2021 SENATE HUMAN SERVICES

SB 2179

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2179
1/20/2021

A BILL for an Act to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to health insurance coverage of telehealth; and to declare an emergency.

Madam Chair Lee opened the hearing on SB 2179 at 2:34 p.m. All members present: Senator Lee, Senator K. Roers, Senator Clemens, Senator Hogan, Senator Anderson, Senator O. Larsen.

Discussion Topics:

- States that have adopted coverage of telehealth
- Telehealth & E-visit definition language
- Mental Health Services V.S. Telehealth re-imbursement rates
- Health care cost study
- Hospital operating revenue
- Intent of Amendment proposed by AHIP
- Memo of highest telehealth usage
- Telehealth utilization data

[2:35] Senator Lee, District 12. Introduced SB 2179.

[2:38] Courtney Koeble, Executive Director, North Dakota Medical Association. Provided testimony #1981 in favor.

[2:43] Andrew Askew, Vice President, Public Policy, Essentia Health. Provided testimony #1972 and PowerPoint #1973 in favor.

[2:57] Carlotta McCleary, Executive Director, Mental Health America North Dakota. Provided testimony #1998 in favor.

[3:09] John Olsen, on behalf of the Psychiatry Association. Provided written testimony #5729 in favor for **Christine Aman (NP-C) and Kristen Getzlaff (BSNRN), Owners of Inspired Life Wellness Clinic LLC, Bismarck, North Dakota.**

[3:12] Gabriela Balf, Psychiatrist, Missouri River Health. Provided testimony #1944 in favor.

[3:18] Jon Godfread, Commissioner, North Dakota Insurance Department. Provided testimony #1956 in opposition.

[3:35] Jack McDonald, on behalf of American Health Insurance Plans (AHIP). Provided testimony #1827 in opposition.

[3:39] Megan Houn, Director, Government Relations, Blue Cross and Blue Shield. Provided oral testimony in opposition.

[3:45] Dylan Wheeler, Senior Legislative Affairs Specialist, Sanford Health. Provided testimony #1864 in opposition.

[3:51] Scott Miller, Executive Director, North Dakota Employees Retirement System (NDPERS). Provided neutral testimony #2018.

Additional written testimony: (9)

Dr. Robert Sticca, Chair, Legislative Committee, North Dakota Board of Medicine. Provided written testimony #1585 in favor.

Marsha Waind, UND. Provided written testimony #1781 in favor.

Matt Schafer, Medica. Provided written testimony #1768 in opposition.

Cindy Flom-Meland, President, APTA North Dakota. Provided written testimony #1945 in favor.

Brian Balstad, Lobbyist, North Dakota Psychological Association. Provided written testimony #1966 in favor.

Monica Bertagnolli, Chair, Association for Clinical Oncology. Provided written testimony #2137 in favor.

Sherri Miller, Executive Director, North Dakota Nurses Association. Provided written testimony #1937 in favor.

Rebecca Fricke, Chief Benefits Officer, North Dakota Public Employees Retirement System (NDPERS). Provided written neutral testimony #1491.

Derrick Hohbein, Chief Operating/Financial Officer, North Dakota Employees Retirement System (NDPERS). Provided written neutral testimony #1536.

Madam Chair Lee closed the hearing on SB 2179 at 3:58 p.m.

Justin Velez, Committee Clerk

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

Senate Human Services Committee
SB 2179
January 20, 2021

Chairman Lee and Committee Members, I am Courtney Koebele, the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

NDMA strongly supports SB 2179.

NDMA adopted a policy position in support of telehealth parity at its 2020 policy forum. Payment parity is an issue that is supported by all types of physicians and specialties. To assess the need, NDMA assembled a broad coalition of health care stakeholders, including Essentia Health, CHI St. Alexius, Trinity Health, Altru Health, Mid Dakota Clinic, Bone and Joint, ND Academy of Physician Assistants, Physical Therapy Association of North Dakota, ND Federation of Families for Children's Mental Health, Mental Health America of North Dakota, and the Mental Health Advocacy Network. Together, this group supports telehealth payment parity legislation that will require health plans to reimburse providers for covered telehealth services delivered to patients at reimbursement rates not less than in-person services.

While telehealth cannot replace all patient care, the extension of telehealth benefits in recent months has rapidly changed the way clinicians see patients and has provided a push for innovation that has allowed clinicians to safely increase access to high quality care.

Patients have reported that telehealth has been a positive experience, which results in fewer "no-shows" than in-person visits. Patients are grateful to have telehealth as an option.

As this committee is aware, North Dakota has a law regarding insurance mandates. That law provides "A legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be

acted on by any committee of the legislative assembly unless the measure is accompanied by a cost-benefit analysis provided by the legislative council."

SB 2179 provides for neither of those since the proposed changes do not mandate new coverage or provide coverage to new provider types. Telehealth services are already covered services and no new providers are directed in the statute.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

SUPPORT COMPETITIVE, FAIR REIMBURSEMENT RATES FOR TELEHEALTH
SB 2179

SB 2179 requires health plans to reimburse providers for all covered telehealth services delivered to patients at reimbursement rates not less than in-person services.

Due to the pandemic, increased flexibilities and broader insurance coverage for telehealth services made it possible for health care professionals to continue treating patients and increase access to care.

- Payment parity – or equal reimbursement rates - would ensure patients have increased access to timely, value-based, and integrated care, especially for rural and underserved communities throughout the state. Under current law, health plans reimburse telehealth services **20% to 40% lower** than in-person services.

- By continuing to utilize virtual visits, health care professionals and hospitals alike will be able to provide three very important elements, which are:

    - Continuity of care – Virtual visits allow patients to be cared for by their care team or an extension of this team – not a third party from a national vendor.
    - Access to the entire patient record – Virtual visits ensure that nothing is left unaddressed with regard to patients' past medical history, medication lists, previous health events, etc.
    - Access to comprehensive and integrated health care – Virtual visits allow providers to easily hand over care needs to other members of the health care team, such as future testing needs, follow up, or referrals to a specialist – all of which can be done within electronic medical records systems to ensure that the patient is receiving comprehensive care. This is not easily done with a third party like Teledoc or AmWell.

While telehealth cannot replace all patient care, the extension of telehealth benefits in recent months has rapidly changed the way health care professionals see patients. The advancements provided a push for innovation that now allow health care providers to safely increase access to high quality care, particularly in the rural health care setting.

Historically, access to rural health care has been met with challenges and the advancement of telehealth carries its benefits to rural health care professionals and how they are able to treat patients. This revolutionary approach to health care services can reduce or minimize challenges and burdens patients encounter, such as transportation issues related to traveling for specialty

care. Telehealth can also improve monitoring, timeliness, and communications within the healthcare system.

Key telehealth benefits extended to patients provide more accessibility for care:

- For patients who are unable to use video software and patients who lack broadband access or technology for video-only, the current ability to reach patients virtually or over telephone has been critical to ensuring continuity of care.

- When patients have access to timely comprehensive care, chronic medical conditions can be addressed sooner; thus, when treatment is more easily accessible, the need for emergency care services is most likely reduced - resulting in health care cost savings for both the patient and insurers.

We urge you to support payment parity for telehealth services to ensure that these services are reimbursed at the same rate as services provided in-person.

Altru Health System

Mental Health Advocacy Network

APTA North Dakota

TRINITY HEALTH

NDRHA North Dakota Rural Health Association

Mental Health America of North Dakota

MDC MID DAKOTA CLINIC The doctors you know and trust.

NDNPA NORTH DAKOTA Nurse Practitioner Association

CHI St. Alexius Health Imagine better health.

North Dakota Academy of Physician Assistants

Essentia Health

North Dakota Academy of Family Physicians

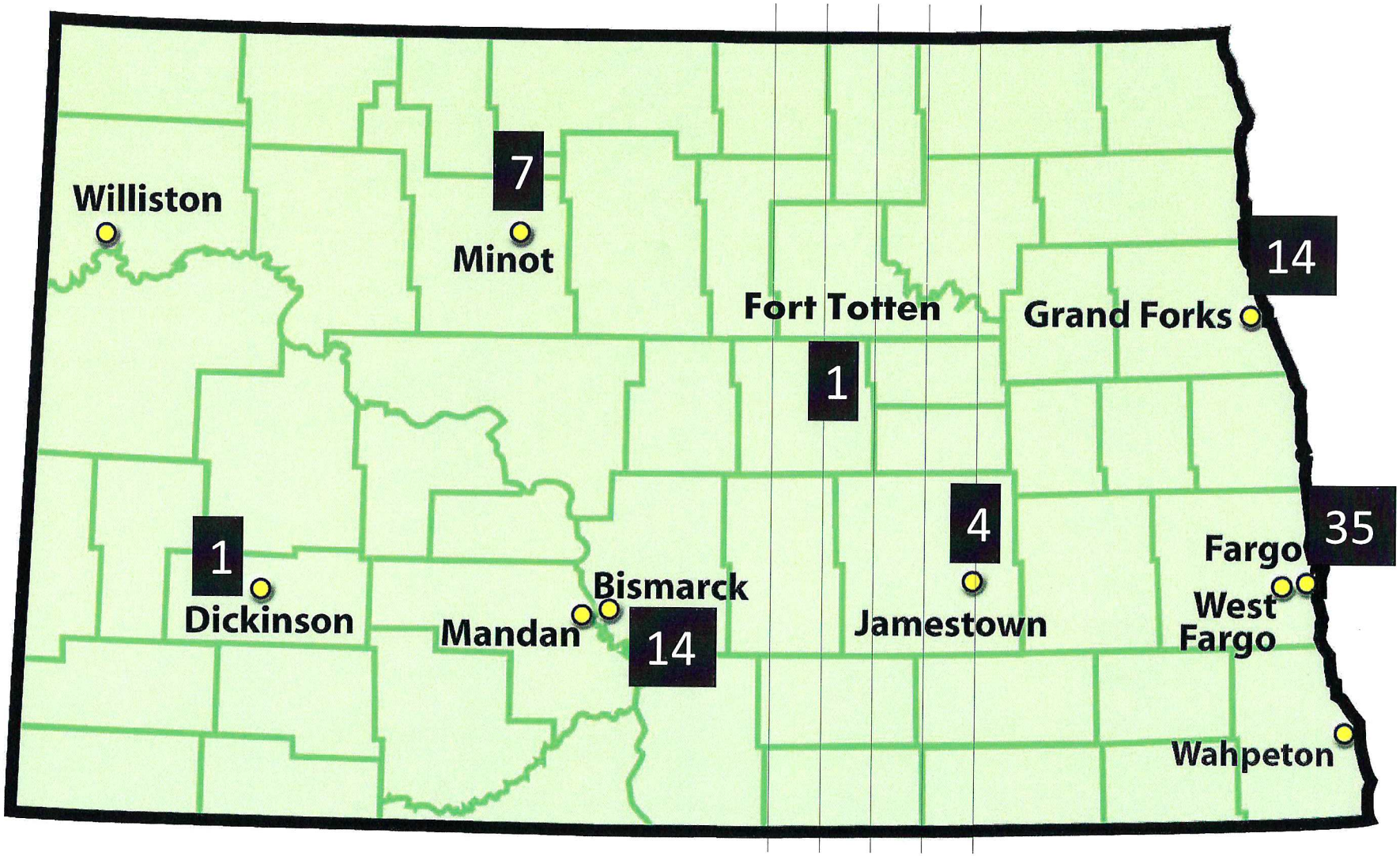
The Bone & Joint Center Orthopaedic Center of Excellence

NDMA Est. 1887 North Dakota Medical Association

North Dakota Psychiatric Society

North Dakota Federation of Families For Children's Mental Health

North Dakota Practicing Psychiatrists by City



1/18/2021

Essentia Health

Senate Human Services Committee
SB 2179
January 20, 2021

Chair Lee and committee members, thank you for this opportunity to weigh in on this important issue to health care in North Dakota. My name is Andy Askew, and I serve as Essentia Health's Vice President of Public Policy. Prior to joining Essentia last February, I served as its contract lobbyist here in Bismarck while working as an attorney at the Pearce Durick law firm.

Essentia Health is an integrated health system serving patients in North Dakota, Minnesota, and Wisconsin. Headquartered in Duluth, Minnesota, we have 13,500 employees serving patients and communities throughout our 14 hospitals, 70 clinics, and 12 assisted care and long term care facilities. Since March 2020, Essentia Health has conducted approximately 340,000 virtual visits, which have assured that its patients have access to high quality, comprehensive, and integrated health care services directly to their homes. This has allowed our patients to avoid unnecessary risks of infection, taking time away from work, or having to find childcare in order to seek health care services. In June, Essentia received the Blue Cross and Blue Shield of Minnesota Trailblazer Award for its nation-leading efforts to improve access to virtual care during the COVID-19 pandemic.

Prior to the pandemic, telehealth was limited to a small set of services and usually required patients to be at a clinic or a health care facility. However, to aid in the response to COVID-19, Medicare and numerous states afforded various regulatory and payment policy flexibilities that allowed patients access to care from primary and specialty care providers using a phone, tablet, laptop, or personal computer, and to do so without having to leave home. These flexibilities also required that these virtual visits be reimbursed at rates similar to or equal to in-person visits. This is commonly referred to as "payment parity."

In North Dakota, Governor Burgum and Insurance Commissioner Godfread mandated expanded insurance coverage of telehealth services through Executive Order 2020-05.1 and Bulletin 2020-3.[1] According to these mandates, insurance carriers were required to "start or continue to provider covered services via telehealth."[2] These services included:

- Office visits for existing patients;
- Physical therapy, occupational therapy, and speech therapy plan evaluations;
- Behavioral health and substance use disorder treatment;
- Diabetes education; and
- Nutrition counseling[3]

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[1] *See* Executive Order 2020-05.1; Bulletin 2020-3 (relating to expansion of telehealth services).
[2] Bulletin 2020-3.
3 Id.

Governor Burgum and Commissioner Godfread also prohibited insurance carriers from imposing any specific requirements on the technologies used to deliver telehealth, virtual check-ins, and e-visit services.[4] These mandates are currently in effect and required throughout the duration of the peacetime emergency.

Because of the various flexibilities granted during the pandemic, health care providers are now offering two distinct telehealth services: virtual visits and e-visits. When we discuss the costs of delivering of telehealth services, it is important to understand the difference between the costs of virtual visits and the costs of e-visits because the costs to deliver are drastically different.

Simply stated, a "virtual visit" allows a patient to see their primary and specialty care provider using a phone, tablet, laptop, or personal computer directly from the patient's home. These virtual visits have allowed patients to maintain access to health care services without taking time away from work, having to find childcare, or without subjecting themselves to unnecessary risks of infection. In addition to the traditional fixed costs of delivering health care – which includes the costs of maintaining care facilities and infrastructure, employing health care staff, and billing and coding health services as required by insurance carriers – virtual visits require new, additional costs, such as:

- Technology infrastructure costs, including hardware, software, applications, and licenses;
- Expanded data storage costs;
- Implementation and training costs;
- Maintenance and integration costs; and
- Increased IT support

By utilizing these virtual visits, North Dakota's providers and hospitals alike have ensured that they are prepared to care for patients during the pandemic in a manner that not only assures easy access to health care services, but one that also protects patients and workforce from unnecessary risks of infection and preserves PPE, bed capacity, and other medical resources.

In addition to virtual visits, providers offer what we call an "e-visit," which is a virtual visit for a specific set of acute conditions, such as allergy symptoms, colds, eye infections, skin conditions, and UTIs. These visits cost anywhere between $30 and $50 and are often paid directly by the patient. Although North Dakota providers like Essentia Health and Sanford Health offer e-visits,[5] national, out-of-state vendors like Teledoc and AmWell are most well-known for offering e-visits. These out-of-state vendors do not maintain emergency rooms, hospitals, urgent care, labs, or pharmacies and, in some instances, do not need to hire the same level of staff to authorize services and submit claims to insurance companies. As a result, Teledoc and AmWell can offer these e-visits for a lower cost than compared to the more robust "virtual visits" offered by hospitals like Essentia which must maintain infrastructure for both in-person and virtual care and provide patients with high quality, comprehensive, and integrated care from North Dakota providers.

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4 Executive Order 2020-05.1; Bulletin 2020-3 (relating to expansion of telehealth services).
5 See e.g., Sanford Health, E-visits, https://www.mysanfordchart.org/MyChart/Authentication/Login?mode=stdfile&option=evisit (Jan. 20, 2021).

Unfortunately, despite the glaring difference between virtual visits and e-visits, North Dakota insurance plans reimburse virtual visits substantially lower than in-person services. More specifically, the reimbursement health care providers throughout the state receive for virtual visits can be anywhere from 20% to 40% lower than in-person services. This is a drastic deviation from Medicare and some of North Dakota's sister states. Simply said, despite the overwhelming success of this new virtual care delivery model, North Dakota's insurance plans are reluctant to negotiate fair and competitive reimbursement rates for virtual visits. Because of the substantial costs of virtual care, the current reimbursement rates for virtual visits are simply unsustainable and serve as a barrier to future innovation in virtual care – especially in rural and undeserved communities where access to primary and specialty care is needed most.

Momentarily, you will hear from numerous health care providers that will attest to the overwhelming benefits of virtual visits and the costs of this new virtual care delivery model. Before handing it over to them, I want to quickly address the actuary analysis that was completed by Deloitte in conjunction with Sanford Health's insurance plan and encourage this committee to look past this incomplete analysis.

