MATOD - SB 393 FAV - BH Telehealth.pdf
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Senate Finance Committee
January 27, 2021

Senate Bill 393
Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services
Support

MATOD stands in strong support of Senate Bill 393 – Telehealth Expansion for Mental Health and Substance Use Disorder Services.

Telehealth reduces the traditional obstacles that have previously kept individuals out of treatment. The COVID-19 pandemic has provided substance use disorder and mental health treatment providers the opportunity to utilize telehealth services to maintain connection during a period of social distancing and quarantines with success. Stakeholder surveys from the Maryland Department of Health's Behavioral Health Administration (BHA)[1] in the spring of 2020 and then again in November found that benefits to telehealth have included providing easier access to treatment and increased client participation in treatment.

With the use of telehealth, providers can bypass obstacles such as stigma and geography challenges. Common barriers for engagement and attendance (transportation, childcare and travel time) are reduced or eliminated. The option of telehealth services allows consumers to create treatment schedules that meet their individualized needs.

In addition to treatment accessibility, telehealth appears to have similar or enhanced benefits to developing or maintaining the therapeutic relationship. Therapeutic connection may be preserved or enhanced through the use of telehealth, suggests a Maryland Community Behavioral Health survey[2]. Likewise, a consumer survey conducted by the Maryland Addiction Directors Council showed that 78% of consumers using telehealth had a positive experience either all of the time or most of the time. Specifically with the use of audio-only telehealth, 80% of respondents reported positive experiences all or most of the time.

Even after the public health emergency orders are lifted, transportation and childcare will resume as real barriers to treatment. This forced experiment with telehealth has proved to be an effective alternative that provides the consumers with continued convenience and flexibility.

BHA's latest survey results show the following important outcomes:

- No outpatient SUD respondent indicated an inability to provide telehealth in the second survey, compared to 25% in the first survey;
- 42% of programs reported individuals were keeping their treatment/service appointments more often at the time of the second survey compared to 36% in the first; and
- Outpatient SUD programs were twice as likely to indicate that individuals were taking their medications as prescribed more often (32%) in the second survey than in the initial survey 15%).

(over)

MATOD members include community and hospital based Opioid Treatment Programs, local Health Departments, local Addiction and Behavioral Health Authorities and Maryland organizations that support evidence-based Medication Assisted Treatment. MATOD members include thousands of highly trained and dedicated addiction counselors, clinical social workers, physicians, nurse practitioners, physician assistants, nurses, peer recovery specialists and dedicated staff who work every day to save and transform lives.

MATOD understands that telehealth is not appropriate in every instance, nor desired by all clients. The digital divide is also a significant barrier, as BHA's survey found the most frequently reported telehealth challenges dealt with technology issues such as access to internet connectivity, access to hardware, and phone plan limitations. But the evidence is clear that the use of telehealth is effective and should continue as a tool used by substance use disorder and mental health programs to meet the needs of clients.

Keeping telehealth a treatment delivery option is crucial, given clinical appropriateness and patient choice. The last nine months has given consumers that opportunity to tailor treatment around their lives and has made treatment more accessible than ever. Evidence shows that telehealth has enabled providers to meet their clients' needs without risk to clients or staff. Further, it has increased engagement, decreased no-shows, and increased access for new clients who otherwise may not have received treatment.

For these reasons, we urge a favorable report for Senate Bill 393.

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[1] https://bha.health.maryland.gov/Documents/COVID%20Survey%202.0%20Report%20FINAL.pdf
[2] http://mdcbh.org/files/manual/169/Telehealth%20Survey.pdf

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[2] http://mdcbh.org/files/manual/169/Telehealth%20Survey.pdf

Cbergan_Favorable_SB393_WrittenTestimony.pdf
Uploaded by: Bergan, Courtney
Position: FAV

Courtney Bergan
6166 Parkway Drive #2
Baltimore, MD 21212

SB393- Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

Favorable

Senate Finance Committee Hearing - January 27, 2021

Dear Madame Chair and Members of the Senate Finance Committee:

I am providing this testimony in support of Senate Bill 393 as a concerned Maryland resident and a student at the University of Maryland Francis King Carey School of Law. However, more importantly, when speaking in the context of this bill, I am an individual who deals with a severe mental health condition whose continuing access to affordable mental health care relies on this bill's outcome. The mental health services I receive, which are covered in part by Maryland Medical Assistance, have allowed me to return to school, reduced my overall healthcare costs, and improve my overall well-being.

I strongly request your support for Senate Bill 393, requiring coverage for mental health services delivered via telehealth. I especially want to implore upon you the importance of two provisions contained within the bill: the requirement for payment parity in both private and public insurance and across service delivery methods (in-person, audio-visual, and audio-only), along with the requirement for consumer consent to receive services delivered via telehealth. These provisions are critical to providing more equitable access to high-quality mental health services that meet the needs of vulnerable individuals.

First, payment parity across service delivery methods makes it more likely mental health practitioners will be willing to provide care using the service delivery method that is most appropriate for each patient. Therefore, payment parity will likely increase the number of qualified practitioners available to address varying mental health care needs and ensure patients have access to the most effective treatment. Furthermore, payment parity helps to ensure continuity of care, despite external barriers that may interfere with a patient's ability to participate in any one method. Circumstances such as a lack of internet access, an inability to locate a private space, a disruption in transportation, or a disability that complicates travel, can all interfere with the use of a single method. Payment parity ensures patients and providers have the flexibility to collaborate and select the service delivery method that is most appropriate for each individual on any given day.

I have personally experienced various barriers to in-person and audio-visual services. However, temporary changes providing for reimbursement of audio-visual and audio-only services at the same rates as in-person care have allowed me to continue receiving the mental health care I rely upon with the providers I know and trust.

Next, consumer consent to the receipt of services rendered via telehealth is just as imperative as payment parity in guaranteeing access to appropriate care, especially when it comes to mental health services. For me, maintaining the option to see my psychologist in-person is crucial. Not having access to in-person care has historically resulted in the deterioration of my mental health and hospitalization. Part of that need is related to my mental health diagnoses, where in-person care is often a more effective form of treatment. However, a more significant portion of that need arises from specific nuances of my circumstances, such as living alone, without access to any form of family support. Over the past year, seeing my psychologist is the only meaningful in-person contact I have had. While post-pandemic, my ability for in-person contact will increase, my need to access in-person care will remain. As a survivor of interpersonal violence, seeing my therapist in her office provides me access to one of the few spaces where I feel safe. Having access to that sense of safety is essential to the efficacy my treatment.

Nonetheless, that does not mean telemental health services will have no place in my care post-pandemic—quite the opposite. Prior to the pandemic, telehealth services were a valuable component of my care. Yet, my access to those services was quite limited due to the lack of coverage for audio-only services. Now, I have come to rely on audio-only services for telehealth service delivery since I have a visual impairment that limits the efficacy of audio-visual services. Moreover, audio-only services provide the added benefit of allowing me to move to a place where I have the most safety and privacy, without the burden of worrying about access to internet connectivity. My psychologist provides me with audio-only services for my benefit. However, her expenses don't change since she must remain in a location where she has sufficient auditory privacy.

Losing the coverage that I currently have for audio-only mental health services poses a devastating risk to my ability to remain in school full-time. When classes return to in-person instruction, I will have the added burden of getting to and from campus, meaning I will have less time and money to pay for transportation to get to and from appointments. While my mental health remains my priority, maintaining my mental health relies just as much on my ability to engage in life as it does on more formal treatment. Returning to school full-time to pursue a career I am passionate about has provided an immense benefit to my mental health. However, the potential loss of coverage for audio-only services reimbursed at the same rate as in-person mental health services could result in the loss of access to an essential component of my care. Since returning to school, I have come to rely upon audio-only mental health services to survive and now thrive.

