' exposure. Remote monitoring tools can also help to catch undiagnosed heart abnormalities, monitor blood oxygen levels, or signal if a patient's blood sugar has spiked or precipitously dropped.

Future Applications of Virtual Care

The pandemic has provided a real-time case study in accelerating the use and familiarity with virtual care. Today, telehealth and remote monitoring are the predominant tools that clinicians use to extend virtual care to patients. However, health care organizations are beginning to experiment with new virtual tools and services to improve care delivery and outcomes in the health system of the future.

For example, electronic triage tools are beginning to proliferate, allowing patients to engage with advanced chatbots or simple diagnostic tools that can help answer questions, assess symptoms, refill medications, and make referrals to appropriate care channels depending on need. Such tools can free up physician and administrative time so that it may be devoted to higher acuity needs and help to improve patients' experience by quickly resolving needs or concerns.

Additionally, clinicians and payers may continue to employ and expand the use of behavioral 'nudges' – texts, alerts, or phone calls – to encourage patients to seek preventive care, to take their medication as prescribed, or to quit smoking. Or, clinicians and payers leverage artificial intelligence (AI) or machine learning, when used in racially and culturally appropriate ways, to help identify in advance which patients may be at higher risk for certain diseases, allowing for more proactive interventions, or to aid in clinical decision-making. Additional research can help to inform how to effectively engage and communicate with patients via these technological nudges.

Incorporating virtual care tools and services into the delivery of healthcare could help to shift the way in which care is delivered today. Health care entities could employ in-person care alongside advanced analytics/machine learning, electronic triage tools, remote monitoring, telehealth, and treatment optimization, to continually monitor and provide convenient and effective access to health care.

In fact, a recent McKinsey analysis estimated that up to 20 percent of emergency room visits could potentially be avoided using virtual care, while almost a quarter of healthcare office visits and outpatient volume could be delivered virtually. Additionally, a Deloitte study found that 50 percent of health care executives thought that at least a quarter of all outpatient care, preventive care, long-term care, and wellbeing services would be delivered through virtual care by 2040.[4]

[4] Deloitte. "The Future of Virtual Health: Executives see industrywide investments on the horizon." April 30, 2020. Available here: https://bit.ly/2AD79mk

The Foundation Needed to Facilitate the New Normal

Virtual care is likely to persist as a key part of health care delivery in the U.S. given its potential to expand care access and provide greater efficiency and flexibility in care delivery – in addition to the high rates of patient and clinician satisfaction seen. Therefore, it is instructive to consider the foundational elements and policies that will need to be in place to establish patient trust and to ensure its future success.

This section will explore critical elements such as equity/infrastructure and digital literacy, interoperability, privacy & security, quality, and authority.

Infrastructure, Equity& Digital Literacy

A critical first step in providing broad access to virtual care services is ensuring patients have access to broadband internet, the tools needed to connect to the internet, and comfort and familiarity with digital tools. Such limitations could inadvertently exacerbate disparities in care, especially in times when in-person care may not be an option.

Remote monitoring devices and two-way telehealth video calls rely on stable internet connections to succeed. Unfortunately, 19 million people, or six percent of the population, have no access to fixed broadband service; and almost a quarter of people living in rural areas lack access to broadband.[5] Compounding this issue is the fact that 77 percent of rural counties are also considered to be health professional shortage areas, where virtual care could help to fill ongoing care gaps.[6]

Moreover, certain population groups are less likely to have internet connectivity or the equipment need to facilitate virtual care. A third of households headed by an individual over the age of 65 lack internet. Additionally, more than one in three households in the U.S. who are headed by an individual over the age of 65 lack a desktop or laptop computer, and more than half do not have a smartphone.[7] Additionally Black and Hispanic adults are less likely than whites to own a traditional computer or have high speed internet at home.[8]

PATIENT AND CLINICIAN EXPERIENCE WITH VIRTUAL CARE

A survey by the Alliance of Community Health Plans found that 89 percent of those who had used telehealth in the last three months were satisfied with their experience.