As you will see, in the analysis, the consultant claims that virtual visits "cost[] less compared to an in-person visit." To support this claim, the consultant suggests that a virtual visits costs $45 – the costs of a Teledoc visit. This analysis is misguided in that virtual visits offered by hospitals like Essentia are markedly different than the product offered by out-of-state vendors such as Teledoc and AmWell – and cost much more. In fact, Essentia and some of the providers here today have found that the cost of providing a virtual visit with a primary or specialty provider currently cost the same or slightly more than an in-person visit.

Said otherwise, the analysis before you fails to provide a meaningful analysis of the cost of virtual visits – not e-visits – and the overall impact of SB 2179.

While the number of virtual visits leveled off since the early months of the pandemic, virtual visits still account for roughly 20% of Essentia's encounters and will remain an important tool to ensuring access to care throughout the rural communities we are privileged to serve. By continuing to utilize these virtual visits, providers and hospitals alike with be able to provide three very important elements, which are:

- Continuity of care – Virtual visits allow patients to be cared for by their care team or an extension of this team – not a third party from a national vendor.
- Access to the entire patient record – Virtual visits ensure that nothing is left unaddressed with regard to patients' past medical history, medication lists, previous health events, etc.
- Access to comprehensive and integrated health care – Virtual visits allow providers to easily handover care needs to other members of the health care team, such as future testing needs, follow up, or referrals to a specialist – all of which can be done within EPIC to ensure that the patient is receiving comprehensive care. This is not easily done with a third party like Teledoc or AmWell.

For these reasons, Essentia joins the ND Medical Association, the ND Psychiatric Society, and numerous providers and health care systems to respectfully request your support of SB 2179 and its goal of requiring health plans to reimburse providers for all covered telehealth services delivered to patients at home at the same rate as in-person services. We believe this is an important step to ensuring that North Dakotans continue to have access to high quality, integrated care from local primary and specialty care providers throughout the remainder of the pandemic and beyond.

Thank you for your time and consideration.

#1973

One Mission, *We are called to make a healthy difference in people's lives.*

The Heart of High Reliability for our Patients

Right Care, Every Patient, Every Time, Everywhere

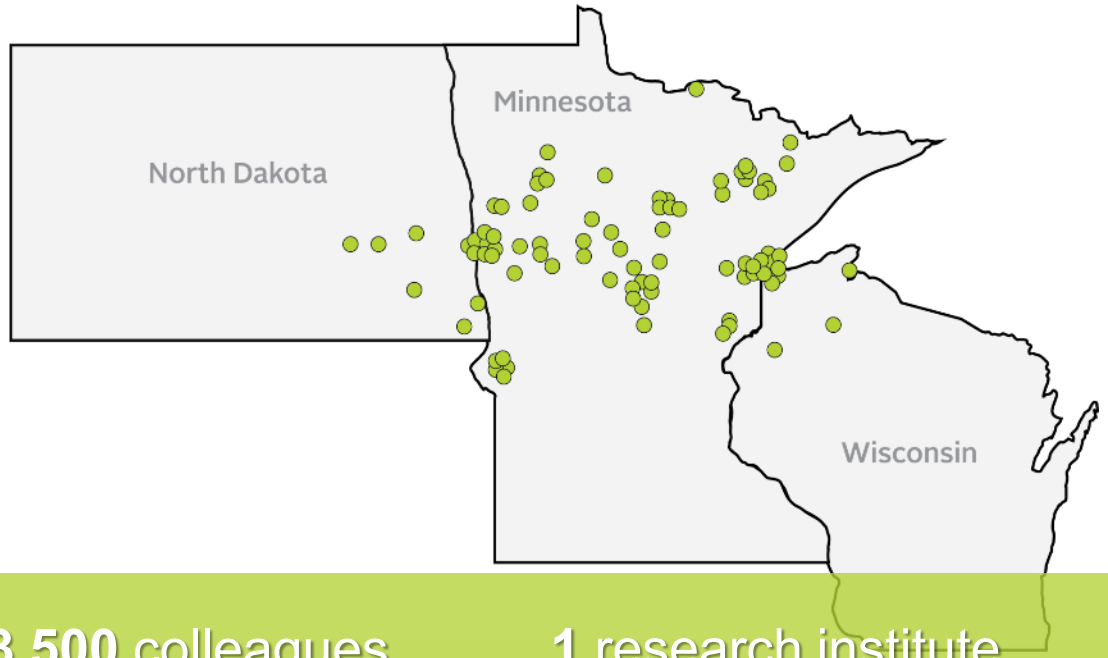
One Essentia

Testimony in Support of SB 2179

January 20, 2021

Our organization

A physician-led, integrated health system serving patients in North Dakota, Minnesota, and Wisconsin



13,500 colleagues

14 hospitals

70 clinics

12 long-term care and assisted living facilities

5 ambulance services

1 research institute

558,968 unique patients*

1,740,310 clinic encounters*

189,194 patient days*

*FY19 Statistics

Recognition for our work

Essentia Health received a "Health Care Hero" award for our innovation with virtual care

June 2020

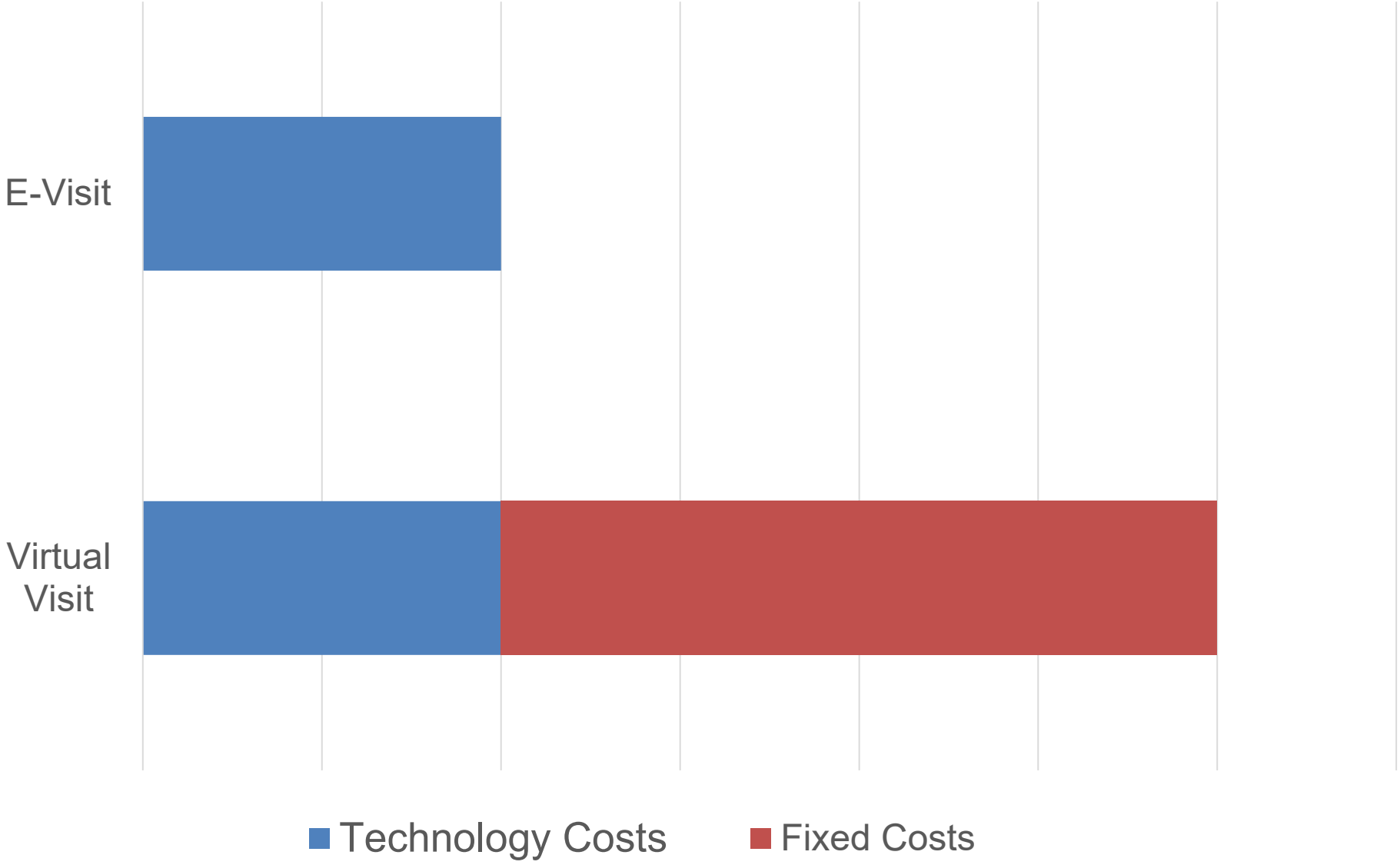
What is virtual health care?

Pre-Pandemic Telehealth Visit - A remote visit to a patient located in a health care facility

Virtual Visit- A visit with primary or specialty care providers using a phone, tablet, laptop, or personal computer directly from the patient's home

E-Visit – A virtual visit for a narrowed set of acute conditions, such as allergy symptoms, colds, eye infections, skin conditions, and UTIs. Usually costs patients $30 to $50.

New Costs of Virtual Care Model



Questions

Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

#1998

Senate Human Services Committee
Sixty-seventh Legislative Assembly of North Dakota
Senate Bill 2179
January 20, 2021
Honorable Senator Judy Lee, Chair

Good morning Chairman Lee and Members of the Senate Human Services Committee. I am Carlotta McCleary, Executive Director of Mental Health America North Dakota and Executive Director of the North Dakota Federation of Families for Children's Mental Health. Today I speak on behalf of the Mental Health Advocacy Network (MHAN). MHAN advocates for a consumer /family driven mental health system of care that provides an array of service choices that are timely, responsive and effective.

MHAN is speaking in support of SB 2179. Advocates for behavioral health system reform have stressed that tele-behavioral health services are a vital means to address several weak points in North Dakota's behavioral health system. The 2018 Human Services Research Institute (HSRI) report has been touted by the Department of Human Services and the North Dakota legislature as the "road map" to ending the behavioral health system crisis in North Dakota. The HSRI devoted much of its report to underscoring the importance of telebehavioral health, with nearly 350 mentions scattered throughout the report. Recommendation 8 of the report were short- and long-term goals in expanding the use of telebehavioral health services in North Dakota. Those recommendations with telebehavioral health services were as follows: "8.1. Support providers to secure necessary equipment/staff," "8.2 Expand the reach of services for substance use disorders, children and youth, American Indian populations," "8.3 Increase types of services available," and "8.4 Develop clear, standardized regulatory guidelines."

The HSRI report found that telebehavioral health services were quickly increasing in North Dakota are well-suited this state as we have both a lack of behavioral health professionals and a large rural population. "In the Center for Rural Health Survey, a majority of facilities providing telebehavioral health services were located in urban areas whereas a majority of those receiving telebehavioral health services were in rural areas, indicating that telebehavioral health is being used effectively to address access and workforce shortage issues experienced in underserved rural communities." The HSRI report also found that "mental health outpatient service was the most commonly delivered service via telebehavioral health in both the Medicaid and [Human Service Center] data…"

This discussion about who uses this service and why leads me to discussing the up close and personal human impact of having access to telebehavioral health services. MHAN advocates for a full continuum of care that gives consumers and families options in how they receive community-based services. For many years, consumers and families have had difficulty accessing behavioral health services, especially services that are near their home. Without telebehavioral health services, consumers and families have difficulty setting appointments that are convenient for them, especially if they live far from the service provider.

Adults with behavioral health disorders have to seek time off from their employer and may have to account for traveling hundreds of miles just to receive services. Having access to reliable transportation can also be a problem for consumers and families who have to make a long trek to receive services. If they have children, they have get respite or find other supervision, which can be limited or cost a lot of money. Children who

receive other supervision which can be limited or costly. Children receiving behavioral health services also face numerous inconveniences or detriments while accessing traditional, non-telebehavioral health services. Children have to be pulled out of school and miss hours of their education to account for extensive travel to receive behavioral health services. Families with multiple children also have to account for the supervision of their other children, leading to a desperate scramble to find other supports.

It comes as no surprise that the COVID-19 pandemic has led to an increase in behavioral health challenges and has forced our society to rethink how it conducts business and serves the community. Our national Mental Health America released a report this year finding that there was a 93% increase from 2019 in the number of people who took their anxiety screen, and a 62% increase in the number of people who took their depression screen. They found that children and youth ages 11-17 had been "more likely than any other age group to score for moderate to severe symptoms of anxiety and depression." In addition, they found that "since the end of May 2020, nearly every racial/ethnic group has been experiencing consistently higher rates of suicidal ideation than the 2019 average." The Centers for Disease Control found that the COVID-19 pandemic has considerably increased the symptoms of anxiety disorder and depressive disorder compared to 2019. In their study, 40.9% of American adults reported at least one adverse mental or behavioral health condition, with 10.7% of respondents reporting to have seriously considered suicide in the previous 30 days. Suicidal ideation was especially pronounced among racial and ethnic minorities, young adults, unpaid caregivers for adults, and essential workers.

The COVID-19 pandemic posed numerous challenges in being able to provide in-person services. Many North Dakotans were at risk of losing whatever services they had access to, and telebehavioral health increased that access. People who ordinarily would have sought or received services in an in-person setting were able to receive telebehavioral health services. While it was not an optimal setting for those individuals, at least they were able to receive services and supports and maintain that needed human connection. We also found consumers and families who preferred the telebehavioral health method, as it removed many of the barriers they faced in being able to access services and maintain appointments. Others found that telebehavioral health services were more comfortable in comparison with in-person appointments. Telebehavioral health services provide consumers and families options in how they seek care.

The COVID-19 pandemic will not become our new normal and we all eagerly await the day when it is over. That said, it would be seriously damaging to consumers and families to view telemedicine through the lens of a temporary delivery method that goes away when the impact of a pandemic or act of God ends. For years consumers and families have asked for a choice in services and how those services are delivered. Over the last five years, North Dakota has substantially increased the prominence of telemedicine services and that has led to an increase of service utilization and convenience for consumers and families. But we and the HSRI report knew we had a lot more work to do. This was all before COVID-19. With or without COVID-19, the needs were always the same. What COVID-19 has done is underscore how right consumers and families were in wanting access to telemedicine in our large, rural state that has experienced several decade shortages in behavioral health professionals.

We should not go backwards. We should take what we learned from the last few years and COVID-19 to make telemedicine as strong as possible.

Thank you for your time and I would be happy to answer any questions you may have.

Carlotta McCleary
Spokesperson
Mental Health Advocacy Network
(701) 255-3692
E-Mail: cmccleary@ndffcmh.com
cmccleary@mhand.org

January 20, 2021

To whom it may concern:

In 2020, healthcare providers were asked to make changes in the delivery of healthcare to patients in order to help fight the Covid-19 pandemic. As mental healthcare providers, not only did we understand the need to move to telehealth, but also understood the current and coming increased need for mental health services. While we were unsure of the outcome in the beginning, we did what we felt was necessary at the time to keep our patients and ourselves safe by moving all services to telehealth.

Laws for coverage parity for insurance subscribers (patients) already exist in the state of North Dakota, however, we do not have laws for payment parity for those providers offering telehealth services. The federal government through CMS understands that this is an issue and has reimbursed telehealth visits at the same rate as in-person visits throughout the pandemic emergency. Unfortunately, commercial insurance carriers in North Dakota have not followed suit. We knew this was the current reality but felt that the emergency called for it. Ten months later, we have a better understanding of the impact of telehealth on both our patients' care and our healthcare business.

For our patients we have seen an overwhelming adoption of the telehealth mode of providing care. With a caseload of over 400 active patients in March of 2020, we had 3 patients who refused telehealth and required a referral to outside sources. Of the over 100 new patient requests in the past 10 months, only 4 did not make an appointment due to services being provided only through telehealth.

We are also seeing an overwhelming benefit in the last 10 months for our patients' health. Telehealth allows our patients greater flexibility in scheduling and keeping appointments – they can be seen anywhere they have an internet connection. Patients can be seen from anywhere in the state – a patient from a rural, underserved part of our state no longer must take a whole day off work to drive 100 miles for services. We are seeing greater progress with their mental health treatment – they feel more comfortable being seen from their own safe space and do not have to worry about taking more time off work to get to an appointment. Patients have also mentioned they do not have to worry about the stigma (which unfortunately still exists) of going to a mental health appointment.

We have seen a dramatic decrease in cancellations of appointments. Being able to be seen by a provider in the comfort of their own space has helped many patients make their mental health a priority. Patients are better able to work around any scheduling/work/family conflicts to make it to their appointments. This leads to better outcomes for patients – symptom resolution is taking less time which ultimately means a savings for them and their insurance companies, along with improved mental health which means an improvement at work, at home, and in the community at large.

Unfortunately, we are seeing the burdens on our end as well. We are a small, independent clinic. We saw an immediate decrease in our reimbursement from commercial insurances by 20-30% depending on the insurance company. Telehealth visits do not require any less than in-person visits. They require the same level of education, knowledge, and expertise. They require office space for providers, and all the business needs that existed while doing in-person visits. There were also increased business expenses in getting our clinic set up to do telehealth and ongoing additional technology expenses related to doing telehealth.