Additionally, consumer consent is vital when considering the overall accessibility of mental health services. Patients' access to each service delivery method varies, making it nearly impossible for third parties to make accurate determinations about whether telemental health services are appropriate for any given individual. Therefore, when contemplating whether telehealth services should count towards network adequacy metrics, requiring consumer consent to the receipt of services offered via telehealth is likely the most effective means for determining accurate network adequacy wait-time standards.

Before the pandemic, I searched long and hard to find an appropriately trained in-network provider under my previous private health insurance coverage. Despite communicating my need

to locate a provider who could see me in-person, my insurer tried to offer me access to a telehealth-only provider in Florida rather than provide coverage for a local specialist. If my insurer had been allowed to use telehealth to meet its network adequacy wait-time metrics, I likely would have been denied access to the in-person care I needed.

Existing consumer protections within the insurance code allow patients to seek a referral to a non-network specialist when an appropriate in-network specialist is not available. Because of these protections, I was finally able to gain approval to see a specialist close to my home because telehealth services are not currently sufficient to count towards network adequacy wait-time metrics. But that protection wouldn't have applied if my insurer could have just met their metrics by offering me telehealth without my consent. Ultimately, gaining affordable access to an appropriately trained mental health provider who can see me, both in-person and remotely, has both saved my life and given me a life far beyond what I ever imagined possible.

I strongly urge you to issue a favorable report for Senate Bill 393 so that all Marylanders can gain access to the mental health care they need. Payment parity across service delivery methods will promote more equitable access to mental health services while requiring consumer consent guarantees consumers can access the most efficacious care for their individual needs. By including these two provisions, Senate Bill 393 helps ensure all Marylanders have access to high-quality mental health services, regardless of their means, diagnoses, or circumstances. Appropriate mental health care shouldn't be limited to those of us with the privilege to wage a public fight; life-saving mental health care should be available to all!

I appreciate you taking the time to consider my concerns supporting the need for the provisions in Senate Bill 393. Please don't hesitate to reach out to me should you have any questions regarding my testimony.

Sincerely,

Courtney A. Bergan
cbergan@umaryland.edu
(443) 681-8191

SB3 and SB393 Telehealth bills_SUPPORT.pdf
Uploaded by: Breidenstine, Adrienne
Position: FAV

Behavioral Health System Baltimore

January 27, 2021

Senate Finance Committee
TESTIMONY IN SUPPORT
SB 3 Preserve Telehealth Access Act of 2021
and
SB 393 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. **Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 77,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.**

BHSB is pleased to support SB 3 Preserve Telehealth Access Act of 2021 and SB 393 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.

The use of telehealth for behavioral health treatment and support services provides people with safe, flexible access to care and helps to address racial inequities that limit access to care for people of color. Telehealth is an important part of a health care delivery system to ensure that individuals receive care in the least restrictive, more cost-effective setting that is best situated to promote long-term recovery.

In addition, the expanded use of telehealth has been a critical component in Maryland's effort to mitigate spread of the coronavirus. Increased flexibility in the delivery of these services has protected providers and consumers from exposure to the virus, ensured continuity of care for Marylanders unable to access in-person treatment, and increased overall access to care. The service expansion has become a vital part of Maryland's continuum of care and it must be preserved.

These bills are similar in several ways:

- Both expand access to audio-only telehealth in Medicaid and commercial health plans. This is an important health equity issue. Low-income individuals and families without access to the internet or smartphones and people living in communities with poor broadband service are unable to access audio-visual telehealth services.

- Both prohibit Medicaid from limiting the delivery of telehealth based on the location of the recipient. This is particularly important for Marylanders experiencing homelessness and for individuals who may not feel safe accessing behavioral health treatment in their home.

- Both require commercial health plans to reimburse providers for telehealth services at the same rate as in-person care.

SB 393 includes some very important additional provisions:

- It authorizes reimbursement of behavioral health programs for telehealth services delivered by peers (people with lived experience) and paraprofessionals – two critical sectors of the behavioral health workforce.

- It protects consumer choice by providing another behavioral health care delivery option along the continuum of care.

- It extends reimbursement parity to telehealth services provide in the Medicaid program.

Telehealth expands access behavioral health treatment and improves care outcomes, makes it easier for consumers to connect with their providers, and helps cut costs to consumers and providers alike. **As such, BHSB urges the Senate Finance Committee to pass SB 3 and SB 393.**

APTA MD - Support - SB393 - Coverage and Reimburse
Uploaded by: Brocato, Barbara
Position: FAV

APTA Maryland

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January 27, 2021

The Honorable Delores Kelley, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: Senate Bill 3 – Preserve Telehealth Act of 2021 - SUPPORT

Senate Bill 393 - Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

Dear Chair Kelley,

The American Physical Therapy Association Maryland is writing to register our strong support of Senate Bill 3 and Senate Bill 393

Among the provisions of SB3 and SB393, it makes clarifications to the State Medicaid program by broadly defining where patients can be cared for via telehealth including in their homes and will also allow for audio only communication. The bill additionally requires commercial

Telehealth and Implications for Physical Therapy Practice

The COVID-19 pandemic has forced health care providers and payers to reconsider how care is delivered in order to reduce the risk of further spreading infection. Access to telehealth has become of paramount importance to ensure the safety of patients and their physical therapy providers. For the duration of this public health emergency, states and many private payers have created telehealth policies that have ensured access to the health care, including physical therapy, that patients need.

While telehealth has played a crucial role in providing needed care during the pandemic, it has become increasingly clear that its many benefits can be utilized well beyond the immediate COVID-19 health emergency. For patients who have difficulty leaving their homes without assistance, have underlying health conditions, lack transportation, or would need to travel long distances, the ability to access physical therapy via telehealth greatly reduces the burden on the patient and family when accessing care.

Telehealth is particularly well-suited for physical therapy, especially when used as an enhancement to services rather than exclusively as a replacement. Education and home exercise programs, including those focused on falls prevention, function particularly well with telehealth because the physical therapist is able to evaluate and treat the patient within the real-life context of their home environment, which is not easily replicable in

the clinic. Patient and caregiver self-efficacy are inherent goals of care provided by physical therapists. A patient's and/or caregiver's ability to interact in their own environment with a therapist when they are facing a challenge, rather than waiting for the next appointment, can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, and promote engagement.

Payment Parity

Payment parity for telehealth is critical, for several reasons. First, most of the cost of a service is attributed to the work relative value unit (RVU) of the Current Procedural Terminology (CPT®) code. Accordingly, the work RVU does not change when care is delivered via telehealth. Second, the practice expense may actually be higher when providing care via telehealth. Although a provider may offer some services via telecommunications technology, they most likely **also** are continuing to provide in-person care in an office. Delivering care via telecommunications technology requires an ongoing investment in technology, IT support, HIPAA-compliant telehealth platforms, and more. Accordingly, the practice expense for telehealth is higher in many instances. Third, liability and malpractice risks are similar to those for in-person services — and may even incur additional costs. For instance, some liability insurers will require providers to purchase a supplemental telehealth insurance policy.

APTA Maryland supports legislation or regulations that would PERMANENTLY allow all physical therapy providers to use telehealth as well as require coverage and reimbursement under Medicaid, Worker's Compensation, and commercial plans to the same extent as for physical therapist services furnished in-person.

For the reasons noted above we ask for a favorable report on Senate Bill 3 and Senate Bill 393.