A survey conducted by Morning Consult for the Better Medicare Alliance found 91 percent of those who have used telehealth services during the coronavirus pandemic had a favorable telehealth experience and 78 percent are likely to complete a medical appointment via telehealth again in the future. Moreover, about half of all seniors in Medicare Advantage plans are comfortable using telehealth.

A McKinsey survey found that 76 percent of individuals surveyed were highly or moderately likely to use telehealth going forward and 74 percent of telehealth users report high satisfaction.[1] Moreover, 57 percent of clinicians view telehealth more favorably than they did before COVID-19 and 64 percent are more comfortable using it.

Clinicians have noted that telehealth helps to reduce the number of missed appointments and increased access to care for patients with mobility or transportation issues.

[5] Federal Communications Commission, "Eighth Broadband Progress Report." Available here: https://bit.ly/2BwMyjZ
[6] Health Resources and Services Administration, "HPSA Find." Available here: https://bit.ly/3ir2lkP
[7] U.S. Census Bureau, "Computer and Internet Use in the United States: 2016." Issued August 2018. Available here: https://bit.ly/2NNQvTS
[8] Pew Research Center, "Smartphones help blacks, Hispanics bridge some – but not all – digital gaps with whites." Available here: https://pewrsr.ch/2Bzzb2B

ADVANCING EQUITY IN VIRTUAL CARE USE

A study in JAMA Network Open found that patients 65+ were less likely than those between 18 and 44 to choose virtual care; and people in neighborhoods with high rates of internet access were more likely than those with low internet access.

Another survey from Black Book Research and Sage Growth Partners found that although the majority of respondents were satisfied with their telehealth experience, older adults are more reluctant to use telehealth. In fact, 81 percent of respondents aged 55 to 64, and 84 percent of respondents over the age of 65 have not had a virtual or telehealth visit. Additionally, 36 percent of people with annual income below $25,000 have access to telehealth, compared to 70 percent of those earning above $100,000.

In addition to patient access and familiarity, virtual care also requires clinicians to have reliable connections and bandwidth, and the ability to invest in digital tools and training needed to provide care and engage patients virtually. Clinicians must also ensure that any platform or tool used is interoperable with the clinician's existing EHR and information systems, and that it appropriately protects patient privacy and security.

Successfully scaling virtual care will require funding and support for improving broadband infrastructure and availability, access to digital tools, and for education and training to improve familiarity and use of such tools - for both patients and clinicians. It may also require adding interpreter or other language access capabilities, to ensure that access is available to all.

To help meet some of these gaps, the Federal Communications Commission (FCC) has issued hundreds of millions of dollars in funding to eligible clinicians through the Rural Health Care Program and the COVID-19 Telehealth program (which was open to both rural and non-rural providers). These programs are intended to help clinicians provide connected care services to patients.[9][10] HHS has also provided funding through the Telehealth Network and Telehealth Resource Centers, the Telehealth Network Grant Program, and other programs.[11][12] Additionally, FCC relaxed certain broadband rules to improve connectivity and relieve bandwidth concerns.[13]

"There will be a challenge to make sure the right investments can be made so we can have the technology available in all communities to connect to the specialists that need to be connected to and to make sure that all communities have access to timely care. So that is going to require investment in infrastructure and technology." Sen. Ben Cardin (D-MD)

As current and new virtual care approaches continue to advance and become more integrated into care delivery, these infrastructure/equity and digital literacy elements will become critical factors in ensuring success.