As a small business in North Dakota, we have been fortunate to have some emergency support during the pandemic. This does not mean that payment parity is not needed. The overwhelming adoption of telehealth and benefits we are seeing means that it is here to stay as a viable option for patients and providers. Unfortunately, without payment parity clinics around the state will struggle to provide much needed services. This also has implications for encouraging additional healthcare providers to relocate here. Why would a healthcare provider choose to work here knowing they will be paid less for the same work? State and local governments work very hard to bring new business to our state; it would be of benefit to everyone to include healthcare businesses in that effort.

Healthcare flourishes when patients have a wide range of options to meet their needs – both small and large clinics, both in-person and telehealth providers. Payment parity from commercial insurances would ensure clinics around the state are able to recruit new providers, continue providing needed services, and be successful businesses providing value to our state.

Thank you for your consideration,

Christine Aman, NP-c and Kristen Getzlaff, BSNRN

Owners – Inspired Life Wellness Clinic PLLC Bismarck ND

#1944

missouri river HEALTH

425 E Ave C Bismarck, ND 58501
Tel: 701-712-9962 Fax: 701-425-0596

January 20, 2021
To: Senate Human Services Committee
Re: Support Bill SB 2179: fair reimbursement rates for telehealth services

Esteemed Madam Chair Sen. Lee, Committee members,

My name is Gabriela Balf, MD, I am a psychiatrist with Missouri River Health, a small private practice in Bismarck, ND, and a Clinical Associate Professor at UND School of Medicine. We see people of all ages, especially adolescents and young adults. I personally have practiced telepsychiatry for more than seven years; it is one of the subjects I teach and train students in.

One of the very few benefits this pandemic has brought to our state is the rapid expansion of telehealth services and its universal embracing by the patients.

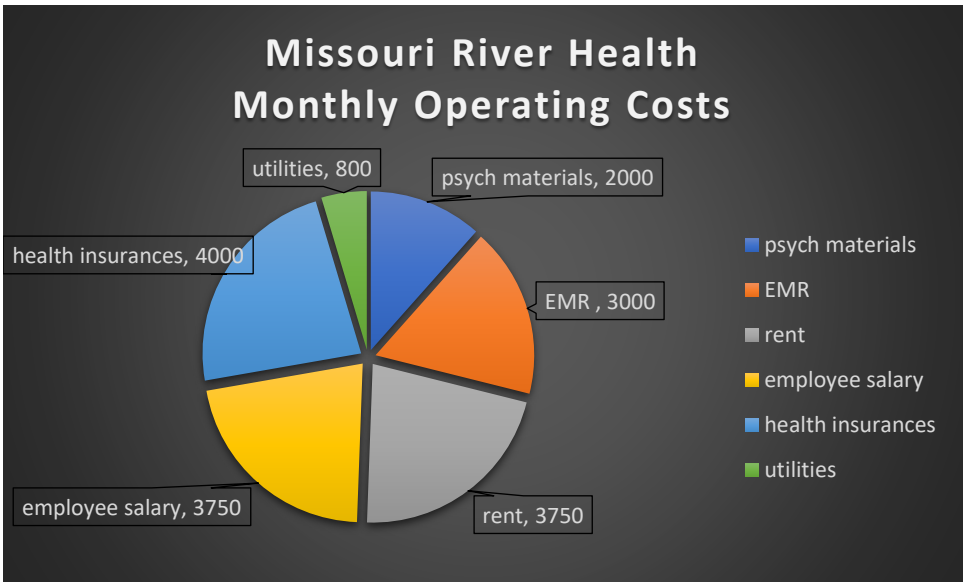
Our patients have expressed gratitude to have this service offered to them while at home, as this has meant, for them, huge relief regarding travel costs, time lost from work and lost wages accompanying their children or their elderly parents.

To give you an example, my 35-year-old woman patient from Bowman (insurance: Medicaid) with five children, had very hard time coming to the office for a half hour follow up. I forfeited her fees several times and I saw her in the peace of her home, because I could not bill for a video appointment with her insurance. As I think of my disadvantaged patients, to whom my heart goes most, it would have been unsustainable to offer this service long-term.

I was able to check on my nursing home, wheelchair bound patient with Parkinson related dementia, when her daughter went there and held up an ipad for a FaceTime visit. I had not seen her in a year because the daughter works full time, the nursing home has difficult time handling my patient, and taking her out of the environment once two years ago prompted such agitation that she had to be hospitalized.

Parents of adolescents with gender issues, PTSD, have been able to bring their kids in front of the computer a lot easier than getting them out of school for a "shrink" appointment.

On the other hand, I have to sustain my practice. Let me show you my expenses:



In terms of expenses, there is no difference for our operating costs between a telehealth visit as compared to in-person visit.

I know telehealth saves the system money indirectly: at least for mental health, the visits are completely replaceable, unnecessary ED visits are avoided. Studies show the cost of an ED visit as $1734 on average. Not in ND. If ambulance is involved, that is at least $900 one way.

The studies showing less costs focused on acute conditions like respiratory infections. Longitudinal care for chronic conditions like diabetes, mental health, etc, they would not benefit from episodic interventions from a party that does not have access to your data, nor communicates with your longitudinal clinicians.

Thank you for listening,
Gabriela Balf-Soran, MD, MPH

Missouri River Health – psychiatrist
Assoc Clin Prof UND School of Medicine

Senate Bill No. 2179

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: Senate Human Services Committee
Senator Judy Lee, Chairwoman

Date: January 20th, 2021

Madam Chair and members of the Senate Human Services Committee, my name is Jon Godfread and I am North Dakota's Insurance Commissioner. I appear before you today in opposition to Senate Bill 2179, the telehealth payment parity bill. For those of you who are unaware, we recently completed a study at the direction of the 66th Legislative Assembly to look at health care cost within the state of North Dakota. If you have not had a chance to review that study, I would encourage you to look at this comprehensive study.

The study highlighted a number of important issues in the North Dakota Hospital market including:

- **Hospital Utilization.** North Dakota has seen an increase in hospital usage. North Dakota Hospitals are seeing longer hospital stays than the national average, and utilization is growing faster in North Dakota than most of the rest of the country.
- **Hospital Expenses.** Hospital Expenses are ranking higher than the national average (usually top 5) and continuing to grow at higher than national average rates (also top 5 rankings)
- **Hospital Operating Revenue.** North Dakota hospitals are seeing high revenue and high revenue growth.
- **Medicare Revenue.** Medicare revenue is also very high and growing for North Dakota Hospitals
- **Hospital Reimbursement.** Private hospital reimbursement based on Medicare rates grew from 170 percent of Medicare in 2010 to over 200 percent of Medicare in 2018.
- **Acute Care vs. Critical Access Hospitals.** Critical access hospitals appear to be reimbursed at a much lower rate (149% of Medicare) than acute care hospital (211% of Medicare)
- **Premiums.** North Dakota premiums are largely average as compared to national average.
- **Claims.** Insurer claims are averaging slightly higher than the national average and are growing at higher than the national average.
- **Administrative costs.** Insurer administrative expenses remain low, but the administrative expenses are growing at a very fast rate.

The data clearly shows a number of warning signs in the North Dakota market. For the Hospitals, Commercial, Medicare, and Medicaid revue appears to be showing sizable growth. Hospitals appear to be offering more services and longer stays. In health insurance, administrative costs have grown substantially – though still generally at or below the national average. These trends bear watching.

I stand before you in opposition to Senate Bill 2179 because it would utilize telehealth to perpetuate many of these issues, despite the potential role that telehealth could play in addressing these issues.

Telemedicine depends on technological innovation that should reduce the cost structure of providing care. If so, those providers should compete on price. Markets can adapt to serve customers' needs under a certain burden of regulation of safety and standardization, but it is very hard for markets to adapt efficiently to regulated prices. If providers are not competing on price, they are not properly competing at all.

We will be unable to realize the cost-cutting and health care delivery modernization with a regulated price floor, the key to successful adoption of telemedicine is to restore a greater share of patient's health spending to their direct control, not impose price regulation.

Imposing payment parity removes any incentive for the health care system to innovate and examine their health care delivery model. I understand the desire for payment parity, but given our most recent and exhaustive health care cost study, it has never been more clear to me that it's our delivery model that needs modernizing and mandating price parity for services that are inherently different does not seem logical and would only further kick the health care delivery discussion down the road.

Some innovator is going to figure this out, some hospital system will figure this out, with payment parity in place it removes the incentive from solving this delivery model problem and only further exacerbates the issues we have with the cost of health care. Telemedicine should lead to a reduction of health care costs for our consumers. For this reason we oppose this bill.

If structured properly, telehealth services may increase access to needed care while also controlling costs. In a rural state like North Dakota, telehealth can provide the opportunity to access medical specialists without time consuming travel. For those with mental health issues, telehealth can be an important lifeline. With more frequent visits and early interventions available, telehealth can help avoid costly delays in care (such as undiagnosed conditions that becomes worse with time) and, in situations where an in-person visit may not be required, virtual encounters may be priced at a lower rate than in-person care (if there is no state mandate requiring payment parity).

For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000+ percent increase in telehealth visits in the midwestern U.S. between April 2019 and April 2020.Consumers are increasingly becoming accustomed to telehealth.

There are several issues that states should examine to create a permanent infrastructure that supports widespread adoption and utilization of telehealth:

Licensure: Many states have significant licensing barriers that control providers' ability to use telehealth. Provider licensing boards should be encouraged to embrace telehealth, allowing providers to establish relationships remotely as long as necessary conditions are met and the standard of care is upheld. State boards should consider the interstate compacts available, as well as other flexibilities that may enhance providers ability to practice telemedicine.

Payment: Rather than considering legislation that would stifle competition, establish guidance through which insurers and providers set appropriate rates based on the delivery of service. Perhaps looking at

payments based on access to care, or the needs of community. Rural parity would be an area we would be interested in further study, but blanket parity does not seem to make logical sense.

Software: Consumers and medical providers should be allowed to agree on the use of any software service. States shouldn't pick winner and losers.

Scope of practice: The pandemic has allowed many new types of service to be delivered by telehealth. States should look closely at their telehealth practice requirements and permanently modernize the statutes.

Thank you, madam chair and members of the committee, I am happy to attempt to answer any questions you may have.

Wednesday, January 20, 2021

Senate Human Services Committee
SB 2179

SENATOR LEE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. For the reasons outlined below, AHIP opposes this bill as currently drafted.

Health insurers have long supported policy changes to encourage telehealth use and speed its adoption. In response to the COVID-19 public health emergency, our members have taken voluntary, proactive steps to increase access to health care services, including the use of telemedicine. These proactive steps have facilitated an explosion in telehealth use that provided patients and providers the ability to connect despite social distancing.

However, we are concerned about two provisions: 1) mandating payment parity for telehealth services and in-person services, and 2) removing prior authorization for telemedicine services.

Mandating parity in reimbursement for medical services provided via telehealth with identical services provided in-person jeopardizes the cost-saving potential that telehealth promises. This parity requirement essentially requires employers, individuals, and taxpayers to subsidize providers for bricks and mortar infrastructure as part of virtual visits.

Prior authorization is an essential utilization management tool that ensures a patient-centered approach to care delivery. Prior authorization is based on evidence-based medical criteria developed by nationally recognized entities. These criteria are supported by widely accepted, scientific evidence and protect patients from the overuse, misuse, or unnecessary (or even potentially harmful) care and ensuring consistency with evidence-

based practices. As we work to expand access to necessary medical care through the increased use telehealth, consideration must be given to ensure that these treatments are clinically and medically appropriate.

Because these provisions imperil patient safety, the effectiveness of treatments, and eliminate cost savings that could be realized, we respectfully request that the following amendments be made to SB 2179.

Thank you for your time and consideration. I'd be happy to answer any questions.

PROPOSED AMENDMENTS TO SB 2179

Page 3, line 2, delete "any coinsurance or copayment applicable to covered"

Page 3, delete lines 3 and 4

Page 3, line 5, delete "in-person means"

Page 3, delete lines 22 through 24

Renumber accordingly

SANFORD HEALTH PLAN

Chairwoman Lee and members of the North Dakota Senate Human Services Committee,

My name is Dylan Wheeler, Senior Legislative Affairs Specialist, Sanford Health. On behalf of Sanford Health, I would like to provide comments re: SB 2179, legislation requiring Telemedicine Payment Parity.

Telemedicine has played a critical role over the past year during COVID-19 for patients, members, providers, and payers alike. Payers, such as Sanford Health Plan (SHP) in partnership with the ND Department of Insurance, responded by waiving member cost-sharing for telemedicine visits. The provider community stepped up and met the challenge of adapting to and implementing telemedicine to meet the needs of patients. The regulatory and statutory flexibility currently in North Dakota played a key role in quickly responding to the COVID 19/Public Health Emergency. Looking forward, continued regulatory flexibility is recommended as telemedicine continues to evolve – for payer, provider, patient, and member

Sanford Health supports utilization of telemedicine as it leverages one of many tools available to improve health quality outcomes, increase access to care, and reduce costs. However, measures contained in SB2179 could lead to increased costs, cost-shifting, and/or growth in spending which are counterproductive to the shared objective of reducing overall healthcare costs. Moreover, we recognize that in order to effectively maintain access and provider-patient relationship, states must adopt policies that adequately address safe and effective portability/reciprocity for licensure.

We would like to share with the committee several key concerns:

1. Audio Only Definition Addition
2. Coinsurance or Copayment Parity
3. Utilization Management Parity
4. Telemedicine Payment Parity

Expansion of the Definition of Telehealth to Include "Audio Only"

The proposed addition of "audio-only" to the statutory definition of telehealth gives rise to the questions whether an audio-only provider/patient interaction is in parity (the equivalent or directly comparable) with either a video/virtual or in-person interaction. Audio-only may not allow the use of several diagnostic tools often required for medical diagnosis. The wording of the proposed definition change (reference lines 13-19) presents implementation and compliance challenges – such as tracking "adequate broadband access" or determining "other means of communications technology." From an operations perspective, adequately tracking or monitoring those factors may be difficult. Likewise, by carving in audio-only could presents hurdles for care-coordination and utilization management. An audio-only patient interaction, if outside of

traditional patient-provider EHR record platform, could result in an incomplete medical record. However, we do not want to minimize the value that audio-only interactions may have in practice, such as behavioral health. The question here is whether those are to be considered the same for reimbursement.

Coinsurance or Copayment Parity Amendment

As written, this amendment and requirement could actually stifle future telehealth utilization and innovation. For example, by prohibiting payers from allowing lower copayments for telehealth visits, consumers would be penalized, especially if they chose to continue using telehealth after the PHE. Payers-- during the Public Health Emergency/COVID-19- **have waived member cost-sharing for telehealth visits**. As written, this amendment would prohibit such proactive steps and market flexibility. We would recommend removing or striking this amendment in its entirety from the bill.

Utilization Management Parity Amendment

Utilization management is another tool that payers, in partnership with providers, use to help guide and track patients through the healthcare process. The prohibition of "any type of utilization management" as written in the bill is concerning. We are still learning about consumer behavior and telemedicine (e.g. utilization) during the COVID-19 pandemic. Prohibiting payers and providers from adjusting utilization management policies before fully knowing and understanding use patterns post-COVID may lead to unintended consequences or inhibit positive adjustments to adapt to patient behavior. We would recommend removing or striking this amendment in its entirety from the bill.

Telemedicine Payment Parity

SB2179, as currently written, specifically mandates that reimbursement for telehealth services "may not be less than" its in-person counterpart. Statutorily setting the minimum reimbursement threshold would be counterproductive to market flexibility, future innovation, and may inflate costs to the patient/member. This is particularly of concern for the inclusion of "audio-only" in the definition. Under this requirement, payers must reimburse providers for an audio-only interaction not less than an in-person visit – is this the precedent to set?

Other Considerations

The healthcare system has seen a drastic increase in telemedicine utilization over the past year – due in large part to the COVID-19 pandemic. Before setting any statutory price/parity requirements, we should consider to what extent telemedicine has been utilized and can or will be used going forward. As payers and providers move away from fee-for-service reimbursement mechanism – telemedicine payment parity requirements could thwart the health care systems shift to value based payments or other quality based reimbursement/payment models.

This "parity payment" requirement fails to capture the cost savings that telehealth can bring to the health care system for consumers. Telehealth should make health care more efficient. And that

means that telehealth should not only be more affordable, but also used appropriately to best fit each patient's health care needs

Additionally, provider licensure recognition across state lines is an integral part of the long-term and broader telemedicine policy discussion. Recognizing other state licenses of healthcare providers may better serve broader populations, provider greater access, and reduce overall costs and spending.

Thank you for your time and consideration. We respectfully, at this time, oppose the legislation as written.

Respectfully Submitted,

Dylan C. Wheeler, JD
Senior Legislative Affairs Specialist
Sanford Health Plan

TESTIMONY OF SCOTT MILLER

Senate Bill 2179 – Telehealth Coverage Mandate

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding Senate Bill 2179.

