

TELEMEDICINE IS EVOLVING RAPIDLY; LEGAL DEFINITIONS AND REIMBURSEMENT METHODS NEED TO EVOLVE WITH IT

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Good afternoon, Chair Fields, Vice Chair Ginal, and members of the committee.¹ I am grateful for the invitation to testify on Colorado's proposed telemedicine legislation (HB21-1190).² My name is Robert Graboyes, and I am a senior research fellow at the Mercatus Center at George Mason University, where my work focuses on the question of how America can make healthcare as innovative in the next 30 years as information technology was in the past 30 years.³

In commenting on HB21-1190, I offer the following takeaways:

1. *Telemedicine will lower costs and reach underserved communities.* Telemedicine is poised to provide better health for more people at lower cost, year after year, particularly for communities that are currently underserved. This is especially true following the enormous increase in telemedicine usage during the COVID-19 pandemic.⁴
2. *HB21-1190 will help Colorado realize the potential social benefits of telemedicine.* The laws that govern telemedicine should allow the technology to evolve and deliver on its promise to society. HB21-1190 is a big step in that direction because it provides more clarity on who provides telemedicine, how information flows between providers and patients, and what the fundamental goals of telemedicine are.
3. *A rational reimbursement system is the key to a healthy telemedicine system.* America is only beginning to figure out how providers should be paid for telemedicine work. The current reimbursement system does not lead to clear and effective solutions. How telemedicine evolves will depend on how healthcare providers are paid.

1. Portions of this testimony are adapted from Robert F. Graboyes, "CMS's Proposed Rule Is an Admirable First Step toward Removing Healthcare Supply Barriers" (Public Interest Comment, Mercatus Center at George Mason University, Arlington, VA, October 2, 2020)

2. H.B. 21-1190, 73rd Gen. Assemb., 1st Reg. Sess. (Colo. 2021).

3. Some of my ideas on the issue are explained in Robert F. Graboyes, "Fortress and Frontier in American Health Care" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014).

4. Robert F. Graboyes, "Telemedicine Before, During, and After COVID-19," *Discourse*, March 31, 2020.

TELEMEDICINE WILL LOWER COSTS AND REACH UNDERSERVED COMMUNITIES

For a vast and demographically varied state like Colorado, telemedicine can bring prompt, quality care to those who might otherwise go untreated. Telemedicine can bring immediate care around the clock to remote villages, Native American reservations, and isolated ranches. But telemedicine can also serve residents of urban areas who fall ill at night or who live in underprivileged neighborhoods short on medical personnel. Beneficiaries of telemedicine also include foreign-language speakers, people with limited mobility, and those with busy schedules or small children. In areas of medicine such as psychiatry and drug rehabilitation, telemedicine may be superior to in-person encounters, thanks to reduced no-shows, greater treatment compliance, and instant access in time of crisis. For any patient, telemedicine takes less time and dispenses with the stress of transit.⁵

Using early-2020 data, the Mercatus Center's Healthcare Openness and Access Project ranks Colorado as having the most open and accessible healthcare environment of any state.⁶ In recent years, the Colorado General Assembly has passed an admirable series of laws to bolster telemedicine. Legislation in 2016 paved the way for Colorado to join the Interstate Medical Licensure Compact.⁷ Three 2018 laws took steps toward expanding the broadband access necessary to drive telemedicine.⁸ In the midst of the pandemic, the Colorado General Assembly passed and Governor Jared Polis signed SB20-212, legislation to protect telemedicine after the pandemic.⁹ HB21-1190 is thus the logical next step for Colorado's healthcare policy.

HB21-1190 takes a number of positive steps that reflect the transition from 20th- to 21st-century healthcare. I am encouraged to see that this bill expands the definition of telemedicine provider, includes asynchronous communications, recognizes the role of remote monitoring, implicitly recognizes the increasing role of wellness care, and grapples with where (legally) a telemedicine visit takes place. These changes better reflect the purpose and potential of telemedicine in the real world.

HB21-1190 WILL HELP COLORADO REALIZE THE POTENTIAL SOCIAL BENEFITS OF TELEMEDICINE

Expanding the definition of telemedicine provider reflects the important roles of nurse practitioners, pharmacists, nurse midwives, psychologists, optometrists, therapists, and others. These professionals are enabled by their training and technology to ease the burdens on physicians, whose resources are already stretched thin. Automation, virtualization, and delegation can allow doctors and their teams to take care of a much larger population in a more efficient manner. My colleague Lyle Berkowitz has aptly remarked, "We don't have a shortage of [primary care providers], we have a shortage of using them efficiently."¹⁰ Telemedicine will allow physicians and other healthcare professionals to perform up to the level of their qualifications, and by better allocating the resources of its health system, Colorado will ease the shortage.

5. Robert F. Graboyes, "Telepsychiatry — Serving the Underserved," *Inside Sources*, October 9, 2018.

6. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "Healthcare Openness and Access Project 2020: Full Release" (Project Overview, Mercatus Center at George Mason University, Arlington, VA, December 2020); Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "1 | Colorado," Mercatus Center at George Mason University, December 22, 2020, <https://www.mercatus.org/publications/healthcare/1-colorado>.