Sincerely,

Kevin Platt, PT, DPT, MBA
President, APTA Maryland

Maryland Psychological Association - Senate Bill 3

Uploaded by: Brocato, Barbara

Position: FAV

MARYLAND PSYCHOLOGICAL ASSOCIATION

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January 25, 2021

Senator Delores G. Kelley, Chair
Finance Committee
Maryland Senate
11 Bladen Street
3 East, Miller Senate Office Building
Annapolis, MD 21401

Bill: SB0393- Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services

Position: Support

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, would like to offer its strong support for Senate Bill 0393. SB 0393 recognizes the important role of telehealth in the healthcare delivery system, patient/client choice, and parity for mental health care. Telehealth has proved to be an effective platform for treatment of many health/mental health care conditions. Research has demonstrated that the provision of health services through telehealth is as effective as provision through in-person meetings for many conditions.

Telehealth allows increased access to care for all individuals and is especially useful in reducing barriers to care for the underserved and those who live in rural areas. SB 0393 maintains specific provisions which have been temporarily allowed during this Public Health Emergency. For example, SB 0393:

- **Removes specific originating site requirements** which limits access to care (e.g., patients can receive appropriate services at home or another appropriate location);
- **Allows for the continuation of service delivery through audio-only** means when deemed appropriate – this is a critical access to care issue given that many individuals do not have access to computers or other electronic devices and thereby would otherwise suffer an unintended discrimination by being unable to receive needed services via telehealth;
- **Supports appropriate access to care** by requiring insurance companies and other payers to reimburse telehealth services at the same rate and under the same conditions as if they were delivered in person.

This bill also places in the hands of the consumer how they would like to receive their care or in many instances provides the only way they can receive care. For these, and many other reasons, the Maryland Psychological Association asks for a **FAVORABLE** report on Senate Bill 0393.

Please feel free to contact MPA's Executive Director Stefanie Reeves at exec@marylandpsychology.org if we can be of assistance.

Sincerely,

Esther Finglass
Esther Finglass, Ph.D.
President

R. Patrick Savage, Jr.
R. Patrick Savage, Jr.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

2021 SB 393 NAMI-FAV.pdf
Uploaded by: Cyphers, Moira
Position: FAV

January 28, 2021

Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services - SUPPORT

Chair Kelley, Vice Chair Feldman, and members of the Senate Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations and service providers. NAMI Maryland is dedicated to providing education, support and advocacy for persons with mental illnesses, their families and the wider community.

NAMI fights for policies to ensure people get the best possible care. About one in five Americans experience a mental health condition, but only half receive treatment. Comprehensive coverage of mental health care should be the standard for everyone in our country, along with access to quality treatment when and where people need it. Telehealth is an excellent example of all of the above, and as we've seen with the pandemic, have become invaluable to continuing behavioral health care during the COVID-19 pandemic – even more so after state and federal regulators took additional steps to expand access to telehealth for Marylanders.

Please protect these expansions – telehealth has been a lifeline for seniors, families, children, those with disabilities or in rural and underserved communities to stay well and access affordable care. The telehealth expansions NAMI Maryland supports include:

- Audio-only telehealth where appropriate. Not everyone has the same access to technology and everyone needs to receive care whether or not their wi-fi is strong. Almost half a million Marylanders lack access to high speed internet.
- Remove originating and distant site restrictions – meet patients where they are. Feeling safe is of the utmost importance for behavioral health patients.
- Allow the same reimbursement for clinically necessary services.
- Parity. Prevent health insurance carriers from restricting access to telehealth services for mental health or substance use issues.

In addition to the expansions in SB 3, we urge the committee to include important provisions from SB 393, too:

- Access for Marylanders enrolled in Medicaid to continue telehealth services by extending reimbursement parity for Medicaid providers.
- Reimbursement for peers and paraprofessionals – behavioral health workers who ensure individuals can access the care they need and receive mental health treatment and connections to additional services as needed.
- Protects consumer choice, ensuring that a patient may not be required to use telehealth in lieu of an in-person visit.

This legislation focuses on increasing access to health care where it's most needed – safely, in the homes of Marylanders during the pandemic. Please preserve the telehealth expansions above to ensure the best continuity of care possible. For these reasons, NAMI Maryland asks for a favorable report on **SB 393.**

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Moira Cyphers
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Health Care for the Homeless - SB 393 FAV - Behavi
Uploaded by: Diamond, Joanna
Position: FAV

HEALTH CARE FOR THE HOMELESS TESTIMONY
IN SUPPORT OF
SB 393 – MARYLAND MEDICAL ASSISTANCE PROGRAM AND HEALTH INSURANCE - COVERAGE AND REIMBURSEMENT OF TELEHEALTH SERVICES

Senate Finance Committee
January 27, 2021

Health Care for the Homeless strongly supports SB 393, which would make permanent a number of telehealth expansions that have existed under the public health emergency. Among the changes enumerated in the bill are, for Medicaid, effectively removing originating and distant site provisions so both the provider and patient may be off-site for a clinical setting, and requiring reimbursement for audio-only services. Telehealth has been a lifeline for Marylanders as they access mental health (MH) and substance use disorder (SUD) care during the pandemic. Telehealth coverage must be expanded permanently in private and public insurance to help address the skyrocketing need for MH and SUD care as result of COVID-19 and as Maryland recovers from the pandemic.

Audio-only telehealth is lifesaving

Telehealth has immensely increased access to care for people experiencing homeless. While this increased access occurred during the public health emergency, the benefits are so concrete that we strongly believe increasing access to telehealth permanently is critical. **Make no mistake: the ability to provide phone-only services to our clients is lifesaving**. While we support the bill in its entirety, we would like to focus our testimony on the most vital aspects of the bill: maintaining access to audio-only services.

A collection of case studies based on interviews with staff at 17 Health Care for the Homeless programs throughout the country about their experience implementing telehealth demonstrates why increasing access to telehealth permanently is beneficial. Cases specific to Health Care for the Homeless in Maryland are highlighted below.

Contrary to prior belief, telehealth, particularly audio-only telehealth, works well for people experiencing homelessness. With our client population, we have generally found that phones are ubiquitous and inexpensive. Conversely, high speed internet access and video screens are exceedingly inaccessible. Allowing patients to receive services via audio-only telephones can make up for the lack of broadband access in many parts of the State and the lack of affordable internet and computer technology among lower-income families.

Currently 60% of our visits are through telehealth and 97% of those telehealth visits are phone only. Since implementing audio-only telehealth, we found our missed appointment

rate, which was previously around 30%, fell in the first two months of use to 10%.[1] We widely attribute this to the fact that we are meeting our clients where they are and breaking down barriers to care, such as an onerous public transportation system. Importantly, keeping our clients connected to care is pivotal, especially during the pandemic when overdose, suicide and depression rates have increased.[2] Telehealth has been essential to delivering MH and SUD services during the pandemic, and utilization for behavioral health care has far exceeded utilization for other health conditions.

Some clients experiencing homelessness report that telehealth feels safer and more accessible. Policies related to reimbursements and ongoing ability to conduct audio-only visits are likely to determine the ongoing use of telehealth. In other words, phone-only telehealth is the only type of telehealth accessible to the vast majority of our clients. If the ability to conduct phone-only visits goes away, so will our ability to provide any level of lifesaving telehealth care.

Audio-only telehealth is just a tool to deliver health care; all clinical standards and expectations still apply.

We believe there are widespread misconceptions about audio-only telehealth. At its core, audio is just another tool for delivering the same type of and level health care. No clinical or medical requirements, regulations, or standards have changed under audio-only telehealth. We provide the same quality therapeutic and medical services as we always have – whether in person, on video or by phone. The requirements to meet billable standards are robust and nothing about the way we practice is relaxed just because they are over the phone. As highlighted in the examples below, checking in with clients by phone on various issues is a valuable service but not always a *billable* service. There continues to be a distinct set of criteria for a service to be billable. The distinctions between what is a billable phone telehealth visit versus a non-billable phone call are exemplified below.