Senate Bill 2179 proposes to do the following regarding coverage of telehealth services:

- Audio-only visits are allowed when other forms of communication are not feasible (i.e., lack of adequate broadband for video visits)
- Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may not be less than reimbursement of expenses for covered health services that are delivered by in-person means
- Member cost sharing (copays, coinsurance, deductible) must be the same for telehealth as it is for in-person visits.
- No utilization management can be applied to telehealth that is not also applied to in-person visits
- May not require an in-person visit before allowing telehealth visits

Our consultant, Deloitte, noted the following regarding this bill:

- There will likely be an actuarial impact on the Group Health Plan, but there was insufficient time to determine exactly what that impact might be
- The definition of what constitutes "Telehealth Services" is not clear enough to make an accurate analysis
- Two recent sources of information show that the average telemedicine visit costs less compared to an in-person visit. Since this bill mandates that payment or reimbursement of telehealth be no less than in-person visits, we anticipate this bill will result in increased payments for telehealth services and higher cost for the plan and members through coinsurance/deductibles.

Note this bill does not first require application to NDPERS, but instead applies to all health plans issued within ND. As such, it may not comply with the statutory requirement that all new mandates first apply to NDPERS.

This concludes my testimony.

NORTH DAKOTA
BOARD OF MEDICINE

Established 1890
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Phone (701) 450-4060 • Fax (701) 989-6392
www.ndbom.org

Sandra DePountis
Executive Director

Lynette McDonald
Deputy Executive Director

North Dakota Board of Medicine
Support to SB 2179

Dear Chair Lee and members of the Senate Human Services Committee:

Thank you for the opportunity to submit testimony in support of SB 2179. The mission of the North Dakota Board of Medicine is to protect the public's health, safety, and welfare. To this end, the Board expresses its support for the expansion of the definition of "telehealth" as this will provide additional coverage and access to the homebound, rural patients, and individuals who do not have access to healthcare by other remote means. Greater accessibility translates into better health care which we believe to be in the best interest of the public. For these reasons, the Board of Medicine supports SB 2179.

Please do not hesitate to contact us with further questions. We would be happy to provide further information, testimony, and answer any questions the Committee may have.

Sincerely,

/s/ Dr. Robert Sticca
Chair, Legislative Committee
North Dakota Board of Medicine

Human Services Committee
SB2179
January 19, 2021

Chairman Judy Lee and committee members, thank you for taking time to consider improving healthcare with Telemedicine in North Dakota. My name is Marsha Waind. I currently work for the University of North Dakota School of Medicine and Health Sciences within the Dakota Geriatrics Workforce Enhancement Program. My job is to develop Geriatric Telehealth Services and training programs for the medical staff of tomorrow. Previously I spent 15 years at Altru Health System in Grand Forks developing Telemedicine connections to our rural healthcare partners. Altru has shared their data to show the rural importance of these connections. Last year, Altru provided more than 36,000 telemedicine visits, as compared to 12,500 in 2019. Altru connects providers to patients at 14 rural hospitals, 16 Rural Clinics, 15 Skilled Nursing Facilities and 4 Residential care facilities.

Altru uses Telemedicine to connect to specialists in distant locations for expedient care. Using Telemedicine, Grand Forks patients receive care from Stroke Neurologists when they arrive in the GF ER with stroke symptoms; or they are connected to a Burn Center in Minneapolis, and to get Psychiatric care when needed.

During the spring months when most of the clinics were closed due to COVID, Providers turned to telemedicine. The use of telehealth saved precious PPE, protective personal equipment, it provided safety for the providers and the patients. Rural providers in Devils Lake and Lakota used Telemedicine to care for their patients at the nursing home without risking infection to themselves or their patients. A survey by the COVID-19 Healthcare Coalition conducted the Telehealth Impact Claims Data Study (available at https://c19hcc.org/telehealth) to learn about telehealth during the pandemic. Exploring the claims data analysis for North Dakota from Aug 19 to Aug 20, North Dakota showed a growth factor of only 11 times, while Minnesota had a growth factor of 29x, Montana 16x, South Dakota 20x. However, with even a small impact on change to healthcare delivery, Consumers will now expect the innovation and improved care delivery that Telemedicine provides.

Telemedicine in North Dakota is good medicine. Telemedicine saves lives in North Dakota. Telemedicine in North Dakota is NOT Teledoc and to compare it as even slightly similar, is not right.

Telemedicine in North Dakota provides care to rural patients. Telemedicine in North Dakota provides care not available on site in rural locations. A specialist can provide a consult to a patient in rural hospital bed. This consult may keep the patient local, which means financial support for rural hospitals and better-quality care for ND citizens, while keeping families and their dollars in the rural communities.

Most of the telemedicine in North Dakota is behavioral health and we know we do not have enough Psychiatrists to care for our population. Specialty care provided by tertiary care centers connecting to rural patients at rural facilities is the next largest group to use telemedicine. Rural patients travel 2-3 hours away from the Fargo, Bismarck, Minot, and Grand Forks. Using Telemedicine for consults and follow up care is efficient and effective.

Here are more examples of Telemedicine improving care in North Dakota:

- Psychiatric consults into a rural Emergency Room. Rural Hospitals are often staffed by 1 RN on the night shift; they do not have security staff. They need Telemedicine to determine care and help them find a hospital bed for a patient in mental health crisis.
- Telemedicine keeps rural dialysis centers, such as Devils Lake open. There are not enough Nephrologists to support rural sites without Telemedicine and if unserved, those dialysis patients would need to move to Bismarck, Minot, Fargo, if they could obtain a treatment spot at that center.
- Another especially effective use of Telemedicine is care of chronic conditions, such as heart disease, diabetes, kidney disease. Periodic telemed connections to these patient improve outcomes and keep these patients at home, out of long-term care settings. Most of that care is provided by Family Practice providers. Rural providers could use telemedicine to see their own patients at home, but they have not developed that service on the same scale as the specialists in the major hubs. Why would they? It is not paid as well as their in-office visits.

Telemedicine has as much if not MORE value as in-person care and should be paid at the same rate.

- Medicare currently pays for Telemedicine that connects rural EMS rigs to a tertiary care center for diagnosing strokes in the field, saving time and brain. This is better healthcare delivery. Wouldn't it be fair to pay the same rate to that stroke neurologist as an in-person encounter?
- Or what if your grown daughter delivered a baby prematurely in the local rural hospital ER, wouldn't you want that rural doctor or Nurse practitioner to connect with a neonatal specialist at Fargo Children's Hospital to determine best care or to facilitate transport? Neonatal specialists provide the same care in person or over telemedicine. Why wouldn't we pay it at the same rate?

Telemedicine is not cheaper to provide. It takes extra resources to develop protocols that relates to two separate facilities. It takes time and resources to train the local staff and determine workflow at the physician site and set up the IT connections. It takes the same time and resources as in person visits to admit the patient, to bill the services, to code the services, to document the services and there needs to be a building to house those resources and people that clean that building and raise funds to keep the local hospital open. Because if the hospital were not there, the premature baby would perish in a car ride to the hub hospital.

Here is an analogy for North Dakota. There is a new strain of wheat with tremendous value for those that eat it. When baked into bread it heals peoples, in fact it saves lives. Let us ask the farmer to plant this new wonder wheat. It costs a little more to buy this wheat, yet it costs just as much to plant it, to harvest it, to ship it. But since it is new type of wheat, Mr. Farmer will not receive any subsidies or loans for this special wheat, in fact he will be paid less for it when it gets to the Elevator because it is unfamiliar to the Elevator manager. Who loses out the most in this scenario? The people who need the bread.

Telemedicine is vital to better healthcare across North Dakota It improves healthcare to our citizens. Telemedicine is important to North Dakota and should be paid at the same rate as in-person care. I ask your support for this important bill – SB2179.

Thank you for supporting Telemedicine and better healthcare in North Dakota.

#1768

PO Box 9310
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952-992-2900

MEDICA®

January 19, 2021

Senator Judy Lee
Chair, Senate Human Services Committee
North Dakota State Capitol
600 E Boulevard Ave
Bismarck, ND 58505

Dear Madame Chair Lee,

On behalf of Medica, I want to express our concern regarding SB 2179. Medica has covered telemedicine, telehealth, and virtual care services for years and have medical processes in place to outline the instances under which we cover these services. As a nonprofit health plan, we are mission-driven to improve the health of the communities we serve by making health care accessible and affordable for our membership. We are concerned about the negative impact that SB 2179, as introduced, could have on affordability.

Medica supports the ability of plans to work with providers to agree on a reimbursement that maximizes quality and value between remote and in-person care and not mandated by state law. We believe telemedicine, telehealth, and virtual care services can be an innovative modality of care, especially during a public health emergency. But, to continue to drive value and bend the cost curve, such services should not universally be paid at the same rate as a comparable in-person visit. We would oppose mandated reimbursement parity, and would instead recommend the preservation of current law, which requires that payment rates be established through negotiation between payments and providers. This would maximize telemedicine, telehealth, and virtual care services' value.

The onset of the COVID-19 pandemic and the need to socially distance increased the need and use of providing health care services via telehealth. Like many other health plans across the country, Medica voluntarily opted to reimburse health care providers for telehealth visits at the same rate under which we would reimburse for the same service delivered in an in-person setting.

The purpose of this temporary increase was an acknowledgement that due to the COVID-19 pandemic, many Americans may decide, or may be required to, postpone or forego medical appointments in order to free up hospital capacity to treat patients with COVID-19 while mitigating the risk of spread.

While North Dakota did not mandate a postponement of elective procedures, a number of states in our service area, including Minnesota, chose to take that step. The enhanced reimbursement reduced barriers and disincentives for safe care delivery to our members. However, we disagree that such a change should be made permanent, as it would increase health care costs as normal utilization of health care services resumes.

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Looking forward, Medica supports the approach of allowing health plans to work directly with providers to build on those strategies that work, with a focus on preserving accessibility and affordability.

We appreciate the opportunity to offer our concerns, and are happy answer any questions related to our concerns.

Respectfully,

Matt Schafer

#1945

APTA North Dakota
A Chapter of the American Physical Therapy Association

January 20, 2021

Dear Members of the Senate Human Services Committee,

I am a licensed physical therapist from Grand Forks. I am submitting this written testimony on behalf of APTA North Dakota, the membership association of physical therapists and physical therapist assistants in North Dakota. I currently serve as president for this association.

The pandemic has been a challenge to all people in so many ways and I am certain all are more than ready to somehow put it behind us. A silver lining realized by many health care practitioners is the advantages and uses of telehealth in serving the citizens of North Dakota, especially those from very rural parts of the state. Yes, for many patients, 'in-clinic' appointments have returned; however, there are many pros of being able to use telehealth when in-person care cannot happen.

- Decreased cancellations due to weather or other travel related issues
- Decreased cancellations due to family member issues (i.e. no child care, no vehicle, sick sibling)
- Real-time home programming and addressing challenges with caregivers involved in the session
- Ability to see the home environment to assess for safety issues, barriers, etc.
- More efficient communication with parents/caregivers: no need for an extra phone call to discuss how sessions went
- More functional approach to treatment as activities must to be tailored to the home environment

The pandemic has made us pivot in our thinking about health care delivery and even methods of teaching our entry-level students to prepare them for the realities of practice with use of telehealth. Telehealth does not replace all patient care, but certainly has benefits when it is needed.

Whether services are provided in-person or via telehealth, the provider's time is equally as important as the care being delivered. We urge you to support payment parity for telehealth services to ensure that these services are reimbursed at the same rate as services provided in-person and ask you to pass SB 2179.

Sincerely,

Cindy Flom-Meland

Cindy Flom-Meland, PT, MPT, PhD
Board Certified Neurologic Clinical Specialist
President, APTA North Dakota

APTA North Dakota
1301 North Columbia Road, Stop 9037 / Grand Forks, ND 58202 / 701-777-3873 / info@aptand.com

Session: **67th Legislative Assembly, Regular Session (2021)**
Bill: **SB 2179**
Committee: **Senate Human Services Committee**
Hearing: **Wednesday, January 20th, 2021 at 2:30 p.m.**
Testimony: **Written Only**
Witness: **Brian Balstad, Lobbyist for North Dakota Psychological Association**

Chairwoman Lee and Members of the Human Services Committee:

My name is Brian Balstad. I am submitting written testimony on behalf of the North Dakota Psychological Association, the professional association for psychologists in the State of North Dakota. Telehealth serves an important role in providing mental health services for North Dakotans. Telehealth has made mental health services accessible to North Dakotans living in rural areas and North Dakotans with limited mobility. It has made mental health services accessible to North Dakotans during the COVID-19 pandemic without risking harm to the patient/client, mental health service provider, or the public. It has made mental health services more accessible to North Dakotans overall. It is for these reasons the North Dakota Psychological Association has supported and continues to support telehealth.

An issue encountered when providing mental health services using telehealth is the disparate treatment of telehealth by some insurance companies. The services provided using telehealth are the same services provided in-person yet some insurance companies provide lower rates of reimbursement, i.e. pay less, for services provided using telehealth than for services provided in-person. Thus, not only do mental health service providers incur additional cost to provide services using telehealth, mental health service providers are also paid less for services provided using telehealth by some insurance companies. As services provided using telehealth are the same services provided in-person, the rates of reimbursement should be the same. SB 2179 addresses this issue. In addition to addressing the disparate treatment of telehealth in regard to

payments and reimbursement, SB 2179 also addresses the disparate treatment of telehealth in regard to coinsurance, copayments, deductibles, and utilization management requirements.

Imposing requirements for in-person consultations or in-person contact before a patient/client may receive mental health services using telehealth makes receiving mental health services more difficult and makes mental health services less accessible for North Dakotans. SB 2179 addresses this issue by prohibiting such requirements.

SB 2179 also makes mental health services more accessible by extending coverage of telehealth services to residential facilities and group homes and by expanding telehealth to include audio-only telephone.

For these reasons, the North Dakota Psychological Association supports SB 2179. Thank you for your time and consideration. Also, thank you Chairwoman Lee, Senator Anderson, Senator Roers, Representative Dobervich, and Representative Westlind for sponsoring this bill.

#2137

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

January 21, 2021

The Honorable Judy Lee, Chair
The Honorable Jim Roers, Vice Chair
Senate Committee on Human Services
Sakakawea Room
600 E Boulevard Ave
Bismarck, ND 58505

Dear Chair Pendergrass, Vice Chair Pena-Melnyk, and Members of the Committee,

The Association for Clinical Oncology (ASCO) is pleased to support **Senate Bill 2179**, which would allow for patients with cancer to continue receiving necessary care through telemedicine. Senate Committee on Human Services passage of SB 2179 would be a crucial step in helping to make sure this valuable method of care is available to North Dakota patients after the current public health emergency has ended.

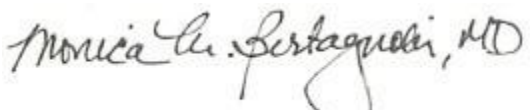
ASCO is a national organization representing physicians who care for people with cancer. With nearly 45,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality cancer care. In keeping with this goal, ASCO has prioritized support for state legislation like SB 2179, which can increase access to care for patients with cancer while reducing treatment burden and disruption to patient lives.

Telemedicine has allowed providers to continue treating patients with cancer during the pandemic, both in rural and urban communities, with minimal disruption. Telemedicine has also led to fewer missed appointments than normally experienced with in-person visits. While telemedicine cannot fully replace face to face cancer care, the extension of covered benefits in recent months has rapidly changed the way we see patients and it prompted innovation that has allowed us to safely increase access to high quality care. Our affiliate organization, the American Society of Clinical Oncology, recently published an Interim Position Statement on Telemedicine in Cancer Care, which highlights the potential for telemedicine to play an important role in cancer care delivery moving forward.

We are encouraged to see that SB 2179 includes coverage and reimbursement for audio-only appointments if video is not available. Not all North Dakota patients have the same access to video connection and this provision would assure all individuals can access the benefits afforded by access telemedicine appointments.

ASCO applauds the swift bipartisan efforts thus far in working to deliver greater access to telemedicine in light of the pandemic. Continuing this coverage after the public health emergency has ended is an important step toward building upon the successes we have seen in telemedicine. If you have questions or would like assistance on any issue involving the care of individuals with cancer, please contact Aaron Segel at ASCO at aaron.segel@asco.org.

Sincerely,



Monica Bertagnolli, MD, FACS, FASCO
Chair of the Board
Association for Clinical Oncology

#1937

NDNA
NORTH DAKOTA NURSES ASSOCIATION

✧ 1912-2021 ✧
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701-335-6376

January 20, 2021

Chair Lee and members of the Senate Human Services Committee:

I am writing today on behalf of the North Dakota Nurses Association. We are in support of SB 2179, a bill relating to health insurance coverage of telehealth.

The mission of the NDNA is to advance the nursing profession by promoting professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and by advocating on health care issues affecting nurses and the public. We know that telehealth can reduce the pressure on healthcare systems and therefore, the public, by minimizing patient demand on facilities and healthcare providers.

From the American Nurses Association *Core Principles on Connected Health* (telehealth) (2019), "the use of connected health technologies does not alter the standards of professional practice when delivering healthcare, conducting research, or providing education." It is vital to maintain continuity of care and avoid additional potential patient issues from delayed preventive, chronic, or routine care. It can allow for long-distance patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions.

We support SB 2179 and ask that you pass this bill.

Sincerely,

Sherri Miller, BS, BSN, RN
director@ndna.org
Executive Director
North Dakota Nurses Association

TESTIMONY OF REBECCA FRICKE

Senate Bill 2179 – Telehealth Coverage Mandate

Good afternoon, my name is Rebecca Fricke. I am the Chief Benefits Officer of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in a neutral position on Senate Bill 2179. I am available should there be any questions related to the impact of the bill on any of the NDPERS benefits.