[9] Federal Communications Commission (FCC), "Funding Broadband-Enabled Health Care." Available here: https://bit.ly/2DkgDnv

[10] FCC, "COVID-19 Telehealth Program." Available here: https://bit.ly/31VrBu2

[11] HHS, "HHS Awards $20 Million to Combat COVID-19 Pandemic through Telehealth." April 13, 2020. Available here: https://bit.ly/2CbVcV2

[12] HHS, "HHS Awards $15 Million to Support Telehealth Providers During the COVID-19 Pandemic." May 13, 2020. Available here: https://bit.ly/2Oh8qCV

[13] FCC, "FCC Waives Rural Health Care and E-Rate Program Gift Rules to Promote Connectivity for Hospitals and Students During Coronavirus Pandemic." March 18, 2020. Available here: https://bit.ly/3gw04TG

Interoperability

Successful integration of virtual care into care delivery will also require full interoperability of systems and health information.

Unlike a traditional model, where a long-time clinician may keep a comprehensive physical record of care for a patient, some virtual care tools and services may require patients to be able to electronically access and share their health records and other information with new clinicians, as well as allow clinicians and other virtual care services to seamlessly access a patient's health record and add new information.

All virtual care tools, including telehealth platforms and digital health tools will need to incorporate standardized and interoperable data elements based on a sufficient digital identify management foundation, ensuring that information collected through one tool can easily be ingested by another, helping to promote more integrated, connected care. Additionally, advanced analytics, clinical decision support, and other tools also depend on standardized and seamless health information sharing to enable accurate data aggregation and analysis.

The 21st Century Cures Act placed new prohibitions on information blocking, and the resulting regulations from the Centers for Medicare & Medicaid Services (CMS) and the HHS Office of the National Coordinator for Health IT (ONC) intend to establish a system where clinicians, payers, and others can seamlessly share, and provide patients with ready access to, standardized electronic health information.[14][15]

INTEROPERABILITY & VIRTUAL CARE

A 2019 study of health care executives found that 94 percent expect that next-generation data and interoperability solutions will enable widespread data sharing among clinical care teams by 2030, while 88 percent expect wearable devices to be more integrated with care delivery, resulting in more personalized, tailored care.[1] Additionally, 86 percent believe that patient-generated data will be automatically integrated into EHRs and available for decision-making.

Privacy & Security

Interoperability of health data and privacy and security of health data must go hand-in-hand.

The Health Insurance Portability and Accountability Act (HIPAA) provides strong safeguards for the privacy and security of patient health data when maintained by a covered entity or a business associate.

However, as virtual care expands, new types of tools and providers are emerging that may not be treated as covered entities or business associates under HIPAA, and therefore are not subject to its privacy and security protections. These limitations in data protections may serve to reduce availability or coverage for digital tools, and/or may lead patients to inadvertently disclose or share their health information or use tools that they believe provide the same protections as those covered by HIPAA.

For example, in response to the growth in demand for and use of telehealth during COVID-19, HHS Office for Civil Rights (OCR) issued a notification of enforcement discretion for telehealth remote communications, allowing clinicians to use non-HIPAA-compliant tools such as FaceTime or Skype to

[14] Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies, and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federal Facilitated-Exchanges, and Health Care Providers. 85 Fed. Reg. 25510-25640. May 1, 2020. Available here: https://bit.ly/2Zf97mn

[15] 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program. 85 Fed. Reg. 25642-25961. May 1, 2020. Available here: https://bit.ly/2ZfFL7i

provide care to patients. Such tools are widely available and used by patients, but do not ordinarily meet HIPAA standards for privacy and security. OCR notes that "providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."[16]

As patients seek the care and services that meet their needs, including telehealth, remote monitoring, and other types of virtual care, they should be able to trust that their health information is protected at all times. It is important to established strong privacy and security safeguards so that patients can safely and in an informed way, select their care options and share their health information.

Quality & Program Integrity

An additional key element to the success of virtual care is ensuring that there are processes and mechanisms in place to oversee and assess the quality of care provided, and to ensure the appropriate use of high-quality virtual services. Incorporating quality and performance metrics into virtual care delivery models will help to improve the care provided while also collecting valuable information that can be used to better understand the benefits and limitations of virtual care and for continuous improvement.