We urge a favorable report on Senate Bill 393.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. We work to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. We deliver integrated medical care, mental health services, state-certified addiction treatment, dental care, social services, and housing support services for over 10,000 Marylanders annually at sites in Baltimore City, and in Harford, and Baltimore Counties. For more information, visit www.hchmd.org.

[1] While our missed appointment rate has increased slightly to slightly over 15%. However, this rate represents nearly half of our pre-telehealth missed appointment rate.

[2] For instance, the number of overdose deaths from drugs and alcohol in Maryland increased 12% in the first three quarters of 2020 compared to the same time period in 2019. *See* https://beforeitstoolate.maryland.gov/opioid-operational-command-center-department-of-health-release-opioid-and-intoxication-fatality-data-for-third-quarter-of-2020/.

SB393 MD MA Program & Health Insurance-Coverage &

Uploaded by: Doyle, Lori

Position: FAV

Testimony on SB 393
Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services
Senate Finance Committee
January 27, 2021
POSITION: SUPPORT

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 95 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

The combined impacts of the COVID pandemic and a workforce crisis that predated the pandemic require creative thinking and an expanded use of technology in order to meet current and projected demand for behavioral health services. The technology solutions required include the use of video and audio-only telehealth and remote patient monitoring (RPM).

The use of video and audio-only telehealth – by both clinicians and paraprofessionals - proved to be a literal life saver throughout the COVID crisis. Governor Hogan's executive orders allowed for the flexibility required to meet the needs of Medicaid recipients who would otherwise have gone without treatment due to distancing requirements, transportation difficulties and quarantine restrictions. Additionally, many of our clients lack the financial means to purchase smart phones or other video technology and the data plans to support them. Others live in rural areas where broadband coverage is spotty at best. Without ongoing supports through audio-only telehealth these individuals would have had great difficulty in accessing needed medications and therapy. And multiple surveys of practitioners and clients – conducted by the Behavioral Health Administration and provider associations – found high satisfaction ratings for telehealth among both practitioners and recipients**. It is important to note that SB 393 also allows ongoing use of audio-only telehealth by paraprofessionals, who are the daily supports for those with serious mental illness and absolutely critical to ensuring the health and safety of those they serve.**

While the pandemic jump-started our use of video and audio-only telehealth, the use of RPM in Maryland continues to lag behind. Our members struggle to hire paraprofessional staff to render important services such as medication monitoring. Many now rely on a technology that allows clients to download their meds in their own homes. Staff are alerted when the meds are downloaded so they can focus their limited time and attention on those clients who are struggling with medication adherence, an almost certain precursor to negative outcomes, such as emergency department and inpatient utilization. Maryland's regulations currently restrict the use of RPM to three health conditions (congestive heart failure, chronic obstructive pulmonary disease and diabetes) – although the regs identify the target populations as "high-risk, chronically ill individuals," a definition that certainly includes those with serious mental illness - and precludes

payment for the durable medical equipment or apparatus involved. As the workforce crisis continues to deepen, we must look to technologies, such as RPM, as staff extenders.

We urge a favorable report on SB 393.

For more information contact Lori Doyle, public policy director at 410-456-1127.

2021 ACNM SB 393 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FAV

Committee:	**Senate Finance Committee**
Bill Title:	**Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance Coverage and Reimbursement of Telehealth Services**
Hearing Date:	**January 27, 2021**
Position:	**Support**

The Maryland Affiliate of the American College of Nurse-Midwives (ACNM) strongly supports *Senate Bill 3 – Preserve Telehealth Act of 2021*. The bill is critical for ensuring that reimbursement continues to support telehealth services for our patients after the pandemic.

In providing services to women, certified nurse-midwives (CNMs) and other health care practitioners can use telehealth technology to increase access to care. Some examples of care are:

- **Hypertension – Prenatal and Post-Partum:** Telehealth, including remote patient monitoring, is a strategy for addressing hypertension for women in both prenatal and postpartum care. It allows for more frequent monitoring and clinical intervention than regular in-person visits.[i] A recent peer-reviewed research study showed that remote patient monitoring reduced prenatal admissions and induced labor for women with gestational hypertension.[ii]

- **Lowering Pregnancy Stress:** The Mayo Clinic's "OB Nest" program, which includes several uses of telehealth communication resulted in lower pregnancy stress and higher patient satisfaction.[iii]

- **PrEP:** Telehealth is being used to increase access to PrEP.[iv]

We need consistent and fair reimbursement rules in order to continue to implement telehealth innovation across the health care spectrum, including somatic, behavioral health, and dental. We ask for a favorable report. If we can provide any further assistance, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443

[i] Hoppe, Kara et al. Telehealth with remote blood pressure monitoring for postpartum hypertension: A prospective single-cohort feasibility study. Pregnancy Hypertension. Volume 15, January 2019, Pages 171-176.

[ii] Lanssens, Dorien et al. The impact of a remote monitoring program on the prenatal follow-up of women with gestational hypertensive disorders. Obstetrics & Gynecology and Reproductive Biology Volume 223, April 2018.

[iii] Butler Tobah, Yvonne et al. Randomized comparison of a reduced-visit prenatal care model enhanced with remote monitoring. American Journal of Obstectics and Gynecology. December 2019.

[iv] Touger, R. & Wood, B.R. Curr HIV/AIDS Rep (2019) 16: 113. https://doi.org/10.1007/s11904-019-00430-z.

2021 MASBHC SB 393 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FAV

masbhc
MARYLAND ASSEMBLY ON
SCHOOL-BASED HEALTH CARE
education+health=success

Committee: **Senate Finance Committee**

Bill: **Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance Coverage and Reimbursement of Telehealth Services**

Date: **January 27, 2020**

Position: **Support**

The Maryland Assembly on School-Based Health Care is in strong support of *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.* The bill supports the provision of telehealth as a strategy to improve health and educational outcomes for students served by school-based health centers. School-based health centers, approved by the Maryland State Department of Education (MSDE), have been able to remain open during the pandemic by continuing to serve students in their homes through telehealth. These services have been critical to support the continuity of care to quarantined students, and providers can also assess if any extra supports are needed because the family may be facing multiple stressors.

MASBHC is advocating for changing State policies to support all school-based health centers to provide telehealth services after the pandemic. In addition to modernizing telehealth rules under MSDE, MASBCH is advocating for a fair and consistent reimbursement policy. During the pandemic, many reimbursement restrictions have been relaxed, and this bill seeks to make those permanent, including:

- Ensuring reimbursement follows the patient, so that the patient may be at the location best suited for them. This policy is critical to ensure school-based health centers can reach students in their homes of the homes of any family members;
- Mandating critical protections to ensure Maryland complies with federal laws to ensure parity for behavioral health services; and
- Providing for reimbursement for audio-only services. This provision is a top priority for our school-based health centers. As we have seen with virtual education, many students struggle with access to computers and broadband. We ask for a favorable vote on this legislation.

If we can provide any additional information, please contact, Robyn Elliott at (443) 926-3443 or relliott@policypartners.net.

2021 MFeast SB 393 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 393 – Maryland Medical Assistance Program and Insurance Coverage and Reimbursement for Telehealth Services**

Hearing Date: **January 27, 2021**

Position: **Support**

Moveable Feast supports *Senate Bill 393 – Maryland Medical Assistance Program and Insurance – Coverage and Reimbursement for Telehealth Srevices*. The bill provides for reimbursement of the telehealth services beyond the pandemic. Telehealth is an important strategy in our health care system's efforts to address inequities in health care.