TESTIMONY OF DERRICK HOHBEIN

Senate Bill 2179 – Telehealth Coverage Mandate

Good afternoon, my name is Derrick Hohbein. I am the Chief Operating / Financial Officer of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in a neutral position on Senate Bill 2179. I am available should there be any questions related to the impact of the bill on any of the NDPERS benefits.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2179
2/2/2021

A BILL for an Act to provide for a legislative management study relating to coverage of telehealth.

Madam Chair Lee opened the discussion on SB 2179 at 2:39 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Telemedicine V.S. Telehealth definition
- E-visit prescription charge responsibility
- Patient - practitioner relationship and prescriptions
- Coverage V.S. parity coverage
- ERISA coverage and co-insurance
- Sanford Health E-visit and Telehealth language

[2:40] John Olson, North Dakota Psychiatric Society. Provided the committee with proposed amendment. (testimony #5000)

[2:44] Senator Howard Anderson. Provided committee with Telehealth and Telemedicine definition from the CDC (testimony #4999)

[2:45] Courtney Koeble, Executive Director, North Dakota Medical Association. Provided the committee with clarification on Telehealth definition.

[2:58] Senator Judy Lee. re-opened discussion on SB 2179 and introduced Jennifer Clark.

[2:58] Jennifer Clark, Legislative Council. Provided the committee with clarification on defining E-visit and Telehealth in statute.

Additional written testimony: N/A

Madam Chair Lee closed committee discussion on SB 2179 at 3:10 p.m.

Justin Velez, Committee Clerk

Proposed Amendment to SB 2179 (21.0532.02000)

Page 1, after line 9, insert: "'E-visit' means the practice of medicine using asynchronous store-and-forward technology without the use of audio-visual technology."

Page 2, line 31, after period insert "This section does not apply to payment or reimbursement of expenses for e-visits."

Renumber accordingly

Telehealth is "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration."[1] Often, telehealth is used interchangeably with the terms telemedicine[2] or eHealth. Telehealth, however, is broader than these other terms; telemedicine and eHealth are distinct areas within telehealth.[3] *Telemedicine* is defined by the Federation of State Medical Boards as "the practice of medicine using electronic communication, information technology, or other means between a physician in one location, and a patient in another location, with or without an intervening health care provider."[4] The World Health Organization defines *eHealth* as "the use of information and communication technologies (ICT) for health."[5]

Telehealth is a promising public health tool because of its potential to significantly increase access to health care for medically underserved populations, as well as the widespread belief that it can reduce healthcare costs and improve health outcomes overall. In rural areas, with federal legislation increasing demand for medical services already in short supply, telehealth is often seen as a more efficient way for people to receive care.

Despite its growth in popularity in recent years, telehealth faces a number of barriers hindering more widespread adoption. Information security, patient privacy, licensing, insurance reimbursement, and liability concerns are all areas where gaps exist in state statutes and regulations. The following resources describe policy and legal considerations for implementing and governing telehealth.[6]

https://www.cdc.gov/phlp/publications/topic/anthologies/anthologies-telehealth.html

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2179
2/3/2021

A BILL for an Act to provide for a legislative management study relating to coverage of telehealth.

Madam Chair Lee opened the discussion on SB 2179 at 2:42 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Stakeholders input on proposed amendment
- Study resolution

[2:43] Senator Hogan, District 21. Provided the committee with proposed amendment 21.0532.02001 (testimony #5257).

Additional written testimony: N/A

Madam Chair Lee closed the hearing on SB 2179 at 2:44 p.m.

Justin Velez, Committee Clerk

21.0532.02001
Title.

Prepared by the Legislative Council staff for
Senator Hogan
January 27, 2021

PROPOSED AMENDMENTS TO SENATE BILL NO. 2179

Page 1, line 2, after the semicolon insert "to provide for a legislative management study;"

Page 3, after line 27, insert:

"**SECTION 2. TELEHEALTH - LEGISLATIVE MANAGEMENT STUDY.** During the 2021-22 interim, the legislative management shall study telehealth costs, services, and reimbursement options. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2179
2/8/2021

A BILL for an Act to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to health insurance coverage of telehealth; and to declare an emergency.

Madam Chair Lee opened the discussion on SB at 2:59 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Telehealth utilization
- Cost & quality
- Increase of consumer costs
- Cost savings
- Payment parity
- E-visits V.S. Telehealth
- Complex Telehealth visits
- Chronic disease care

[2:59] Senator Judy Lee, District 13. Provided the committee with proposed amendment 21.0532.02002 (testimony #5970).

[3:00] Megan Houn, Director, Government Relations, Blue Cross and Blue Shield. Introduced Chelsea Matter to the committee.

[3:01] Chelsey Matter, Director, Provider Contracting, Blue Cross and Blue Shield. Provided the committee with Telehealth utilization data.

[3:20] Maureen Ideker, Senior Telehealth Advisor, Essentia Health. Provided the committee with an overview of Telehealth and cost savings.

[3:26] Marsha Waind, UND Medical School. Provided the committee with an overview of Telehealth services price difference.

[3:29] Andrew Askew, Vice President, Public Policy, Essentia Health. Provided committee with overview of Telehealth visit totals and payment parity.

[3:31] John Olsen, North Dakota Psychiatric Society. Provided the committee with stance on telehealth and behavioral health patients.

[3:38] Courtney Koebele, North Dakota Medical Association. Advised the committee on payment parity.

[3:40] Megan Houn, Director, Government Relations, Blue Cross and Blue Shield. Provided anecdotal story of a Telehealth visit.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on SB 2179 at 3:55 p.m.

Justin Velez, Committee Clerk

21.0532.02002
Title.

Prepared by the Legislative Council staff for
Senate Human Services Committee
February 3, 2021

PROPOSED AMENDMENTS TO SENATE BILL NO. 2179

Page 2, line 31, after the period insert "This subsection does not apply to health care services delivered by means of a patient-initiated, non-face-to-face communication using an online patient portal."

Renumber accordingly

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2179
2/9/2021

A BILL for an Act to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to health insurance coverage of telehealth; and to declare an emergency.

Madam Chair Lee opened the discussion on SB 2179 at 2:30 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Parity Issues
- "shall consider" or "shall study" language
- Adding study language V.S. hoghouse
- Provider price floor on insurance plans
- Mandate V.S. free market

[2:35] John Olsen, North Dakota Psychiatric Society. Advised the committee of stance on medical treatment.

[2:36] Courtney Koebele, Director, North Dakota Medical Association. Provided the committee with clarification on parity.

[2:38] Megan Houn, Director, Government Relations, Blue Cross and Blue Shield. Advised the committee with stance on legislative study.

[2:53] Dennis Pathorff, Lobbyist, Essentia Health. Stood for committee position on full parity with sunset clause.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on SB 2179 at 3:00 p.m.

Justin Velez, Committee Clerk

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2179
2/10/2021

A BILL for an Act to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to health insurance coverage of telehealth; and to declare an emergency.

Madam Chair Lee opened the discussion on SB 2179 at 10:50 a.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Amendment 21.0532.02004 proposal

[10:50] Senator Hogan, District 21. Provided the committee with proposed amendment 21.0532.02004 (testimony #6269).

[10:52] John Olsen, North Dakota Psychiatric Society. Provided stance to the committee on proposed amendment 21.0532.02004.

Senator Hogan moves to **ADOPT AMENDMENT** 21.0532.02004
Senator Anderson seconded.

Voice Vote – motion passed

Senator Hogan moves DO PASS, AS AMENDED.
Senator Anderson seconded.

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	Y
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Oley Larsen	N

The motion passed 5-1-0
Senator Hogan will carry SB 2179.

Additional written testimony: (1)

Joan Connell, MD MPH FAAP, Pediatrician. Provided written clarification on reimbursement of telehealth services (testimony #6190).

Madam Chair Lee closed the discussion on SB at 10:56 a.m.

Justin Velez, Committee Clerk

21.0532.02004
Title.03000

Prepared by the Legislative Council staff for
Senator Hogan
February 10, 2021

PROPOSED AMENDMENTS TO SENATE BILL NO. 2179

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to coverage of telehealth.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - TELEHEALTH COVERAGE. During the 2021-22 interim, the legislative management shall study telehealth costs, services, and reimbursement options. The study should include input from stakeholders, such as providers, payors, and the insurance department. A goal of the study is to encourage providers and payors to collaborate to find a mutually agreeable telehealth reimbursement structure. The study may begin with a focus on behavioral health provided via telehealth. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2179: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). SB 2179 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to coverage of telehealth.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - TELEHEALTH COVERAGE. During the 2021-22 interim, the legislative management shall study telehealth costs, services, and reimbursement options. The study should include input from stakeholders, such as providers, payors, and the insurance department. A goal of the study is to encourage providers and payors to collaborate to find a mutually agreeable telehealth reimbursement structure. The study may begin with a focus on behavioral health provided via telehealth. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

21.0532.02004
Title.

Prepared by the Legislative Council staff for
Senator Hogan
February 10, 2021

PROPOSED AMENDMENTS TO SENATE BILL NO. 2179

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to coverage of telehealth.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - TELEHEALTH COVERAGE. During the 2021-22 interim, the legislative management shall study telehealth costs, services, and reimbursement options. The study should include input from stakeholders, such as providers, payors, and the insurance department. A goal of the study is to encourage providers and payors to collaborate to find a mutually agreeable telehealth reimbursement structure. The study may begin with a focus on behavioral health provided via telehealth. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

Greetings Chairman Lee,

This email is in request of passage of SB 2179, which among other things would provide parity for reimbursement of services delivered via telehealth. I would like to provide 3 current examples from my pediatric practice that illustrate why this is fair as well as making large strides toward our common goal of increasing access to QUALITY care for all North Dakotans.

Example 1: Children's Regional Asthma Clinic branched out to Dickinson via the use of telehealth to increase access to quality asthma services for pediatric patients from western North Dakota. We "see" patients while they are at CHI-Dickinson and we- the clinicians- are at CHI St Alexius Bismarck using audiovisual technology, examining them with digital stethoscopes and otoscopes (which we were able to buy using grant funds from the Center for Rural Health) enabling us to listen to their heart and lungs as well as examine their ears, nose, and throat. This saves hundreds of miles and countless hours of driving, as well as making visits possible when transportation (sometimes due to bad weather) is an issue. At the end of the day, complete assessments completed on these patients via telehealth are equivalent to those assessments completed for patients being seen "live" in our Bismarck clinic. Given the equivalent services provided, why would disparate reimbursement ever be considered?

Example 2: I currently have a special needs patient who does not sleep at night, creating countless behavioral problems that have wreaked havoc on the child and family. With help from my child psychiatrist colleague, I am gradually increasing the dosage of a medication that will help this child sleep through the night. Given the potential for adverse cardiac effects as we gingerly increase the dosage, this medication requires monitoring with ECG in addition to monitoring that is necessary to determine efficacy and any other potential adverse effects. Rather than have the patient miss significant amounts of school frequently, the patient may drop by for the ECG after school, then have an audiovisual visit while the child is at school, minimizing driving and waiting time that would take away from school time. During the visit, we are able to discuss how sleep is going, note any adverse effects, and discuss ECG results. Based on these findings, we are able to make an assessment and plan for medication dosage. The assessment and plan are identical whether this care is delivered via telehealth or live. Why would there be a difference in reimbursement?

Example 3: I have an adolescent patient who came to Bismarck from their rural home to see me for depression with suicidal ideation. At the first appointment, we made a plan that included medication and recommendations for counseling. Given the rural location of this adolescent, it is much better to monitor this patient's depression and medication dosage, as well as to provide counseling services, utilizing audiovisual telehealth rather than have her miss school and her family member miss work transporting her to these frequent appointments. Given parity of services between telehealth and live options, why should reimbursement vary between the two forms of service provision?

I could continue to list many examples of the benefit and equivalence of telehealth care provision when compared with live visits. Reimbursement parity is necessary for sustainability of these services which achieve our goal of improving access to QUALITY care for all North Dakotans. Please support SB 2179. As always, I want to thank you for your time in considering the contents of this email. I am always available for further discussion/questions.

Respectfully, Joan Connell, MD MPH FAAP Pediatrician

2021 HOUSE HUMAN SERVICES

SB 2179

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

SB 2179
3/15/2021

To provide for a legislative management study relating to coverage of telehealth

Chairman Weisz opened the committee hearing at 3:31 p.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	A
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Reimbursement rates
- Licensing barriers
- Payment reimbursement bill
- Blanket payment parity

Sen. Judy Lee, District 13 (3:31) introduced the bill.

Andy Askew, Essentia Health's Vice President of Public Policy (3:34) testified in favor and submitted testimony #10698.

Jon Godfread, North Dakota Insurance Commissioner (3:41) testified in favor and submitted testimony #9221 & #9222.

Gabriela Balf, Psychiatrist Missouri River Health (3:50) testified in favor and submitted testimony #9230.

Megan Houn, Director Government Relations Blue Cross & Blue Shield (3:58) testified in favor.

Marsha Waind, Telehealth Program Manager UND Dakota Geriatrics Medical School & Health Sciences (4:05) testified in favor and submitted testimony #9138.

Dylan Wheeler, Senior Legislative Affairs Specialist Sanford Health Plan (4:12) testified in favor and submitted testimony #9173.

Additional written testimony: #9038, #9039, #9126, #9133, #9187, #9196, #9257, #9344

Chairman Weisz adjourned at 4:16 p.m.

Tamara Krause, Committee Clerk

Essentia Health

House Human Services Committee
SB 2179
March 15, 2021

Chair Weisz and committee members, thank you for this opportunity to weigh in on this important issue to health care in North Dakota. My name is Andy Askew, and I serve as Essentia Health's Vice President of Public Policy. Prior to joining Essentia last February, I served as its contract lobbyist here in Bismarck while working as an attorney.

Essentia Health is an integrated health system serving patients in North Dakota, Minnesota, and Wisconsin. Headquartered in Duluth, Minnesota, we have 13,300 employees who serve patients and communities through our 14 hospitals, 71 clinics, and 6 long term care facilities. Essentia Health is an accredited accountable care organization by the National Committee for Quality Assurance and is focused on the triple aim of better health, improving patient experience, and lowering costs.

Prior to the pandemic, telehealth was limited to a small set of services and usually required patients to be at a clinic or a health care facility. However, to aid in the response to COVID-19, President Trump directed CMS to add more than 80 new telehealth services to the list of services covered by Medicare and, more importantly, to reimburse these telehealth services at the same rate as in-person services.[1] This is commonly referred to as "payment parity." There are currently 13 other states that require reimbursement parity for covered telehealth services.[2]

Since March 2020, Essentia Health has conducted approximately 390,000 virtual visits, which have assured that its patients have access to high quality, comprehensive, and integrated health care services directly to their homes - without having to travel hours or incurring the costs of taking time away from work or to finding childcare. This has also allowed hospitals to increase the integration and coordination of care among providers within the community, and reduce avoidable hospitalizations, admissions, and transfers. As a result, telehealth has improved the quality of care for our patients and lowered overall costs.

Despite the similarities of telehealth visits and in-person visits, and the overwhelming success of this new virtual care delivery model, North Dakota's insurance plans are reluctant to negotiate fair and competitive reimbursement rates for virtual visits. More specifically, the reimbursement health care providers throughout the state receive for virtual visits can be anywhere from 20% to 40% lower than in-person services. This is a drastic deviation from Medicare and some of North Dakota's sister states. Simply said, the current reimbursement rates are unsustainable, and risk North Dakota providers' ability to offer continued access to timely,

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[1] *See* CMS.gov, *Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge*, available at https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19 (March 14, 2021).

[2] States that require payment parity for covered telehealth services include: AR, CA, DE, GA, HI, KY, MA (limited and only through 2023) MN, NH, NM, TN (only through April 1, 2022), UT, and WA.

high-quality, and coordinated health care, especially in rural communities where essential services may not be financially viable given low patient volumes.

While the number of virtual visits leveled off since the early months of the pandemic, virtual visits still account for roughly 20% of Essentia's encounters and will remain an important tool to ensuring access to care throughout the rural communities we are privileged to serve. By continuing to utilize these virtual visits, providers and hospitals alike will be able to provide three very important elements, which are:

- Continuity of care – Virtual visits allow patients to be cared for by their care team or an extension of this team – not a third party from a national vendor.
- Access to the entire patient record – Virtual visits ensure that nothing is left unaddressed with regard to patients' past medical history, medication lists, previous health events, etc.
- Access to comprehensive and integrated health care -- Virtual visits allow providers to easily handover care needs to other members of the health care team, such as future testing needs, follow up, or referrals to a specialist – all of which can be done within EPIC to ensure that the patient is receiving comprehensive care. This is not easily done with a third party like Teledoc or AmWell.

Because of the importance of ensuring North Dakotans continue to have access to high-quality, comprehensive telehealth services, Essentia Health urges North Dakota to join these states in requiring reimbursement parity for these telehealth services. If our state's hospitals and health care providers are continued to be paid 20% to 40% less for telehealth services, they will not be able to afford to invest in expanding their telehealth capabilities or competing with national telehealth vendors like Teledoc and AmWell. Therefore, Essentia joins the ND Medical Association, the ND Rural Health Association, the ND Psychiatric Society, and numerous providers and health care systems in requesting that this committee amend engrossed SB 2179 to require that covered telehealth services are reimbursed at a rate not less than in-person services as part of a two-year pilot program, which sunsets on July 31, 2023.