For example, the National Quality Forum has suggested assessing telehealth quality through evidence-based measures that evaluate (1) a patient's access to care, the clinician's access to appropriate technologies and services, and access to relevant clinical information; (2) the cost savings to the patient, the care team, payers, or the system; (3) the experience of the patient and care team; and (4) the clinical, operational, and technical effectiveness of the care provided.[17]

To meet these goals, current quality performance measurement programs will need to adjust measures and data collection processes to account for care delivered virtually. This may include research and/or focus groups on patients, families, and caregivers to identify aspects of care that are most important to them and/or critical to their patient experience.

As a first step, in June 2020, NCQA announced the approval of a set of adjustments to 40 widely used Healthcare Effectiveness Data and Information Set (HEDIS) measures to account for telehealth services.[18] NCQA, the Alliance for Connected Care, and the American Telemedicine Association also convened a workgroup and issued a Request for Information to develop consensus recommendations for policymakers on expanding virtual care while ensuring "high standards for access, efficacy, quality, patient safety, program integrity, and the integration of remote care into the healthcare ecosystem."[19]

Developing a comprehensive and integrated way to assess quality and performance of care delivered virtually will be a key in improving health outcomes and ensuring appropriate care.

> *"Telehealth has provided a new front door for patients. We have been excited to see, even in our population, who are on average 80 years old, that there has been an excitement to engage in telemedicine and a new channel to access care." Chris Johnson, Landmark Health*

[16] HHS Office for Civil Rights. "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency." Available here: https://bit.ly/3gvdkIn

[17] National Quality Forum, "Creating a Framework to Support Measure Development for Telehealth." August 2017. Available here: https://bit.ly/38F1OaO

[18] NCQA. "COVID-Driven Telehealth Surge Triggers Changes to Quality Measures." June 5, 2020. Available here: https://bit.ly/38A222M

[19] NCQA. "Taskforce on Telehealth Policy." Available here: https://bit.ly/38DKHWw

Authority

Although telehealth and other virtual care services have been in use for decades now, statutory and regulatory barriers at the federal and state levels have limited their scope and reach.

At the federal level, federal law currently regulates coverage of telehealth and remote monitoring in Medicare, largely limiting the use of telehealth services to services provided from certain originating and geographic areas. Specifically, the Medicare fee-for-service program will only cover telehealth services that are provided to a patient located in certain clinical sites or certain rural areas. There are also limitations on the types of clinicians that may bill for telehealth services, restrictions on certain store-and-forward technologies, and limitations on covered codes. Federal law provides Medicare Advantage organizations more flexibility to offer telehealth services to enrollees.

"Telehealth isn't going to solve every problem and it's not always appropriate for every type of visit. But it is a tool in the toolbox. And at this point in our healthcare system. I think we need to do everything we can to support the healthcare system, make healthcare more accessible, make it more affordable, and telehealth is one powerful tool that can solve a lot of the problems that we have in our healthcare system." Seema Verma, CMS Administrator

In response to the COVID-19 PHE, Congress and CMS acted to reduce many of the longstanding barriers to the use of telehealth and other virtual care services in the Medicare program. CMS waived the originating site and geographic location restrictions, expanded the list of covered services, allowed practitioners to practice across state lines in accordance with state law, waived direct supervision requirements, and lifted certain HIPAA and Anti-Kickback Statute limitations.[2021] CMS also provided guidance to states seeking to expand telehealth services in the Medicaid program. *A full summary of federal and state responses can be found in the Appendix.*

Meanwhile, state laws and regulations related to scope of practice, licensure, and coverage for telehealth services in state Medicaid and CHIP programs have also served to limit the scalability and broad applicability of telehealth as a virtual care tool.

Nearly every state and territory temporarily waived – through Executive Order or state guidance – state licensure laws to allow certain out-of-state clinicians to provide care during COVID-19. States have also waived established relationship and scope of practice requirements.