Moveable Feast's mission is to provide medically tailored meals to individuals facing life threatening illnesses to improve their quality of lives. We deliver meals to our clients' homes since many of our clients face transportation and mobility issues. Telehealth is based on a similar principle – bringing health care directly to consumers so that they do not have to navigate scheduling and transportation challenges.

By providing for reimbursement of audio-only services, the bill addresses one of the major barriers to telehealth services. Many individuals and sometimes whole communities do not have access to broadband or computers. Audio-only visits are essential to connect people to the health services they need. The bill also provides that reimbursement policies comply with federal parity rules for behavioral health.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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Moveable Feast is a 501 (c)(3) charitable organization, contributions to which are tax-deductible. A copy of our current financial statement is available upon request by contacting our accounting office. Documents and information submitted to the State of Maryland under the Maryland Charitable Solicitations Act are available from the Office of the Secretary of State, State House, Annapolis, MD 21401 for the cost of copying and postage.

2021 MNA SB 393 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FAV

Committee:	**Senate Finance**
Bill Number:	**Senate Bill 393**
Title:	**Maryland Medical Assistance Program and Health Insurance Coverage and Reimbursement of Telehealth Services**
Hearing Date:	**January 27, 2021**
Position:	**Support**

The Maryland Nurses Association (MNA) supports *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance Coverage and Reimbursement of Telehealth Services.* The bill provides for fair and consistent reimbursement rules to continue the support of telehealth after the pandemic. We would like to highlight the bill's support of audio-only visits, which are critical to serve communities without access to broadband or have limited technology resources. In addition, this bill offers critical protections to ensure reimbursement polices comply with the federal parity rules for behavioral health services.

Under our Total Cost of Care Model in Maryland, it is critical that health care providers continue to be able to utilize telehealth to communicate efficiently and effectively with patients. According to the American Hospital Association Center for Health Innovation[i]:

> *"Telehealth and digital health care enable a model of care that is ubiquitous and seamless, more affordable and integrated into patients' lives. In the shift to demand-driven health care, telehealth becomes the patient's first — and most frequent — point of access for urgent care, triage for emergent conditions, specialty consults, post-discharge management, medication education, behavioral health counseling, chronic care management and more."*

Telehealth can be used to:

- Increase access to primary care services, urgent care, and specialist services in shortage areas;
- Support facilities and programs in managing the use of the use of their ambulatory care space. If some patients can be treated through telehealth, it is a more efficient use of resources; and
- Increase patient satisfaction. Patients can probably be seen more quickly and without having to take time off from work.

We ask for a favorable report on this legislation. If we can provide additional perspective on telehealth, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

[i] The American Hospital Association Center for Health Innovation. "Telehealth: A Path to Virtual Integrated Care". February 2019. https://www.aha.org/system/files/media/file/2019/02/MarketInsights_TeleHealthReport.pdf

2021 PPM SB 393 Senate Side.pdf
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Position: FAV

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Planned Parenthood of Maryland

Support
Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance Coverage and Reimbursement of Telehealth
Senate Finance Committee
January 27, 2021

Planned Parenthood of Maryland (PPM) supports *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance Coverage and Reimbursement of Telehealth.* The bill provides for fair and consistent reimbursement policies for telehealth after the public health emergency. In particular, the bill provides for payment of audio-only visits, which are critical for individuals without access to computers or broad band.

During the pandemic, PPM has used telehealth to ensure our clients can continue to receive family planning services:

- **PrEP:** Telehealth, including asynchronous platforms, can expand access to PrEP. As with birth control, many individuals may be anxious to ask their providers abut PreP in a face-to-face encounter, so asynchronous communication increases access[i];

- **Birth Control:** Our patients have continued to receive birth control without the interruption of coming to the office to make a visit. They can receive birth control from a mail order pharmacy or at a local pharmacy;

- **Uncomplicated UTIs:** Some sexually transmitted infections, such as uncomplicated urinary tract infections (UTIs) , can be treated without an in-person visit. Untreated UTIs can impact future fertility and result in emergency room visits.

PPM asks for a favorable vote on the bill. We want Maryland to move forward, not backwards, in implementing telehealth. We care about the overall health, beyond birth control, of our patients. They deserve for their health care providers to be utilizing all the available communication tools. If we can provide any further information, please contact Robyn Elliott at (443) 926-3443.

[i] Touger, R. & Wood, B.R. Curr HIV/AIDS Rep (2019) 16: 113. https://doi.org/10.1007/s11904-019-00430-z.

2021 LCPCM SB 393 Senate Side.pdf
Uploaded by: Faulkner, Rachael
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 393**
Title: **Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Service**
Hearing Date: **January 27, 2021**
Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.* This bill would require insurers, including the Maryland Medicaid Program, to reimburse for telehealth services provided through audio-only.

Prior to the current health care pandemic, Marylanders across the state experienced difficulties accessing behavioral health services. The onset of COVID last year has exacerbated that demand for behavioral health services, at a time when we know that there are not enough behavioral health providers overall.

One way licensed clinical professional counselors (LCPC) have adapted over the past year is by providing more services via telehealth. The importance of using technology to continue seeing clients when social distancing and stay at home orders went into effect cannot be overstated. Unfortunately, we know that using video format has not been available to everyone, for a variety of reasons. In instances where clients do not have a smartphone or computer, reliable internet, or sufficient privacy, professional counselors have been able to provide needed services via telephone to clients. This has ensured continuity of care throughout this crisis, and has allowed individuals seeking services for the first time, or returning to care, the ability to access services when they need it.

We know that the ability to provide behavioral health services via telehealth, including audio-only, will continue to be needed and a valuable took in providing behavioral health services post-COVID.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Rachael faulkner at rfaulkner@policypartners.net or 410-693-4000.

2021 MOTA SB 393 Senate Side.pdf
Uploaded by: Faulkner, Rachael
Position: FAV

Maryland Occupational Therapy Association

PO Box 36401 ♦ Towson, Maryland 21286 ♦ motamembers.org

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 393**
Title: **Preserve Telehealth Access Act of 2021**
Hearing Date: **January 27, 2021**
Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.* This bill makes permanent in law several telehealth provisions permitted during the current health care pandemic.

MOTA has long supported efforts in Maryland to expand the delivery of occupational therapy services through telehealth. As health and behavioral health providers, we often provide occupational therapy services in a client's home and other community-based setting. Doing this through telehealth has obvious advantages. It accomplishes in a relatively brief interaction what would otherwise require hours of round-trip travel for the occupational therapist. This in turn reduces staff costs and affords access to services for a greater number of individuals.

Patient counseling on the use of durable medical equipment is an example of use of telehealth in occupational therapy. Common equipment for seating and positioning, feeding, bathing and toileting lend themselves to synchronous and asynchronous telehealth solutions through measurements and follow-up that can be conducted remotely. Eliminating Medicaid's originating site requirement that a patient be in a clinical health setting allows occupational therapists the ability to more closely utilize telehealth when providing services to a patient in their home and community.

In addition, being able to do provide services via audio-only means that individuals will have greater access to occupational therapist services. This is especially important as patients of all ages transition back home from a hospital or rehabilitation center and require assistance in home modifications and the use of durable medical equipment.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Rachael Faulkner at rfaulkner@policypartners.net or (410) 693-4000.

2021 NASW SB 393 Senate Side.pdf
Uploaded by: Faulkner, Rachael
Position: FAV

NASW MARYLAND CHAPTER
National Association of Social Workers

Testimony before the Senate Finance Committee

****Support****

SB 393 –
Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services

January 27, 2021

Maryland's Chapter of the National Association of Social Workers (NASW-MD), which represents professional social workers across the state, supports SB 393 – Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Servics.