We believe this is an important step to ensuring that North Dakotans continue to have access to high quality, integrated care from local primary and specialty care providers. It will also give the Legislature an opportunity to monitor the benefits of competitive reimbursement rates during the pilot program and how these rates spur continued investment and innovation in telehealth services.

Thank you for your time and consideration.

Andrew Askew
Essentia Health
Vice President of Public Policy

Engrossed Senate Bill No. 2179

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: House Human Services Committee
Representative Robin Weisz, Chairman

Date: March 15th, 2021

Chairman Weisz and members of the House Human Services Committee, my name is Jon Godfread and I am North Dakota's Insurance Commissioner. I appear before you today in support of the study that currently makes up Engrossed SB 2179.

I was opposed to the original intent of the bill and I remain opposed to telehealth payment parity. As this has been amended into a study, we are supportive of the study but would offer the committee one thought to add to the study. Payment parity essentially sets a floor for payment schedules, it would effectively increase the reimbursements from our carriers to our providers based on this law and remove the inherent efficiencies that can be found using technology. This legislature has discussed the issue of caps, reimbursement caps, perhaps setting a reimbursement cap of 200% of Medicare for all medical services, that is a ceiling and our providers are adamantly opposed to those price ceilings. So if we are going to study the impact of a payment floor, I think it's only fair to study the impact of a payment ceiling. I think through the study, neither option will be shown to be a good idea. But, if we are going to look, let's make sure we are not just looking at increasing reimbursements, perhaps the increase in reimbursements can be made up by instituting a payment cap in other areas.

For those of you who are unaware, we recently completed a study at the direction of the 66th Legislative Assembly to look at health care cost within the state of North Dakota. If you have not had a chance to review that study, I would encourage you to look at this comprehensive study.

The study highlighted a number of important issues in the North Dakota Hospital market including:

- **Hospital Utilization.** North Dakota has seen an increase in hospital usage. North Dakota Hospitals are seeing longer hospital stays than the national average, and utilization is growing faster in North Dakota than most of the rest of the country.
- **Hospital Expenses.** Hospital Expenses are ranking higher than the national average (usually top 5) and continuing to grow at higher than national average rates (also top 5 rankings)
- **Hospital Operating Revenue.** North Dakota hospitals are seeing high revenue and high revenue growth.
- **Medicare Revenue.** Medicare revenue is also very high and growing for North Dakota Hospitals

- **Hospital Reimbursement.** Private hospital reimbursement based on Medicare rates grew from 170 percent of Medicare in 2010 to over 200 percent of Medicare in 2018.
- **Acute Care vs. Critical Access Hospitals.** Critical access hospitals appear to be reimbursed at a much lower rate (149% of Medicare) than acute care hospital (211% of Medicare)
- **Premiums.** North Dakota premiums are largely average as compared to national average.
- **Claims.** Insurer claims are averaging slightly higher than the national average and are growing at higher than the national average.
- **Administrative costs.** Insurer administrative expenses remain low, but the administrative expenses are growing at a very fast rate.

The data clearly shows a number of warning signs in the North Dakota market. For the Hospitals, Commercial, Medicare, and Medicaid revue appears to be showing sizable growth. Hospitals appear to be offering more services and longer stays. In health insurance, administrative costs have grown substantially – though still generally at or below the national average. These trends bear watching.

I stand before you in opposition to the original intent of Senate Bill 2179 because it would utilize telehealth to perpetuate many of these issues, despite the potential role that telehealth could play in addressing these issues.

Telemedicine depends on technological innovation that should reduce the cost structure of providing care. If so, those providers should compete on price. Markets can adapt to serve customers' needs under a certain burden of regulation of safety and standardization, but it is very hard for markets to adapt efficiently to regulated prices. If providers are not competing on price, they are not properly competing at all.

We will be unable to realize the cost-cutting and health care delivery modernization with a regulated price floor, the key to successful adoption of telemedicine is to restore a greater share of patient's health spending to their direct control, not impose price regulation.

Imposing payment parity removes any incentive for the health care system to innovate and examine their health care delivery model. I understand the desire for payment parity, but given our most recent and exhaustive health care cost study, it has never been more clear to me that it's our delivery model that needs modernizing and mandating price parity for services that are inherently different does not seem logical and would only further kick the health care delivery discussion down the road.

Some innovator is going to figure this out, some hospital system will figure this out, with payment parity in place it removes the incentive from solving this delivery model problem and only further exacerbates the issues we have with the cost of health care. Telemedicine should lead to a reduction of health care costs for our consumers. For those reason we oppose the original intent of this bill.

If structured properly, telehealth services may increase access to needed care while also controlling costs. In a rural state like North Dakota, telehealth can provide the opportunity to access medical specialists without time consuming travel. For those with mental health issues, telehealth can be an important lifeline. With more frequent visits and early interventions available, telehealth can help avoid costly delays in care (such as undiagnosed conditions that become worse with time) and, in situations where an in-person visit may not be required, virtual encounters may be priced at a lower rate than in-person care (if there is no state mandate requiring payment parity).

For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000+ percent increase in telehealth visits in the midwestern U.S. between April 2019 and April 2020.Consumers are increasingly becoming accustomed to telehealth.

There are several issues that states should examine to create a permanent infrastructure that supports widespread adoption and utilization of telehealth:

Licensure: Many states have significant licensing barriers that control providers' ability to use telehealth. Provider licensing boards should be encouraged to embrace telehealth, allowing providers to establish relationships remotely as long as necessary conditions are met and the standard of care is upheld. State boards should consider the interstate compacts available, as well as other flexibilities that may enhance providers ability to practice telemedicine.

Payment: Rather than considering legislation that would stifle competition, establish guidance through which insurers and providers set appropriate rates based on the delivery of service. Perhaps looking at payments based on access to care, or the needs of community. Rural parity would be an area we would be interested in further study, but blanket parity does not seem to make logical sense.

Software: Consumers and medical providers should be allowed to agree on the use of any software service. States shouldn't pick winner and losers.

Scope of practice: The pandemic has allowed many new types of service to be delivered by telehealth. States should look closely at their telehealth practice requirements and permanently modernize the statutes.

Lastly, I have proposed an amendment for the committee's consideration, which addresses some of the areas I outlined above. On March 20th, 2020, we worked with the Governor's Office on Executive Order 2020-05.1, primarily on the telehealth services portion. The goal of this executive order was meant to relax some of the requirements around telehealth to ensure our consumers would have access to their health care providers during the pandemic without having to go into the hospital. This was critically important for those seeking and providing mental and behavioral health services. This has been a very successful expansion of telehealth and our consumers and providers have all adapted to the utilization of telehealth. Essentially, this executive order was a success and it did what we thought it would do.

The amendment you have before would essentially update the law to reflect some of the changes that were made through the executive order. Without this amendment, when the executive order

is taken down or the emergency is declared over, these relaxations of current law will end. This would have an impact on our providers.

We did not bring this amendment to the Senate Committee, as I was surprised that it was not offered by the provider community. Rather than seeking the meaningful regulatory relief that was offered in the executive order and also offered in this amendment, SB 2179 as introduced was primarily a payment reimbursement bill. The amendment we are offering, I think, is a reasonable compromise to ensure our consumers still have access, our providers are able to utilize the new technology deployed during the pandemic and the market can respond in terms of payment schedules.

Thank you, Chairman Weisz and members of the committee, as I mentioned we support the study language currently contained in the bill and would offer the inclusion of studying the payment caps for health services, as well as the amendment we have just offered that would essentially update our current laws, to reflect what happened during the pandemic. We, however, remain opposed to blanket payment parity for telehealth services. Happy to answer any questions you might have.

Prepared by the North Dakota
Insurance Department
March 15, 2021

PROPOSED AMENDMENTS TO SENATE BILL NO. 2179

Page 1, line 1, after "Act" insert "to amend and reenact section 26.1-36-09.5 of the North Dakota Century Code, relating to coverage of telehealth services; and"

Page 1, after line 3, insert:

"**Section 1. AMENDMENT.** Section 26.1-36-09.15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:
   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
   b. "E-visit" means digital communication initiated by a patient to a provider through the provider's online patient portal.
   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
   d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
   e. "Non-public facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.
   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
   g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
   h. "Secure connection" means a connection made using a non-public facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.
   i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.
   j. "Telehealth":
      (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver

health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary."

Renumber accordingly

NORTH DAKOTA PSYCHIATRIC SOCIETY

A District Branch of the American Psychiatric Association

missouri river HEALTH

March 15th, 2021
To: House Human Services Committee
Re: Support Bill SB 2179: fair reimbursement rates for telehealth services

Esteemed Chairman Weisz, members of the House Human Services Committee,

My name is Gabriela Balf, MD, MPH, I am a psychiatrist with Missouri River Health, a small private practice in Bismarck, ND, and a Clinical Associate Professor at UND School of Medicine. We see people of all ages, especially adolescents and young adults. I personally have practiced telepsychiatry for more than seven years; it is one of the subjects I teach and train students in.

One of the very few benefits this pandemic has brought to our state is the rapid expansion of telehealth services and its universal embracing by the patients. Our patients have expressed gratitude to have this service offered to them while at home, as this has meant, for them, huge relief regarding travel costs, time lost from work and lost wages accompanying their children or their elderly parents. I attached an audio testimony provided by the mother of one of my adolescents with PTSD. https://youtu.be/zHvVKDO1aQw

Other examples: a 35-year-old woman patient from Bowman (insurance: Medicaid) with five children, had hard time coming to the office for a half hour follow up. I waived her fees several times and I saw her in the peace of her home, because I could not bill for a video appointment with her insurance. As I think of my disadvantaged patients, to whom my heart goes first, it would have been unsustainable to offer this service long-term.

I was able to check on my nursing home, wheelchair bound patient with Parkinson-related dementia, when her daughter went there and held up an ipad for a FaceTime visit. I had not seen her in a year because the daughter works full time, the nursing home has difficult time handling my patient, and taking her out of the environment once, two years ago, prompted such agitation that she had to be hospitalized.

Parents of adolescents with gender issues, PTSD, have been able to bring their kids in front of the computer a lot easier than getting them out of school for a “shrink” appointment.

On the other hand, I have to sustain my practice. Let me show you my expenses:

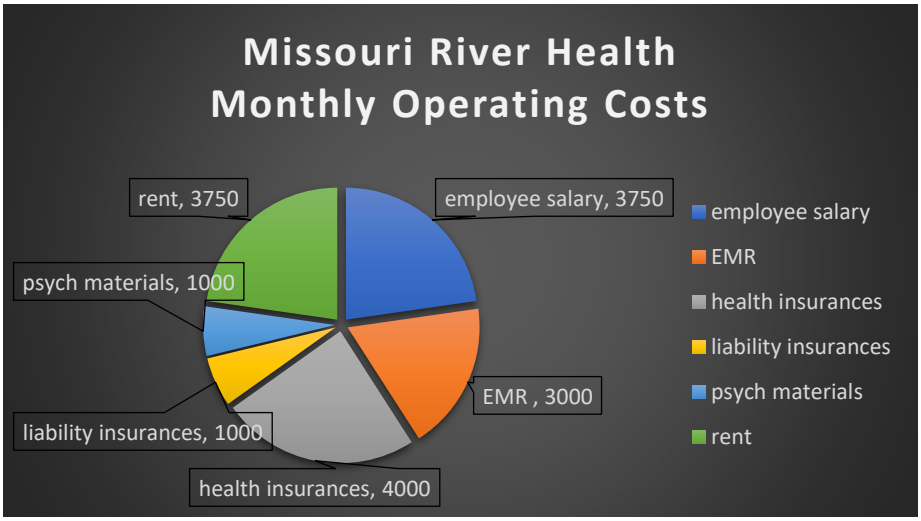

Fig. 1. The majority of operating costs are **not** contingent upon the physical presence of patients.

Besides coffee and tissues costs, there is no operating costs difference between a telehealth visit and an in-person visit.

Telehealth saves the system money indirectly: at least for mental health, the visits are equivalent to in-person appointments, suicides are averted, and unnecessary ED visits avoided[1] (some studies show the cost of an ED visit as $1734 on average. Not in ND. If ambulance is involved, that cost is at least $900 one way. If we find a bed in ND.)

The studies showing lesser costs and possibly increased spending only focused on **acute conditions** like respiratory infections, where liability drives up follow ups, etc.[2] **Longitudinal care for chronic conditions** like diabetes[3], mental health[4], etc., would not benefit from episodic interventions from a party that does not have access to your data, nor communicates with your personal clinicians. Hopefully, we will continue to evolve from the acute care medical model, to the prevention and thoughtful care model that leads to a long and healthy life.

Thank you for listening,

Gabriela Balf-Soran, MD, MPH

Missouri River Health – psychiatrist
Assoc Clin Prof UND School of Medicine
ND Psychiatric Society Immediate Past-President

References:

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2. Ashwood JS, Mehrotra A, Cowling D, Uscher-Pines L. Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending. Health Aff Proj Hope 2017;36(3):485–91.
3. Lu AD, Gunzburger E, Glorioso TJ, et al. Impact of Longitudinal Virtual Primary Care on Diabetes Quality of Care. J Gen Intern Med 2021;1–8.
4. Thomas N, McDonald C, de Boer K, Brand RM, Nedeljkovic M, Seabrook L. Review of the current empirical literature on using videoconferencing to deliver individual psychotherapies to adults with mental health problems. Psychol Psychother 2021;

House Human Services Committee
SB2179
March 15, 2021 2:30-5:00 pm

Chairman Robin Weisz and committee members, thank you for reviewing the requests to enact telehealth payment parity in North Dakota. My name is Marsha Waind. I currently work for the University of North Dakota School of Medicine and Health Sciences within the Dakota Geriatrics Workforce Enhancement Program. My job is to develop Geriatric Telehealth Services and training programs for the older citizens of North Dakota and for the healthcare staff of tomorrow. Previously I spent more than 30 years at Altru Health System in Grand Forks, 20 of those years in Regional Development and Telehealth. I traveled the Altru Service Area learning the rural healthcare needs and making connections to improve that care with our rural healthcare partners. Telehealth became an important connection between rural providers and Altru specialists. When I retired in 2020, Altru connected to 14 rural hospitals, 16 Rural Clinics, 15 Skilled Nursing Facilities and 4 Residential care facilities.

Telehealth in North Dakota:

- provides care to rural patients that otherwise would not receive that care
- it keeps money local, for the hospital and for the local grocery store and gas station
- it improves relationships between small town providers and tertiary care
- it reduces cost to small rural facilities and at times, keeps the ambulance in town for calls instead of transporting to a clinic visit out of town

Here are five examples of how a North Dakota HealthCare System and its providers use Telehealth to improve access to care. Nelson County Health System is in McVille. This is how they use Telehealth

1) Outpatients come to the hospital telehealth room, which is staffed by a Nelson county nurse. A variety of specialists and providers are available by telemed. Today a 12 yr. old boy leaves school and walks to the Hospital, where his mom joins him from her workplace. They have the telemed visit with the behavioral health provider. The boy goes back to school, Mom goes back to work. Mom doesn't lose a day of work; the boy doesn't miss a day of school. Mom doesn't buy gas in the larger town or get groceries while she is there. The extra cost of the Nelson Co nurse, room and equipment was financed by Nelson Co hospital. The behavioral health provider is paid less because the visit is over telehealth.
2) Nelson Co Health System operates the Nelson County Care Center, a 39 bed skilled nursing facility. The facility recently admitted an 88yr old female with post-surgical hip fracture. There are orders for a recheck in 10 days. The orthopedist is an hour and ten minutes away, if the weather is good. Without telehealth, Nelson Co skilled nursing center would have had to arrange for an ambulance and two attendants to take the patient. A costly transport. And this would have taken the only ambulance out of town. If a trauma call came while they were gone, an ambulance from surrounding area would need to be called. However, the recheck can be scheduled through Telehealth. The patient has her Xray, and labs done at Nelson Co prior to the clinic visit and sent to the orthopedist. Those tests generate income at the local healthcare facility, instead of going to the larger hospital. The orthopedist's service or time is no less valuable over telehealth, yet he would be reimbursed less by insurance other than Medicare.

3) Nelson Co in McVille also has a satellite clinic in Michigan, ND. It is open four days a week with the FNP providers from McVille, two days by telehealth and two days by onsite care. A nurse supports both the providers on site and through telehealth, on telehealth days. Nelson Co Health System bears the cost of the keeping the nurse on location for telehealth visits. Use of telehealth increases access to care using the limited resources of healthcare providers in the rural area. Langdon clinic uses the same strategy for its clinic in Walhalla, Nd. Should Nelson County Health System be reimbursed less for their care over telehealth to the satellite Clinic?
4) Nelson Co has developed a home nursing service. Today the nurse arrives to find her patient is in distress and determines that the patient should have a visit with their provider. She gets out her telehealth equipment and connects to the Nelson co provider allowing her to assess the patient. Heart and lungs sound, even an EKG can be done quickly so the provider can avoid a critical situation or an ER visit. The provider uses the same skill set and devotes the same amount of time to this patient over telehealth as the next patient that she sees in the clinic. Yet she is not paid at parity for this service. Nelson Co Health System should not be paid less for services that cost just as much or more to provide as they strive to improve access to much needed rural healthcare.
5) A 58 yr old patient is admitted to Nelson Co hospital with kidney disease. The local provider requests a teleconsult with his Nephrologist to determine his care plan. The Nephrologist reviews the labs and other tests performed at Nelson Co and supports the local team in providing care. The patient can stay at the McVille hospital while he improves. The patient is confident of the care provided by both his specialist and his local care team. The patient is not put at risk of further COVID infection in a new location. The local hospital retains patient revenue. Yet the time and talent of the specialist is reimbursed at a lower rate because it is telehealth.