Many of these waivers and flexibilities are tied to the PHE and will not remain after COVID-19. Therefore, federal and state governments need to act to continue the growth and integration of virtual care.

"We're looking at how we can integrate virtual care and telemedicine into the care delivery spectrum. Not just to replace care or to fill the gaps, but how we can best use technology to extend the reach of providers, to make sure we address things like health disparities, to make sure we are able to treat patients, to provide mental health, and also managing chronic illness, and engaging in patient nudging. So really focusing on sick care, but also shifting our attention to well care. I think through this grand experiment, we have opened it up for providers to think about technology in a new way. We can truly transform the health system to make it not just more effective and more efficient, but to use technology to drive value in health care." – Clara Evans, CommonSpirit Health

[20] CMS, "Coronavirus Waivers & Flexibilities." Available here: https://go.cms.gov/3epIG1y
[21] CMS, "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers." Available here: https://go.cms.gov/3dX1iai

Steps to Continue to Evolution and Growth of Virtual Care

Virtual care – whether telehealth, remote monitoring, behavioral nudges, e-triage, or data-informed clinical decision making – serves to extend the current reach of our health care delivery system.

It can improve access to care by bringing care right to the patient, especially for patients that may live in a medically underserved area or experience other barriers to accessing in-person care. It can also improve efficiency of care, by increasing monitoring capabilities, improving triage processes, relieving crowded waiting rooms, and reducing no-show rates for providers.

Over the past few months, COVID-19 has greatly expedited the integration of virtual care into the spectrum of the health care delivery system. The shift has shown the innovation and ingenuity of the health care system, while also bringing to light the fundamental elements that are needed for virtual care to become a part of the 'new normal' of care delivery and to continue to improve care delivery into the future.

Below, we list several of the key steps that were raised as part of the Roundtable discussion, which would collectively serve to improve access, efficiency and flexibility for virtual care, while maintaining strong patient trust in the 'new normal' of care delivery.

Access, Efficiency, & Flexibility

- **Equity / Infrastructure** – Expanding the use of virtual care across the healthcare system will require additional investments in broadband services across the country, and funding for clinicians to invest in virtual care tools.
    - *Congress should provide additional funding to the FCC and to HRSA to expand the reach of and eligible for, the Rural Healthcare Program, the Telehealth Network and Telehealth Resource Centers, and the Telehealth Network Grant Program.*
- **Interoperability** – Successfully integrating virtual care requires seamless exchange of health information between telehealth clinicians, remote monitoring devices, and other care providers across the health care continuum.
    - *HHS should continue to work with stakeholders to promote interoperability and patient access to health care information.*
- **Authority** – In the wake of COVID-19, the federal government and other payers and clinicians expanded coverage for many virtual care services. Continued growth of virtual care will require many of these flexibilities to continue.
    - *Congress should permanently lift many of the current barriers to the use of virtual care in the Medicare FFS program* with *focus on increased access, value and flexibility including site of service restrictions, modality restrictions, and supervisory requirements.*
    - *Additionally, States should consider what flexibilities should be maintained post-COVID-19, based on the unique circumstances and characteristics of their state populations.*

Patient Experience and Trust

- **Digital Literacy** – For virtual care to succeed, patients must understand how virtual care will work, how it may benefit them, know how to use virtual care tools and services, and receive care in a language of their choice.
    - *HHS and health care stakeholders should provide funding and promote targeted outreach and education campaigns to help patients understand the types of virtual care tools and services that might be available to them and how they integrate with the rest of the health care delivery system.*