The past year has been remarkable for the challenges and stresses which all Marylanders have faced as we have struggled with the health and financial aspects of COVID 19. Social workers provide more mental health services in our country than any other profession and social workers in Maryland have risen to the challenge and pivoted to continue providing quality mental health services while keeping themselves and their clients safe through the use of Telehealth. The process has taught us that telehealth is a vital form of providing care to clients who for one reason or another cannot access a practitioner in person.

This option must continue to be available during the rest of the public health emergency and beyond.

We support any legislation which makes telehealth accessible to more Maryland residents.

We ask that you give a favorable report on SB 393.

Respectfully,

Daphne McClellan, Ph.D., MSW
Executive Director, NASW-MD

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LeadingAge Maryland - 2021 - SB 393- telehealth co
Uploaded by: Greenfield, Aaron
Position: FAV

6811 Campfield Road
Baltimore, MD 21207

TO: The Honorable Delores Kelley
Chairwoman, Finance Committee

FROM: LeadingAge Maryland

SUBJECT: Senate Bill 393, Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

DATE: January 27, 2021

POSITION: **Favorable**

LeadingAge Maryland supports, Senate Bill 393, Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services.

LeadingAge Maryland is a community of not-for-profit aging services organizations serving residents and clients through continuing care retirement communities, affordable senior housing, assisted living, nursing homes and home and community-based services. We represent more than 120 not-for-profit organizations, including the vast majority of CCRCs in Maryland. Our mission is to expand the world of possibilities for aging in Maryland. We partner with consumers, caregivers, researchers, faith communities and others who care about aging in Maryland.

This bill requires Medicaid to provide health care services appropriately delivered through "telehealth" to program recipients regardless of their location at the time services are provided and allow a "distant site provider" to provide health care services to a recipient from any location at which the services may be delivered through telehealth. The bill expands the definitions of "telehealth" for both Medicaid and private insurance. Insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) must provide coverage for health care services appropriately delivered through telehealth regardless of the location of the patient at the time the services are provided. A carrier must reimburse for services appropriately provided through telehealth on the same basis and at the same rate as if delivered in person. A carrier must allow an insured to select the manner in which a service is

delivered, may not require an insured person to use telehealth in lieu of in-person service delivery and may use telehealth to satisfy network access standards under specified circumstances. The bill's insurance provisions apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2022.

This legislation focuses exclusively on mental health and substance use disorder services because there has been an increased need for those services during the pandemic, especially with seniors who are experiencing tremendous social isolation. We are seeing high and disproportionate use of telehealth for mental health services as compared to any other somatic condition. Limited access to mental health and substance abuse providers in private carrier networks in Maryland can be addressed in part by telehealth, as long as patients consent. Using telehealth has allowed for greater flexibility with regard to outreach. As patients move through different continuums of care (skilled nursing homes to home as an example), access to technology may vary, yet treatment continues. Allowing for non-video aspects is helpful. With COVID in mind, it allows for safe treatment and for treatment when transportation is a concern (again, especially given COVID and older adults not wanting to use public transportation). Treatment should be offered in all communication/connection formats.

For these reasons, LeadingAge Maryland respectfully requests a favorable report for Senate Bill 393.

For additional information, please contact Aaron J. Greenfield, 410.446.1992

Sheppard Pratt written testimony SB393:HB551.pdf
Uploaded by: Grossi, Jeffrey
Position: FAV

Sheppard Pratt

Written Testimony
Senate Finance Committee
House Health and Government Operations Committee
SB393 / HB551 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services

January 27, 2021

Position: SUPPORT

Sheppard Pratt thanks the Maryland General Assembly for your longstanding leadership and support for mental and behavioral health providers in Maryland. This testimony outlines the Sheppard Pratt support for SB393/HB551 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services. It is our hope that the Maryland General Assembly will pass this legislation.

As the COVID-19 pandemic began in Maryland, Sheppard Pratt worked tirelessly to ensure that we could continue to help both individuals in crisis and our existing patients access life-changing care.

Thanks to emergency orders enabling reimbursement for telehealth, we successfully launched our Virtual Psychiatric Rehabilitation Program throughout the state of Maryland. The Psychiatric Rehabilitation Programs (PRP), Community Employment Programs, Occupational Therapy Programs, Residential Rehabilitation Programs, and Chesapeake Connections Program participated in the development, launch, and follow up supports as it relates to the new Virtual Psychiatric Rehabilitation Program. While operating the virtual PRP, each of these teams continue to provide needed in person services and telephonic services as well.

This equates to over eleven hundred virtual rehabilitation group services delivered since May 2020 for individuals needing to access a more structured support model while pursuing desired rehabilitation goals. Many of the individuals served with in these programs have been hindered by location, finances, lack of transportation and motivation. The ability to provide telehealth and audio only services to the individuals receiving services within the rehabilitation programs has eased burdens on emergency departments and emergency personal across the State at a time when an all hands on deck approach is so desperately needed.

Since the start of the COVID-19 pandemic, telehealth has rapidly expanded in all areas such as: crisis treatment, initial consultations, follow up treatment and prevention strategies, psychotherapy, group rehabilitation for substance use and mental health programming.

Jeffrey Grossi, JD, Chief of Government Relations | jgrossi@sheppardpratt.org | 410.938.3181

Sheppard Pratt

This has proven to be a heavy lift for the health care industry as IT systems needed to be further developed and expanded, as well as an increase in the need for supportive equipment like tablets, smart phones, Wi-Fi service, desktop computers, smart televisions, and adaptive speaker systems. This lift was met with eagerness and willingness to take charge and pivot into a digital world that our health care system was just starting to envision.

To date, Sheppard Pratt has found that our clients receiving rehabilitation services within our programming, include:

- 81% of clients have the ability to join the virtual rehabilitation groups on a telehealth platform;
- 19% of the clients have the ability to join the virtual rehabilitation groups through audio only options;
- 88% of the clients have access to a phone;
- 22% have access to a laptop;
- 10% have access to a tablet;
- 7% have access to a desktop; and
- 60% of the above referenced clients have access to internet/Wi-Fi service.

There is a delicate balance that the rehabilitation programs need to take as we forge ahead into the digital support world. A lot of learning and re-directing of varying engagement approaches were explored since the start of the virtual programming. Integration and collaboration are the key drivers of what makes the programming successful. Currently, we are monitoring a small-scale study group of 37 patients utilizing 99% audio only supports. To date, we found that 51% of these individuals received a positive change score in their stress indicators, meaning 51% of these individuals report to feel less stress now than they did before they had access to virtual rehabilitation support both via telehealth and audio only. Audio only services enable the patient to continue to receive the care that they need regardless of their connection to technology. If the patient has a phone, they can access the support that they need in real time versus waiting and or possibly never receiving the help that they need.

Sheppard Pratt asks that you support the SB393/HB551 because the legislation will ensure the extension of four policy changes that continue to remove barriers to telehealth during COVID-19 and beyond:

- Eases restrictions on originating and distant sites, meaning that both providers and patients have greater discretion on the most appropriate physical location to hold their telehealth appointment or schedule virtual visit

- Allows for reimbursement parity between in-person and telehealth services inclusive of audio-only services

- Acknowledges value of health care services delivered via audio-only modalities, especially to vulnerable and underserved populations with internet and technology challenges—the communities most likely to have limited health care access

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- Removes barriers to coverage for remote patient monitoring services, so providers can identify health issues and intervene before they escalate and require emergency care

It is vitally important that Marylanders have easier access to the quality mental health services they deserve – and we can make that access possible by making permanent the telehealth flexibilities that were granted at the beginning of the pandemic inclusive of audio only service ability. This bill brings Maryland in line with neighboring jurisdictions that passed legislation to ensure access to necessary health care, regardless of the modality through which it is delivered. Backing away will leave thousands of Marylanders without access to the care they need and deserve.