7. Colorado had already joined the Interstate Medical Licensure Compact as a result of HB16-1047. H.B. 16-1047, 70th Gen. Assemb., 2nd Reg. Sess. (Colo. 2016).

8. Jeff Botranger et al., *Telemedicine in Colorado: The Jetsons, a RAPID Response to COVID-19, and the Big Questions Ahead* (Denver, CO: Colorado Health Institute, May 2020).

9. S. B. 20-212, 72nd Gen. Assemb., 2nd Reg. Sess. (Colo. 2020).

10. Lyle Berkowitz, "We Don't Have a Shortage of PCPs, We Have a Shortage of Using Them Efficiently," *AI in Healthcare*, January 2, 2013.

Telemedicine has progressed far beyond what even the visionaries of a generation ago could have imagined. Colorado's current legal definition of telemedicine assumes a real-time conversation between provider and patient. One of the advances incorporated into this bill is to update the definition to include asynchronous provision of healthcare. Complex, unusual, or particularly specific questions can be responded to via email, text, or webform messages after a provider considers the diagnosis and conducts some research. In turn, the patient can refer to the provider's carefully written responses, rather than trying to remember extemporaneous verbal comments.

The bill also updates the definition to include remote monitoring technologies, recognizing the mediating role of "intelligent" machines in patient-provider communication. I myself have had occasional cardiac problems (none too serious, so far), and I have worn remote monitoring devices that have tracked my vital signs and reported them to my physician more accurately than I would have. Consequently, the time spent by healthcare providers processing telemetry collected by vital signs monitors ought to count as service provision in the same way that an office auscultation does.

I praise the bill's use of the term "assessment" insofar as the term emphasizes the importance of wellness and prevention of illness and injury.

Lastly, there is much to be found in the phrase "while the patient is located at an originating site and the person who provides the services is located at a distant site." From a legal perspective, one of the great unanswered questions of telemedicine is where encounters between patient and provider occur (legally) and, hence, which jurisdiction's laws and regulations should govern such an encounter. If I, a Virginia resident, fall ill during a trip to Florida and consult with a New York physician who is at a ski resort in Colorado and works for a California-based telemedicine company, in which of those five states did this encounter occur? The bill does not answer that question, but it flags the issue of geography as crucial to the situation. I have little doubt that the Colorado General Assembly and other legislative bodies will be called upon in the future to answer that question. And this bill is the first step toward answering it.

All of these features of this bill add a measure of flexibility that current law does not offer. Telemedicine is evolving at an astonishing pace, and yet antiquated laws and regulations could stymie its development. This bill reduces that possibility by giving Colorado's telemedicine system room to adapt to demand and to grow to meet it.

A RATIONAL REIMBURSEMENT SYSTEM IS THE KEY TO A HEALTHY TELEMEDICINE SYSTEM

As more providers and patients participate in telemedicine, questions regarding reimbursement will arise. One of the really daunting questions will be of whether rigid parity undermines one of the great virtues of telemedicine—the capacity to reduce unit costs of medical care. Telemedicine doctors presumably have lower brick-and-mortar costs than in-office practices. And telemedicine physicians with national range can ease localized shortages (say, during a regional flu outbreak); this effectively allows communities across the country to share resources that are needed only during local peak-load-demand situations.¹¹ (This was the justification for dropping barriers to interstate telemedicine consults during the pandemic.)

11. Rhoads, Bryan, and Graboyes, "Healthcare Openness and Access Project 2020," 14–15.

I saw a reimbursement issue firsthand recently, in a lengthy set of interactions with my primary care provider. When helping me navigate a transitory health problem, she was reimbursed for two virtual visits lasting perhaps 15 minutes apiece. But she spent far more time over a four-week period on my case, communicating with me frequently via text message (through a secure portal) and doing administrative work. Whereas an attorney or accountant could bill for such uses of time, my doctor received no compensation for anything outside of the two virtual visits. When I asked her about it, she told me, “Under our current system, the only thing that generates income are in-person visits, virtual visits (some insurances aren’t covering them) and some telephone visits. . . . I have to learn two mutually exclusive ways to understand my patient’s conditions—one to help them and one to get paid.”¹²

As providers devise innovative means of communicating with patients, state governments and the federal government will be challenged to set payment methodologies that compensate the time and effort of healthcare providers in ways that help patients get well.

CONCLUSION

Expanding access and enabling the growth of telemedicine is a key part of my professional research and holds personal significance to me as well. In January 2015, my then-92-year-old mother was on her iPad, using FaceTime to talk with her grandson, who is a medical doctor. She did not feel unwell, but casually mentioned having a painful sore. In a few days, she told him, she’d visit her doctor. My nephew asked her some questions, used her iPad to examine the wound, and observed her face and breathing. He realized she was entering septic shock. He sent her straight to the hospital, where they saved her life. Waiting a day or two for an office appointment would likely have led to her untimely death. This experience impressed upon me the enormous value of telemedicine and early intervention. And it constantly reminds me that one should not require a physician in the family to receive such lifesaving care.

12. Web portal message from physician to author, February 18, 2021.