- **Quality and Program Integrity** – Patients need to be able to trust in the quality and appropriateness of care provided through virtual care, or they may not use it. Similarly, payers, including the federal government, and providers of virtual care services need to ensure that there is sufficient oversight of care provided, so that virtual services are not used to promote fraud and abuse.
    - *HHS and health care stakeholders should work together to identify the key goals and outcomes of interest and modify current program oversight and quality and performance programs to ensure they can appropriately measure care delivered virtually.*
    - *Healthcare stakeholders should ensure transparency about virtual services.*
- **High-Quality, Equitable Care –** Additionally, more research is needed to ensure that virtual care meets patients' needs and is evaluated in a way that takes into account patient experience and preferences.
    - *Congress or HHS should provide funding for research to understand how to measure patient experience with virtual care, including what aspects of virtual care is most important and critical to patient experience.*
    - *Health care stakeholders covering or providing virtual care services should ensure that care is able to be delivered in a culturally and linguistically appropriate way.*
- **Privacy and Security** – Patients using virtual care tools should be able to trust that health care information collected by the virtual care tool or service is protected and kept secure.
    - *Congress should establish a data privacy structure that ensures health data is protected regardless of whether it is covered by HIPAA, aligning privacy and security rules where possible.*

Appendix A

Agenda from Health IT Leadership Roundtable Event

9:00 a.m. **Welcome & Housekeeping**

Kristen McGovern, Sirona Strategies

9:05 a.m. **Opening Remarks**

Justine Handelman, Senior Vice President, Office of Policy and Representation, Blue Cross Blue Shield Association

9:15 a.m. **The "New Normal:" How the COVID Pandemic Has Changed Healthcare**

The Honorable Ben Cardin, U.S. Senator for Maryland

9:30 a.m. **Remarks by The Honorable Seema Verma, Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services**

9:55 a.m. **Panel #1: Patient/Provider Experience with Virtual Care**

- *Juddson Rupp, Patient Advocate*
- *Gail Guerrero-Tucker, MD, MPH, Gila Valley Clinic, Safford, Arizona*
- *Peter Antall, MD, Chief Medical Officer, Amwell; President, Amwell Medical Group*
- *Malaika Stoll, MD, Senior Medical Director, Blue Shield of California*

10:25 a.m. **Panel #2: Opportunities and Challenges for Virtual Care in a Post-COVID World**

- *Sophia Tripoli, Director of Health Care Innovation, Families USA*
- *Clara Evans, System Director, Public Policy & California Government Relations, CommonSpirit Health*
- *Roberta Capp, MD, MHS, Medical Director of Clinical Innovations and Operations, Blue Cross NC*
- *Chris Johnson, Vice President, Head of Corporate Development, Landmark Health*

11:00 a.m. **Remarks by Nicholas Uehlecke, Advisor, Immediate Office of the Secretary, U.S. Department of Health and Human Services**

11:30 a.m. **Closing Remarks**

12:00 p.m. **Adjourn**

Appendix B

Congressional & Administrative Actions to Expand Access to Telehealth During COVID-19

On March 13, 2020, President Trump issued a national emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as known as the "Stafford Act," in response to COVID-19. This declaration followed a declaration of public health emergency (PHE) made by HHS Secretary Azar on January 31, 2020, made retroactive to January 27, 2020. The combination of these two declarations gives the Department of Health and Human Services (HHS) the broad ability to use the authority in Section 1135 of the Social Security Act (Section 1335) to waive certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) program requirements and conditions of participation.

Under the Coronavirus Preparedness and Response Supplemental Appropriations Act, signed into law on March 6, 2020 and Section 1135 waiver authority, CMS expanded Medicare coverage for telehealth services. Effective March 6, 2020, CMS temporarily removed originating site and geographic restrictions from coverage of telehealth under Medicare fee-for-service for services furnished by a range of clinicians including physicians and certain non-physician practitioners including nurse practitioners, physician assistants, and nurse midwives. Other practitioners, such as clinical psychologists, licensed clinical social workers, registered dieticians and others were also permitted to furnish services. Prior to this announcement, Medicare could only pay for telehealth when a beneficiary receiving services is located in a designated rural area and at a qualifying originating site – which did not include the home.