   These five examples exemplify that provider services over telehealth provide the same quality and the same service as in person care and should be paid at parity.

- Perception of telehealth overuse leading to increased healthcare costs has not been borne out in States with parity for telehealth.
- Telehealth is a tool in our tool kit that is largely substitutive not additive to in-person care. That is why Medicare has paid at parity for many years and has expanded coverage to more services and to service in the home.
- Telehealth is not cheaper to provide.
- Telehealth is vital to better healthcare across North Dakota. It improves healthcare to our citizens.
- Telehealth is important to North Dakota and should be paid at the same rate as in-person care.

We are asking the committee to amend the engrossed bill SB 2179 to require insurance plans to reimburse covered telehealth services at rates not less than in-person services as part of a two-year pilot project, which sunsets on July 31, 2023.

Thank you,

Marsha Waind

mawaind@gra.midco.net

March 15, 2021

#9173

Chairman Weisz and members of the North Dakota House Human Services Committee,

My name is Dylan Wheeler, Senior Legislative Affairs Specialist, Sanford Health. On behalf of Sanford Health, I would like to provide comments In Support of SB 2179, as amended.

Telemedicine has played a critical role over the past year during COVID-19 for patients, members, providers, and payers alike. Payers, such as Sanford Health Plan (SHP) in partnership with the ND Department of Insurance, responded by waiving member cost-sharing for telemedicine visits for a period of time. The provider community stepped up and met the challenge of adapting to and implementing telemedicine to meet the needs of patients. The regulatory and statutory flexibility currently in North Dakota played a key role in quickly responding to the COVID 19/Public Health Emergency. Looking forward, telemedicine policy at the Federal level continues as the Public Health Emergency declaration triggered additional flexibility for telemedicine utilization and access.

The previous version of this bill had several concerning areas in addition telemedicine payment parity – including copay parity, utilization management parity, and the inclusion of audio-only for purposes of payment parity. We previously shared concerns with this bill - concerns that provide context and may be informative if the bill is further amended:

Expansion of the Definition of Telehealth to Include "Audio Only"

The proposed addition of "audio-only" to the statutory definition of telehealth gives rise to the question whether an audio-only provider/patient interaction is in parity (the equivalent or directly comparable) with either a video/virtual or an in-person interaction. An audio-only patient interaction, if outside of traditional patient-provider EHR record platform, could result in an incomplete medical record. However, we do not want to minimize the value that audio-only interactions may have in practice, such as behavioral health. The question here is whether those – and all telemedicine uses - are to be considered the same for reimbursement.

Coinsurance or Copayment Parity Amendment

By prohibiting payers from allowing lower copayments for telehealth visits, consumers would be penalized and payers inhibited from offering different copays for telemedicine.

Utilization Management Parity Amendment

Utilization management is another tool that payers, in partnership with providers, use to help guide and track patients through the healthcare process. The prohibition of "any type of utilization management" as written in the bill is concerning. We are still learning about consumer behavior and telemedicine (e.g. utilization) during the COVID-19 pandemic. In addition, this provision may hinder innovation towards value based reimbursement arrangements.

Telemedicine Payment Parity

Payment parity specifically mandates that reimbursement for telehealth services "may not be less than" its in-person counterpart. Statutorily setting the minimum reimbursement threshold would be counterproductive to market flexibility, future innovation, and may inflate costs to the patient/member. This is particularly of concern for the inclusion of "audio-only" in the definition.

Other Considerations

Before setting any statutory price/parity requirements, we should consider to what extent telemedicine has been utilized and can or will be used going forward. As payers and providers move away from fee-for-service reimbursement mechanism – telemedicine payment parity requirements could thwart the health care systems' shift to value based payments or other quality based reimbursement/payment models. Additionally, provider licensure recognition across state lines is an integral part of the long-term and broader telemedicine policy discussion. Recognizing other state licenses of healthcare providers may better serve broader populations, provider greater access, and reduce overall costs and spending.

Support SB2179 as Amended

Currently, SB 2179, as amended, would require a study over the next legislative interim regarding telehealth costs, services, and reimbursement options. This study shall include input from key stakeholders, encourage collaboration between providers and payers, and begin with a focus on behavioral health. These are ideas that Sanford Health supports.

Efforts to amend this bill to possibly include a pilot program or other parity amendments, however, give us concern. The purpose of the interim study would be to inform all stakeholders as to where opportunities for improvement and efficiencies would be. If a pilot program is narrowly tailored to a particular service or provider, then undoubtedly, that would call into question whether it is a "mandate" and its cost, scope, and applicability to NDPERS. The study is an opportunity to do just that – study. The interim study is a proactive measure to understand costs, look at payment models, and seek North Dakota specific solutions – this must be completed before a pilot or additional amendments are considered.

Through COVID-19, we have learned the significant potential for utilization of telemedicine for North Dakotans. By studying this essential tool available to patients, members, providers, and payers – we may better understand where telemedicine may be going in the future, but also what can we learn from the past.

Thank you for your time and consideration – I would be glad to answer any questions.

Respectfully Submitted,

Dylan C. Wheeler, JD
Senior Legislative Affairs Specialist – Sanford Health Plan

House Human Services Committee
SB 2179
March 15, 2021

Chairman Weisz and Committee Members, I am Courtney Koebele, the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

NDMA strongly supports SB 2179 as it was originally filed.

NDMA adopted a policy position in support of telehealth parity at its 2020 policy forum. Payment parity is an issue that is supported by all types of physicians and specialties. To assess the need, NDMA assembled a broad coalition of health care stakeholders, including ND Psychiatric Society, Essentia Health, CHI St. Alexius, Trinity Health, Altru Health, Mid Dakota Clinic, Bone and Joint, ND Academy of Physician Assistants, Physical Therapy Association of North Dakota, ND Federation of Families for Children's Mental Health, Mental Health America of North Dakota, and the Mental Health Advocacy Network. Together, this group supports telehealth payment parity legislation that will require health plans to reimburse providers for covered telehealth services delivered to patients at reimbursement rates not less than in-person services.

While telehealth cannot replace all patient care, the extension of telehealth benefits in recent months has rapidly changed the way clinicians see patients and has provided a push for innovation that has allowed clinicians to safely increase access to high quality care.

Patients have reported that telehealth has been a positive experience, which results in fewer "no-shows" than in-person visits. Patients are grateful to have telehealth as an option.

As this committee is aware, North Dakota has a law regarding insurance mandates. That law provides "A legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be

acted on by any committee of the legislative assembly unless the measure is accompanied by a cost-benefit analysis provided by the legislative council."

SB 2179 provides for neither of those since the proposed changes do not mandate new coverage or provide coverage to new provider types. Telehealth services are already covered services and no new providers are directed in the statute.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

SUPPORT COMPETITIVE, FAIR REIMBURSEMENT RATES FOR TELEHEALTH SB 2179

Due to the pandemic, increased flexibilities and broader insurance coverage for telehealth services made it possible for health care professionals to continue treating patients and increase access to care.

- Payment parity – or equal reimbursement rates - would ensure patients have increased access to timely, value-based, and integrated care, especially for rural and underserved communities throughout the state. Under current law, health plans reimburse telehealth services **20% to 40% lower** than in-person services.

- By continuing to utilize virtual visits, health care professionals and hospitals alike will be able to provide three very important elements, which are:

    - Continuity of care – Virtual visits allow patients to be cared for by their care team or an extension of this team – not a third party from a national vendor.
    - Access to the entire patient record – Virtual visits ensure that nothing is left unaddressed with regard to patients' past medical history, medication lists, previous health events, etc.
    - Access to comprehensive and integrated health care – Virtual visits allow providers to easily hand over care needs to other members of the health care team, such as future testing needs, follow up, or referrals to a specialist – all of which can be done within electronic medical records systems to ensure that the patient is receiving comprehensive care. This is not easily done with a third party like Teledoc or AmWell.

While telehealth cannot replace all patient care, the extension of telehealth benefits in recent months has rapidly changed the way health care professionals see patients. The advancements provided a push for innovation that now allow health care providers to safely increase access to high quality care, particularly in the rural health care setting.

Historically, access to rural health care has been met with challenges and the advancement of telehealth carries its benefits to rural health care professionals and how they are able to treat patients. This revolutionary approach to health care services can reduce or minimize challenges and burdens patients encounter, such as transportation issues related to traveling for specialty care. Telehealth can also improve monitoring, timeliness, and communications within the healthcare system.

Key telehealth benefits extended to patients provide more accessibility for care:

- For patients who are unable to use video software and patients who lack broadband access or technology for video-only, the current ability to reach patients virtually or over telephone has been critical to ensuring continuity of care.

- When patients have access to timely comprehensive care, chronic medical conditions can be addressed sooner; thus, when treatment is more easily accessible, the need for emergency care services is most likely reduced - resulting in health care cost savings for both the patient and insurers.

We urge you to support payment parity for telehealth services to ensure that these services are reimbursed at the same rate as services provided in-person.

Senate Bill 2179- IN SUPPORT
House Human Services Committee
67th Legislative Assembly of North Dakota
March 15, 2021

Good morning Chairman Weisz, Vice Chair Rohr and House Human Services Committee,
My name is Joan Connell. As a pediatrician in our state, I am asking for a DO PASS on SB 2179, which would study the concept of parity for reimbursement of services delivered via telehealth. I would like to provide 3 current examples from my pediatric practice that illustrate why this is fair as well as making large strides toward our common goal of increasing access to QUALITY care for all North Dakotans.

Example 1: Children's Regional Asthma Clinic branched out to Dickinson via the use of telehealth to increase access to quality asthma services for pediatric patients from western North Dakota. We "see" patients while they are at CHI-Dickinson and we- the clinicians- are at CHI St Alexius Bismarck using audiovisual technology, examining them with digital stethoscopes and otoscopes (which we were able to buy using grant funds from the Center for Rural Health) enabling us to listen to their heart and lungs as well as examine their ears, nose, and throat. This saves hundreds of miles and countless hours of driving, as well as making visits possible when transportation (sometimes due to bad weather) is an issue. At the end of the day, complete assessments completed on these patients via telehealth are equivalent to those assessments completed for patients being seen "live" in our Bismarck clinic. Given the equivalent services provided, why would disparate reimbursement ever be considered?

Example 2: I currently have a special needs patient who does not sleep at night, creating countless behavioral problems that have wreaked havoc on the child and family. With help from my child psychiatrist colleague, I am gradually increasing the dosage of a medication that will help this child sleep through the night. Given the potential for adverse cardiac effects as we gingerly increase the dosage, this medication requires monitoring with ECG in addition to monitoring that is necessary to determine efficacy and any other potential adverse effects. Rather than have the patient miss significant amounts of school frequently, the patient may drop by for the ECG after school, then have an audiovisual visit while the child is at school, minimizing driving and waiting time that would take away from school time. During the visit, we are able to discuss how sleep is going, note any adverse effects, and discuss ECG results. Based on these findings, we are able to make an assessment and plan for medication dosage. The assessment and plan are identical whether this care is delivered via telehealth or live. Why would there be a difference in reimbursement?

Example 3: I have an adolescent patient who came to Bismarck from their rural home to see me for depression with suicidal ideation. At the first appointment, we made a plan that included medication and recommendations for counseling. Given the rural location of this adolescent, it is much better to monitor this patient's depression and medication dosage, as well as to provide counseling services, utilizing audiovisual telehealth rather than have her miss school and her family member miss work transporting her to these frequent appointments. Given parity of services between telehealth and live options, why should reimbursement vary between the two forms of service provision?

I could continue to list many examples of the benefit and equivalence of telehealth care provision when compared with live visits. Reimbursement parity is necessary for sustainability of these services which achieve our goal of improving access to QUALITY care for all North Dakotans. Please support SB 2179. As always, I want to thank you for your time in considering the contents of this email. I am always available for further discussion/questions.

APTA North Dakota
A Chapter of the American Physical Therapy Association

March 15, 2021

Dear Members of the House Human Services Committee,

I am a licensed physical therapist from Grand Forks. I am submitting this written testimony on behalf of APTA North Dakota, the membership association of physical therapists and physical therapist assistants in North Dakota. I currently serve as president for this association.

The pandemic has been a challenge to all people in so many ways and I am certain all are more than ready to somehow put it behind us. A silver lining realized by many health care practitioners is the advantages and uses of telehealth in serving the citizens of North Dakota, especially those from very rural parts of the state. Yes, for many patients, 'in-clinic' appointments have returned; however, there are many pros of being able to use telehealth when in-person care cannot happen.

- Decreased cancellations due to weather or other travel related issues
- Decreased cancellations due to family member issues (i.e. no child care, no vehicle, sick sibling)
- Real-time home programming and addressing challenges with caregivers involved in the session
- Ability to see the home environment to assess for safety issues, barriers, etc.
- More efficient communication with parents/caregivers: no need for an extra phone call to discuss how sessions went
- More functional approach to treatment as activities must to be tailored to the home environment

The pandemic has made us pivot in our thinking about health care delivery and even methods of teaching our entry-level students to prepare them for the realities of practice with use of telehealth. Telehealth does not replace all patient care, but certainly has benefits when it is needed.

Whether services are provided in-person or via telehealth, the provider's time is equally as important as the care being delivered. We urge you to support payment parity for telehealth services to ensure that these services are reimbursed at the same rate as services provided in-person and ask you to pass SB 2179.

Sincerely,

Cindy Flom-Meland

Cindy Flom-Meland, PT, MPT, PhD
Board Certified Neurologic Clinical Specialist
President, APTA North Dakota

APTA North Dakota
1301 North Columbia Road, Stop 9037 / Grand Forks, ND 58202 / 701-777-3873 / info@aptand.com

Telehealth testimony

House Human Services Committee

SB 2179

March 15, 2021

Chairman Weisz and committee members:

I am Eric L. Johnson, M.D., a physician in Grand Forks. I am a Professor at the University of North Dakota School of Medicine and Health Sciences and an Assistant Medical Director of the Diabetes Center at Altru Health System. I have been doing telemedicine for over 7 years, primarily in partnership with Heart of American Medical Center in Rugby, but also with clinics in Carrington, Cavalier, and Devil's Lake, providing diabetes care services. My entire practice is specialty diabetes care. I am also working on a telehealth teaching project for the American Medical Association at the national level to create an understanding of quality, appropriate telehealth to be delivered by students, residents, and providers.

Let's briefly review different types of telehealth encounters for patients:

Telehealth refers to any electronic interaction between provider and patient. This can include secure messaging and telemedicine visits.

There are 3 basic types of telemedicine visits:

- E-visit: Short encounters usually focused on a single uncomplicated problem such as a rash or a urinary infection. I

don't do these, as they are generally not appropriate for complex chronic disease care such as diabetes management.

- Virtual Visit: A more complex encounter between provider and patient. The patient may actually be in their home, as they are usually on their own device. These approach a traditional clinic visit. Some of these patients have other supportive technology in their home, infrastructure such as an electronic stethoscope or cardiac monitor. Many patients also do things like checking their own blood pressure. In my diabetes care practice, we often review insulin pump and continuous glucose monitoring data as well as other lab values. A complete history is reviewed as well as other elements of a traditional clinic visit.

- Classic Telemedicine visit: This type of visit is almost identical to a regular in person visit, and can almost always substitute for a regular clinic visit. In this case, the patient goes to a remote clinic, in my example, usually in Rugby. In the clinic setting, electronic stethoscopes are available, along with high quality cameras, or other exam devices. Again, we often review insulin pump and continuous glucose monitor data as well as other lab values. This type of visit is very suitable for complex diabetes care visits.

All of these visits require clinic infrastructure, but that is especially true for the virtual visit and classic telemedicine visit since they can almost always be a substitute for a regular clinic visit. Patients are actually in a remote clinic. Of course, for all of these,

we need the electronic medical record, nurse support, other professionals such as social work, dietician, diabetes educator and lab. I have some patients who live west of Rugby, some over a 100 miles away who come to Rugby to be seen. Prior to my doing diabetes telemedicine, many of them were not receiving specialty care.

Reasons telemedicine to the region is important

- preventative and chronic disease care
- travel, day care and other costs are reduced. Some of these patients were taking up to 2 days off for an appointment with me in Grand Forks.

As well,

- Telemedicine is made possible due to reimbursement by payers
- Our costs do not change or reduce by going virtually
- Patients may have more of a cost share for a telemedicine visit as opposed to in person due to decreased rate of reimbursement if not paid as parity

Telemedicine visits are not just brief Facetime visits where a medical problem is discussed. To do this well and give the patient high quality care, the provider, such as myself, is really creating a clinical experience

In a rural state like North Dakota, with a shortage of specialty providers, it's important to have many specialty services are available via telehealth. I know for a clinic like Rugby, that really supports their primary care services to have these specialties available.