Sheppard Pratt urges the committee's favorable report on SB393/HB551.

About Sheppard Pratt

Sheppard Pratt is the nation's largest private, nonprofit provider of mental health, substance use, developmental disability, special education, and social services in the country. A nationwide resource, Sheppard Pratt provides services across a comprehensive continuum of care, spanning both hospital- and community-based resources. Since its founding in 1853, Sheppard Pratt has been innovating the field through research, best practice implementation, and a focus on improving the quality of mental health care on a global level. Sheppard Pratt has been consistently ranked as a top national psychiatric hospital by *U.S. News & World Report* for nearly 30 years.

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Telehealth bill SB 393 Senate Finance testimony (1

Uploaded by: Gutman, James

Position: FAV

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SB 393 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services
SUPPORT
Senate Finance Committee hearing Jan. 27, 2021

Good afternoon Chairwoman Kelley and members of the Senate Finance Committee. My name is Jim Gutman. I am from Howard County and am the health care issues lead advocacy volunteer for AARP MD. I represent it on the Maryland Health Care Commission's ongoing telehealth policy workgroup. In addition, I have been a Maryland SHIP volunteer counselor for five years. Aside from my volunteer work, I have had more than 25 years of writing, editing, publishing and owning (for 10 years) subscription business and regulatory newsletters on managed care, Medicaid and Medicare.

I am here today representing AARP MD and its more than 870,000 members in support of SB 393, which would broaden the permissible uses and methods of telehealth in Maryland's Medicaid program while also providing safeguards that telehealth is used only in ways that are clinically appropriate and desired by the patient. We thank Senator Augustine for bringing this important bill forward.

As you may know, AARP is the largest nonprofit, nonpartisan organization representing the interests of Americans age 50 and older and their families. Key priorities of our organization include ensuring all Marylanders can achieve financial and health security by having timely access to needed health services, including via audio when necessary. This is particularly important since, as a new Abell Foundation report shows, 520,000 Maryland households do not have a home wireline broadband subscription, with the percentages particularly high in African American and rural households.

In my AARP and SHIP volunteer work, I have seen the dire consequences when Marylanders don't have adequate access to health care. The ongoing covid-19 pandemic has only made these consequences more serious and immediate. Even before the pandemic and just in the overall population, in 2017 22% of Maryland residents stopped taking medication as prescribed due to rising costs. Among Medicaid recipients, the percentage was surely higher. That means they need more easy access to prompt and effective health care.

SB 393 would help furnish this in several important ways. First, it would ensure that insurers in the Maryland Medicaid program continue to provide coverage for telehealth services even

Real Possibilities

after the pandemic. It would also establish a requirement that telehealth services coverage include mental health and substance abuse, two areas that are very conducive to telehealth but in which coverage has been an issue. Equally important, it would change existing law to define telehealth as including audio-only services, recognizing that many Marylanders, and especially many seniors, do not have access to the broadband needed for video services.

The bill also would allow health care services to be considered as appropriately delivered regardless of the location of the program recipient at the time of services, which is important for many Marylanders who cannot now receive them either at health care provider offices or at home.

While expanding the allowable uses of telehealth in Maryland, the legislation also incorporates several key protections for the patients, which is an important issue for AARP. Providers, for instance, may use telehealth services only when they are, as the bill says, "clinically appropriate," available, accessible, and, very importantly, when the insured patient elects them. The covered entities under the legislation cannot compel an insured patient to use telehealth. Moreover, services such as e-mail or fax that don't constitute real two-way-communication telehealth are excluded from the bill's provisions, and insurers can't impose a lifetime dollar maximum benefit for the telehealth services.

We believe this bill will furnish major and needed help for Maryland Medicaid beneficiaries, including those age 50 and over that AARP represents. For these reasons **AARP Maryland respectfully requests a favorable report for Senate Bill 393.**

For questions or additional information, please feel free to contact Tammy Bresnahan, Director of Advocacy, at tbresnahan@aarp.org or call her at 410-302-8451.

SB0393_FAV_MedChi, MDAAP, MDACEP, MACHC, MdCSWC_Me
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Position: FAV

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TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Affairs Committee
The Honorable Malcolm Augustine

FROM: Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman

DATE: January 27, 2021

RE: **SUPPORT** – Senate Bill 393 – *Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, the Maryland Chapter of the American College of Emergency Physicians, the Mid-Atlantic Association of Community Health Centers, and the Maryland Clinical Social Work Coalition, we submit this letter of **support** for Senate Bill 393.

Telehealth has been a critical tool for the provision of health care services during the pandemic. Of particular note, is the critical importance it has played in expanding access to mental health (MH) and substance use disorder (SUD) services, especially given the dramatic increase in the incidence of MH and SUD disorders that has occurred over the course of the pandemic. While ensuring that telehealth remains a viable service delivery avenue generally, it is essential that issues specific to MH and SUD services are addressed. Senate Bill 393 captures those issues that require affirmative adoption if telehealth coverage is to be authorized permanently following the public health emergency.

Senate Bill 393 will improve access to life-saving MH and SUD treatment by: 1) authorizing patients to receive telehealth services in their homes or wherever they are located to maximize access to care, while reducing financial barriers; 2) authorizing audio-only/telephonic telehealth to reduce health disparities associated with race, income, and place of residence, while progress is made to bridge the digital divide; 3) requiring payment for telehealth services at the same rate as in-person services to ensure that providers are fully reimbursed for the care they provide; 4) authorizing certified MH and SUD programs to be reimbursed for peers and paraprofessionals providing telehealth services, under supervision; 5) requiring reimbursement for remote patient monitoring for patients with MH and SUD; 6) requiring plans to comply with the Mental Health Parity and Addiction Equity Act and eliminating barriers to MH and SUD telehealth services that are more restrictive than those for medical/surgical telehealth services; and 7) protecting the patient's right to consent to receive services via the service mode they choose.

Ensuring that Marylanders who need access to MH and SUD services retain the ability to access those services via telehealth will dramatically improve both access and health outcomes. Passage of Senate Bill 393 is critical to achieving those objectives. A favorable report is requested.

For more information call:
Pamela Metz Kasemeyer
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410-244-7000

WDC Bill Testimony SB0393_FINAL.pdf
Uploaded by: Koravos, JoAnne
Position: FAV

MONTGOMERY COUNTY, MARYLAND
WOMEN'S DEMOCRATIC CLUB
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Senate Bill SB0393-Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services
Senate Finance Committee – 1/27/21
SUPPORT

Thank you for this opportunity to submit written testimony concerning an important priority of the **Montgomery County Women's Democratic Club** (WDC) for the 2021 legislative session. WDC is one of the largest and most active Democratic Clubs in our County with hundreds of politically active women and men, including many elected officials. Affordable and accessible health care, including mental health care for all Marylanders is a primary focus for WDC.

WDC urges the passage of SB0393 because of its focus on supporting the use of telehealth for treatment of mental health and substance use disorders. There has been an increased need for those services during the pandemic. There has been a disproportionate use of telehealth for mental health services as compared to any other somatic condition. Limited access to mental health and substance use disorder providers in private carrier networks can be addressed in part by the continued use of telehealth even after the current health emergency is over.

This bill would:

- Require Medicaid to provide payment parity with in-person services and cover psychiatrists and psychiatric nurse practitioners who work in mobile ACT programs. It would also require private insurers to give patients a choice in selecting the delivery mode and obtain patient consent to use telehealth. It would further require all public and private insurers to be in compliance with the Mental Health Parity and Addiction Equity Act making mental health telehealth services comparable to services in other health conditions.
- Benefit working women in particular because telehealth provides appointment flexibility, saves travel time, and saves on transportation and childcare expenses. The use of telehealth is also important for those who have a physical disability making it difficult to get to in-person treatment. According to the Community Behavioral Health Association of Maryland's survey more than 70% of patients would continue using telehealth at least some of the time after the pandemic.