While the Coronavirus Preparedness and Response Supplemental Appropriations Act limited applicability of this expansion to "qualified providers" who have a previous relationship, the third package; the Coronavirus Aid, Relief and Economic Security (CARES) Act, signed into law on March 27, removed it.

The CARES Act created additional changes, including the ability for the HHS Secretary to waive all requirements under section 1834(m) including to waive restrictions of originating and geographic sites, eligible practitioners, eligible services and qualifying technology. The legislation also provides an exemption for telehealth services to allow a payer or employer to provide pre-deductible coverage of telehealth and other remote care for individuals with health savings account (HSA) eligible high-deductible health plans (HDHP), and extends payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to bill Medicare for telehealth services provided in the home or other setting.

CMS announced numerous temporary 1135 waivers and issued two interim final rules, the first on March 30 and the second on April 30, implementing provisions of COVID-19 relief packages. The temporary regulatory waivers and interim final rules include several expansions related to telehealth, remote patient monitoring and telephone services during the COVID-19 PHE. The rules expand Medicare coverage for telehealth including 80 additional services that can be furnished via telehealth, payment for prolonged audio-only evaluation and management services, permits physician supervision requirements to be provided virtually using real-time audio/video technology, and expands the ability to practice telehealth services to all clinicians eligible to bill Medicare including physical therapists, and occupational therapist and speech language pathologists.

Pre-COVID-19 PHE, Medicare coverage of remote patient monitoring services was limited to patients with one or more chronic conditions. To respond to COVID-19 and provide more monitoring of acute conditions such as COVID-19, CMS issued guidance to allow for remote patient monitoring of patients with acute

and/or chronic conditions,[22] permit clinicians to provide remote patient monitoring services to both new and established patients and to allow for remote patient monitoring services to be reported to Medicare for periods of time that are fewer than 16 days, but not less than 2 days, during a 30-day period.[23][24]

The 1135 waivers also temporarily waive Medicare and Medicaid's requirement that physicians and non-physician practitioners be licensed in the state where they are providing services. CMS issued guidance for states seeking to expand telehealth for Medicaid. While the guidance does not create new policy, it reminded states about the flexibility that exists in the Medicaid program Nearly every state and territory have temporarily waived – through Executive Order or state guidance – state licensure laws in some way to allow varying out-of-state clinicians to provide care across state lines during COVID-19. It is important to note that, while states have waived to various extents their licensure laws, there still remains broad variation in telehealth laws and coverage policies. For example, some states have waived established relationship requirements, and states have differed in types of clinicians who can practice telehealth across state lines.

Other federal agencies have taken action to allow physicians to utilize telehealth during the COVID-19 pandemic. While a prescription for a controlled substance issued by means of the Internet (including telemedicine) generally requires an in-person medical evaluation, the Controlled Substances Act contains certain exceptions to this requirement including when the HHS Secretary has declared a PHE. The Drug Enforcement Administration (DEA) announced that as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided certain conditions under Section 802(54)(D) are met.[25]

In addition, in response to the rapid expansion of telehealth and the need to communicate with patients, HHS Office for Civil Rights (OCR) issued a "Notification of Enforcement Discretion" for telehealth remote communications during the public health emergency.[26] The enforcement discretion clarifies the ability of telehealth to be delivered through platforms such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, without risk that OCR might seek to raise HIPAA compliance concerns.

The combination of federal, regulatory and state actions taken during the COVID-19 pandemic have greatly expanded access to telehealth services and facilitated the delivery of safe and effective care for both patients and clinicians.

[22] CMS, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." Available here: https://go.cms.gov/30LzbVK
[23] Ibid.
[24] CMS, "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program. Available here: https://go.cms.gov/3hHg4mI
[25] U.S. Department of Justice, "United States Code Controlled Substances Act." Available here: https://bit.ly/3jE6pPz
[26] HHS, Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency." Available here: https://bit.ly/3gvdkIn