I don't use telehealth as a chance to increase the number of visits to increase costs. I still see my diabetes patients via telemedicine remotely 2 to 4 times a year, which is what we do with in-person visits, and is the American Diabetes Association recommendation. Again, we need to think about the different types of visits and how they are used for appropriate patients, not just to have a bunch of video calls which may or may not be helpful for chronic disease management. The goal is to create a clinic-like atmosphere to deliver quality, not quantity. Anybody who is serious about telemedicine knows this.

Many rural distance patients have told me they will no longer want to do in-person visits with me for diabetes care as it is just too inconvenient to do in-person. Rural critical access hospitals will have send patients sometimes great distances for specialty care that could've been provided via telemedicine on-site- that is certainly cost effective.

I also have positive outcome data to share. We studied patients who had diabetes care via telemedicine in Rugby versus those who didn't. The common blood test marker A1C, which measures blood sugar control over 3 months was studied. Those in Rugby who had at least one telemedicine visit had better blood sugar control as measured by A1C, and this study was presented at the American Diabetes Association's annual meeting in 2018

Finally, I am also a patient with type 1 diabetes, and I have been served by telemedicine care during the pandemic. It's been interesting to see it from the patient side, and I can understand why patients like it.

Thank you very much for the opportunity to testify today.

Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

House Human Services Committee
Sixty-seventh Legislative Assembly of North Dakota
Senate Bill 2179
March 15, 2021
Honorable Representative Robin Weisz, Chair

Good morning Chairman Weisz and Members of the House Human Services Committee. I am Carlotta McCleary, Executive Director of Mental Health America North Dakota and Executive Director of the North Dakota Federation of Families for Children's Mental Health. Today I speak on behalf of the Mental Health Advocacy Network (MHAN). MHAN advocates for a consumer /family driven mental health system of care that provides an array of service choices that are timely, responsive and effective.

MHAN is speaking in support of SB 2179 in its original form. Advocates for behavioral health system reform have stressed that tele-behavioral health services are a vital means to address several weak points in North Dakota's behavioral health system. The 2018 Human Services Research Institute (HSRI) report has been touted by the Department of Human Services and the North Dakota legislature as the "road map" to ending the behavioral health system crisis in North Dakota. The HSRI devoted much of its report to underscoring the importance of telebehavioral health, with nearly 350 mentions scattered throughout the report.

Recommendation 8 of the report were short- and long-term goals in expanding the use of telebehavioral health services in North Dakota. Those recommendations with telebehavioral health services were as follows: "8.1. Support providers to secure necessary equipment/staff," "8.2 Expand the reach of services for substance use disorders, children and youth, American Indian populations," "8.3 Increase types of services available," and "8.4 Develop clear, standardized regulatory guidelines."

The HSRI report found that telebehavioral health services were quickly increasing in North Dakota are well-suited this state as we have both a lack of behavioral health professionals and a large rural population. "In the Center for Rural Health Survey, a majority of facilities providing telebehavioral health services were located in urban areas whereas a majority of those receiving telebehavioral health services were in rural areas, indicating that telebehavioral health is being used effectively to address access and workforce shortage issues experienced in underserved rural communities." The HSRI report also found that "mental health outpatient service was the most commonly delivered service via telebehavioral health in both the Medicaid and [Human Service Center] data…"

This discussion about who uses this service and why leads me to discussing the up close and personal human impact of having access to telebehavioral health services. MHAN advocates for a full continuum of care that gives consumers and families options in how they receive community-based services. For many years, consumers and families have had difficulty accessing behavioral health services, especially services that are near their home. Without telebehavioral health services, consumers and families have difficulty setting appointments that are convenient for them, especially if they live far from the service provider.

Adults with behavioral health disorders have to seek time off from their employer and may have to account for traveling hundreds of miles just to receive services. Having access to reliable transportation can also be a problem for consumers and families who have to make a long trek to receive services. If they have children, they have get respite or find other supervision, which can be limited or cost a lot of money. Children who

receive other supervision which can be limited or costly. Children receiving behavioral health services also face numerous inconveniences or detriments while accessing traditional, non-telebehavioral health services. Children have to be pulled out of school and miss hours of their education to account for extensive travel to receive behavioral health services. Families with multiple children also have to account for the supervision of their other children, leading to a desperate scramble to find other supports.

It comes as no surprise that the COVID-19 pandemic has led to an increase in behavioral health challenges and has forced our society to rethink how it conducts business and serves the community. Our national Mental Health America released a report this year finding that there was a 93% increase from 2019 in the number of people who took their anxiety screen, and a 62% increase in the number of people who took their depression screen. They found that children and youth ages 11-17 had been "more likely than any other age group to score for moderate to severe symptoms of anxiety and depression." In addition, they found that "since the end of May 2020, nearly every racial/ethnic group has been experiencing consistently higher rates of suicidal ideation than the 2019 average." The Centers for Disease Control found that the COVID-19 pandemic has considerably increased the symptoms of anxiety disorder and depressive disorder compared to 2019. In their study, 40.9% of American adults reported at least one adverse mental or behavioral health condition, with 10.7% of respondents reporting to have seriously considered suicide in the previous 30 days. Suicidal ideation was especially pronounced among racial and ethnic minorities, young adults, unpaid caregivers for adults, and essential workers.

The COVID-19 pandemic posed numerous challenges in being able to provide in-person services. Many North Dakotans were at risk of losing whatever services they had access to, and telebehavioral health increased that access. People who ordinarily would have sought or received services in an in-person setting were able to receive telebehavioral health services. While it was not an optimal setting for those individuals, at least they were able to receive services and supports and maintain that needed human connection. We also found consumers and families who preferred the telebehavioral health method, as it removed many of the barriers they faced in being able to access services and maintain appointments. Others found that telebehavioral health services were more comfortable in comparison with in-person appointments. Telebehavioral health services provide consumers and families options in how they seek care.

The COVID-19 pandemic will not become our new normal and we all eagerly await the day when it is over. That said, it would be seriously damaging to consumers and families to view telemedicine through the lens of a temporary delivery method that goes away when the impact of a pandemic or act of God ends. For years consumers and families have asked for a choice in services and how those services are delivered. Over the last five years, North Dakota has substantially increased the prominence of telemedicine services and that has led to an increase of service utilization and convenience for consumers and families. But we and the HSRI report knew we had a lot more work to do. This was all before COVID-19. With or without COVID-19, the needs were always the same. What COVID-19 has done is underscore how right consumers and families were in wanting access to telemedicine in our large, rural state that has experienced several decade shortages in behavioral health professionals.

We should not go backwards. We should take what we learned from the last few years and COVID-19 to make telemedicine as strong as possible. Without payment parity, providers may not be able to continue to provide services, because they are not being reimbursed at the same rate. Without an adequate reimbursement rate, service providers may not see it as financially feasible to attempt to provide services that address a significant community need. Reduced rates will thereby reduce the access to telebehavioral health services in North Dakota.

Thank you for your time and I would be happy to answer any questions you may have.

Carlotta McCleary
Spokesperson
Mental Health Advocacy Network
(701) 255-3692
E-Mail: cmccleary@ndffcmh.com
cmccleary@mhand.org

Session: **67th Legislative Assembly, Regular Session (2021)**
Bill: **SB 2179 (as amended)**
Committee: **House of Representatives, Human Services Committee**
Hearing: **Monday, March 15th, 2021 at 3:15 p.m.**
Testimony: **Written Only**
Witness: **Brian Balstad, Lobbyist for North Dakota Psychological Association**

Chairman Weisz and Members of the Human Services Committee:

My name is Brian Balstad. I am submitting written testimony on behalf of the North Dakota Psychological Association ("NDPA"), the professional association for psychologists in the State of North Dakota.

Telehealth serves an important role in providing mental health services for North Dakotans. Telehealth has made mental health services accessible to North Dakotans living in rural areas and North Dakotans with limited mobility. It has made mental health services accessible to North Dakotans during the COVID-19 pandemic without risking harm to the patient/client, mental health service provider, or the public. It has made mental health services more accessible to North Dakotans overall. It is for these reasons NDPA has supported and continues to support telehealth.

The mental health services provided using telehealth are the same mental health services provided in-person yet some insurance companies provide lower rates of reimbursement, i.e. pay less, for mental health services provided using telehealth than for mental health services provided in-person. Thus, not only do mental health service providers incur additional cost to provide mental health services using telehealth, mental health service providers are also paid less for mental health services provided using telehealth. Moreover, some insurance companies have different requirements regarding coinsurance, copayments, deductibles, and utilization management for mental health services provided using telehealth. As mental health services provided using telehealth are the same mental health services provided in-person, the rates of reimbursement and

the requirements regarding coinsurance, copayments, deductibles, and utilization management should be the same.

NDPA supports studying the disparate treatment of mental health services provided using telehealth, and therefore, NDPA supports SB 2179 as amended. Also, if a study is conducted, NDPA would like to participate in the study.

Thank you for your time and consideration and for the opportunity to submit written testimony.

PO Box 9310
Minneapolis, MN 55440-9310
952-992-2900

MEDICA®

March 15, 2021

Rep. Robin Weisz
Chair, House Human Services Committee
North Dakota State Capitol
600 E Boulevard Ave
Bismarck, ND 58505

Dear Chairman Weisz,

On behalf of Medica, I want to express our position regarding SB 2179, which enacts a number of changes with respect to telehealth. Medica has covered telemedicine, telehealth, and virtual care services for years and have medical processes in place to outline the instances under which we cover these services. As a nonprofit health plan, we are mission-driven to improve the health of the communities we serve by making health care accessible and affordable for our membership. We support SB 2179, as amended, which seeks to study the issue of payment parity as a means for helping lawmakers understand the cost implications of the approach the original bill sought to enact.

Medica supports the ability of plans to contract with providers in ways that maximize quality and value for our members. We believe telemedicine, telehealth, and virtual care services can be an innovative modality of care during the public health emergency and in the future. However, the amount paid for these services versus in-person services should continue to be determined by our contracts with health care providers, not dictated by state law. We view the study of payment parity in the bill as amended as a fair compromise with the proponents of the bill and support its continued inclusion.

The onset of the COVID-19 pandemic and the need to socially distance increased the need and use of providing health care services via telehealth. Like many other health plans across the country, Medica voluntarily opted to reimburse health care providers for telehealth visits at the same rate under which we would reimburse for the same service delivered in an in-person setting. The purpose of this temporary increase was an acknowledgement that due to the COVID-19 pandemic, many Americans may decide, or may be required to, receive care in such alternative settings in order to mitigate the risk of COVID-19 to themselves and their family members.

Looking forward, Medica supports the approach of allowing health plans to work directly with providers to build on those strategies that work, with a focus on preserving accessibility and affordability.

We appreciate the opportunity to offer our concerns, and are happy answer any questions related to our concerns.

Respectfully,

Matt Schafer

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

SB 2179
3/24/2021

To provide for a legislative management study relating to coverage of telehealth

Chairman Weisz opened the committee meeting at 9:52 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Payment parity
- Rural healthcare
- Two-year pilot program
- Insurance mandates

Rep. Greg Westlind (9:52) moved proposed amendment that creates pilot project for 2 years to support telehealth. It also would make the reimbursement on pare with other providers, especially the large providers - #10649 & #10650.

Rep. Bill Tveit (9:53) second

Rep. Todd Porter (10:00) requested a roll call vote

Representatives	Vote
Representative Robin Weisz	N
Representative Karen M. Rohr	N
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	N
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y

Representative Dwight Kiefert	N
Representative Todd Porter	N
Representative Matthew Ruby	N
Representative Mary Schneider	Y
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Carried 8-6-0 to adopt amendment

Rep. Greg Westlind (10:01) moved **Do Pass As Amended**

Rep. Bill Tveit (10:02) second

Representatives	Vote
Representative Robin Weisz	N
Representative Karen Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	N
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Dwight Kiefert	N
Representative Todd Porter	N
Representative Matthew Ruby	N
Representative Mary Schneider	Y
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Carried Do Pass As Amended 9-5-0

Bill Carrier: Rep. Greg Westlind

Chairman Weisz adjourned at 10:34 a.m.

Tamara Krause, Committee Clerk

Adopted by the Human Services Committee

March 24, 2021

3/24/21

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2179

Page 1, line 1, after "Act" insert "to create and enact section 26.1-36-09.17 of the North Dakota Century Code, relating to a telehealth reimbursement parity pilot project;"

Page 1, line 1, remove "relating to coverage of"

Page 1, line 2, replace "telehealth" with "; and to provide an expiration date"

Page 1, after line 3, insert:

"**SECTION 1.** Section 26.1-36-09.17 of the North Dakota Century Code is created and enacted as follows:

Telehealth reimbursement parity - Pilot project.

1. Notwithstanding contrary provisions in section 26.1-36-09.15, there is created a telehealth reimbursement parity pilot project.

2. As used in this section, "telehealth" includes audio-only telephone if no other means of communications technology is available to the patient, including a lack of adequate broadband access, or the other means of communications technology is infeasible, impractical, or otherwise not medically advisable, as determined by the health care provider or health care facility providing telehealth services to the patient or as determined by another health care provider or health care facility with an existing relationship to the patent.

3. Under the pilot program, payment or reimbursement of expenses for covered services delivered by means of telehealth under this section may not be less than the reimbursement of expenses for covered services that are delivered by in-person means.

4. Under the pilot program, any deductible, copayment, or cost-sharing included for services delivered by telehealth must be limited to an amount that does not exceed, and is not in addition to, the amount that would apply if the service was delivered by in-person means."

Page 1, after line 11, insert:

"**SECTION 3. EXPIRATION DATE.** Section 1 of this Act is effective through July 31, 2023, and after that date is ineffective."

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2179, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (9 YEAS, 5 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2179 was placed on the Sixth order on the calendar.

Page 1, line 1, after "Act" insert "to create and enact section 26.1-36-09.17 of the North Dakota Century Code, relating to a telehealth reimbursement parity pilot project;"

Page 1, line 1, remove "relating to coverage of"

Page 1, line 2, replace "telehealth" with "; and to provide an expiration date"

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3. Under the pilot program, payment or reimbursement of expenses for covered services delivered by means of telehealth under this section may not be less than the reimbursement of expenses for covered services that are delivered by in-person means.

4. Under the pilot program, any deductible, copayment, or cost-sharing included for services delivered by telehealth must be limited to an amount that does not exceed, and is not in addition to, the amount that would apply if the service was delivered by in-person means."

Page 1, after line 11, insert:

"**SECTION 3. EXPIRATION DATE.** Section 1 of this Act is effective through July 31, 2023, and after that date is ineffective."

Renumber accordingly

PROPOSED AMENDMENTS TO SENATE BILL NO. 2179

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 26.1 of the North Dakota Century Code, relating to a pilot project for telehealth reimbursement parity; and"

Page 1, line 11, after the period insert:

"**SECTION 2.** A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Telehealth reimbursement parity – Pilot Project

Notwithstanding subsections 1, 3, and 4 of 26.1-36-09.15 of the North Dakota Century Code, from August 1, 2021 to August 1, 2023:

(a) "Telehealth" includes audio-only telephone if no other means of communications technology are available to the patient, including lack of adequate broadband access, or that other means of communications technology is infeasible, impractical, or otherwise not medically advisable, as determined by the health care provider or health care facility providing telehealth services to the patient or as determined by another health care provider or health care facility with an existing relationship with the patient;

(b) Payment or reimbursement of expenses for covered services delivered by means of telehealth under this section may not be less than reimbursement of expenses for covered services that are delivered by in-person means; and

(c) Any deductible, copayment, or cost-sharing included for services delivered by telehealth must be limited to an amount that does not exceed, and is not in addition to, the amount that would apply if the service was delivered by in-person means.

Renumber accordingly

RE: #10650

From: Ben Bucher benb@tcmedcenter.org
To: Westlind, Greg gwestlind@nd.gov
Date: Tuesday, March 23, 8:14 AM

Greg,

As a Rural Health Clinic, we are not compensated at all for telehealth visits. However, during the pandemic we were allowed to provide telehealth visits, but this was a waiver due to COVID and will expire. We did about 100 telehealth visits during the pandemic. Now that our ability to continue to provide telehealth will likely go away, BCBS pays us a facility fee of about $58.00 per visit. Medicare and Medicaid will then pay us a percentage of the $58.00. So, as you can see, continuing to provide telehealth is not feasible with this type of reimbursement. A non-Rural Health Clinic such as Sanford or Altru are reimbursed at much higher rates from BCBS, this is why the Big 6 PPS hospitals push for telehealth. Furthermore as we talked about recently, we have to carve all of our costs related to telehealth out of our cost report as they are considered non-allowable costs.

Hope this helps,

Ben Bucher, FNP-BC, MBA, LNHA
Chief Executive Officer
Towner County Medical Center
Phone: 701-968-2550
Email: benb@tcmedcenter.org

TOP 20 CRITICAL ACCESS HOSPITAL 2020 Best Practice in Quality
TOP 20 CRITICAL ACCESS HOSPITAL 2019 Overall Winner

Towner County Medical Center

From: Westlind, Greg [mailto:gwestlind@nd.gov]
Sent: Monday, March 22, 2021 11:13 AM
To: benb@tcmedcenter.org