Telehealth has been shown to be, and will continue to be, essential for delivering mental health and substance use disorder treatment during and after the pandemic. Maryland laws need to be updated to reflect these new technological advances developed to address the changing environment and preferences of its residents.

We ask for your support for SB0393 and strongly urge a favorable Committee report.

Respectfully,

Diana Conway
President

SB0393 Telehealth Coverage.pdf
Uploaded by: Martin, Dan
Position: FAV

MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 3 Preserve Telehealth Access Act of 2021
and
Senate Bill 393 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services
Finance Committee
January 27, 2021
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to present this testimony in support of Senate Bill 3 and Senate Bill 393.

Expanded use of telehealth has been a critical component in Maryland's effort to mitigate spread of the coronavirus. Increased flexibility in the delivery of these services has protected providers and patients from exposure to the virus, ensured continuity of care for Marylanders unable to access in-person treatment, and increased overall access to care. The service expansion has become a vital part of Maryland's continuum of care and it must be preserved.

The increased access to care that telehealth allows will be particularly important as Maryland works to address the serious behavioral health impact of COVID-19. Isolation, loss of income and grief resulting from the loss of a loved one – not to mention the threat of actually contracting the virus – are all having a profound effect on our mental health. Up to 40% of Marylanders have reported feeling anxious or depressed as a result of the pandemic and state crisis hotlines are receiving a startling increase in calls from individuals at risk for suicide. Drug-and-alcohol-related deaths jumped by more than 18% in the second quarter of 2020 as compared to the same period a year earlier, including a 30% increase in opioid-related deaths. If we expect to meet this increased demand, SB 3 and SB 393 are essential.

The bills are similar in several ways:

- Both expand access to audio-only telehealth in Medicaid and commercial health plans. This is an important health equity issue. Low-income families without access to the internet or smartphones and families living in rural communities with poor broadband service are unable to access audio-visual telehealth services.

- Both prohibit Medicaid from limiting the delivery of telehealth based on the location of the recipient. This is particularly important for Marylanders experiencing homelessness and for individuals who may not feel safe accessing behavioral health treatment in their home.

- Both require commercial health plans to reimburse providers for telehealth services at the same rate as in-person care.

However, SB 393 includes some very important additional provisions:

- It authorizes reimbursement of behavioral health programs for telehealth services delivered by peers and paraprofessionals – two critical sectors of the behavioral health workforce.

- It protects consumer choice, ensuring that a patient may not be required to use telehealth in lieu of an in-person visit.

- It extends reimbursement parity to telehealth services provide in the Medicaid program.

Telehealth is a critical tool in our efforts to meet an increasing demand for mental health and substance use treatment. For this reason, **MHAMD supports the expanded telehealth provisions covered in both bills, and the additional measures included in SB 393.**

For more information, please contact Dan Martin at (410) 978-8865

SB393-Support-RMC-01-27-2021.pdf
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Position: FAV

Rural Maryland Council

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John Hartline, Chairman
Charlotte Davis, Executive Director

Testimony in Support of
Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services
Finance
January 27,2021

The Rural Maryland Council **Supports** SB393 Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services . On March 5, 2020 a state of emergency and catastrophic health emergency was proclaimed as COVID-19 began to spread throughout the state. As Marylanders were advised to avoid contact with others as much as possible to stop the spread of the virus, certain telehealth capabilities were expanded to require health insurance companies to reimburse health care providers who were providing telehealth services to patients that would have otherwise been covered in person. SB393 will extend the telehealth definition to include audio only and remote patient monitoring services and allow distant site providers to provide these services to program recipients from any location which the service may be appropriately delivered. The Council requests that these adjustments be made to safely provide adequate healthcare services to Marylanders who would possibly otherwise go without.

Rural Maryland is currently experiencing a shortage in healthcare providers, particularly in specialty areas, mental health and dental. In addition to having a lack of healthcare providers, Rural Marylanders tend to be both older and in worst health that their suburban counterparts. This puts many individuals of rural Maryland at a greater risk during the COVID -19 pandemic, making it less safe for them to leave their homes, especially to go to a high-risk location such as a medical facility.

Senate Bill 393 will allow for safer means of healthcare and provide easier access to healthcare for rural Marylanders. While telehealth is a more accessible option to many, those in certain parts of the state do not either own the proper materials for a telehealth visit or live in areas that lack proper broadband access to participate in a telehealth visit. By adding audio-only and remote patient monitoring services to the services covered under telehealth, it reaches those who would have been cut off from these services because of a lack of digital literacy or technology. Also, allowing Distant Site providers to provide services to a program recipient from any location increases the number of possible providers for each individual, allowing for more coverage and better health. This includes services for mental health and substance use disorders, which are much needed during these stressful times. According to the CDC, the amount of telehealth visits during the last two weeks of March 2020, rose 154% compared to the same time period from 2019. The increase may have been a result of the telehealth related policy changes made during that time.

The Rural Maryland council respectfully asks for your favorable support on SB393 Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

The Rural Maryland Council (RMC) is an independent state agency governed by a nonpartisan, 40-member board that consists of inclusive representation from the federal, state, regional, county and municipal governments, as well as the for-profit and nonprofit sectors. We bring together federal, state, county and municipal government officials as well as representatives of the for-profit and nonprofit sectors to identify challenges unique to rural communities and to craft public policy, programmatic or regulatory solutions.

SB3 and SB393 MSCAN.pdf
Uploaded by: Miicke , Sarah
Position: FAV

Maryland Senior Citizens Action Network

MSCAN

AARP Maryland

Alzheimer's Association, Maryland Chapters

Baltimore Jewish Council

Catholic Charities

Central Maryland Ecumenical Council

Church of the Brethren

Episcopal Diocese of Maryland

Housing Opportunities Commission of Montgomery County

Jewish Community Relations Council of Greater Washington

Lutheran Office on Public Policy in Maryland

Maryland Association of Area Agencies on Aging

Mental Health Association of Maryland

Mid-Atlantic LifeSpan

National Association of Social Workers, Maryland Chapter

Presbytery of Baltimore

The Coordinating Center

MSCAN Co-Chairs:
Carol Lienhard
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Testimony in Support of SB3 and SB393- SB3 Preserve Telehealth Access Act of 2021 and Senate Bill 393 Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services
Senate Finance Committee
January 27, 2021

The Maryland Senior Citizens Action Network (MSCAN) is a statewide coalition of advocacy groups, service providers, faith-based and mission-driven organizations that supports policies that meet the housing and care needs of Maryland's low and moderate-income seniors.

MSCAN enthusiastically supports both SB3 and SB393 for their potential to positively impact the lives of seniors by allowing more access to telehealth. Expanded use of telehealth has been a critical component in Maryland's effort to mitigate spread of the coronavirus. The service expansion has become a vital part of Maryland's continuum of care and it must be preserved well past the current pandemic. Specifically, the continued use of audio only telehealth has been invaluable to our Seniors who do not always have stable internet or have technological challenges to video health care.

While MSCAN supports both SB3 and SB393, SB393 includes three additional provisions, two of which would be seriously impactful to our seniors; 1. Protecting consumer choice, ensuring that a patient may not be required to use telehealth in lieu of an in-person visit and 2. extending reimbursement parity to telehealth services provide in the Medicaid program.

For these reasons, MSCAN urges a favorable report on SB3 and SB393

SB3_SB393 Telehealth BJC final.pdf
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Position: FAV

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BALTIMORE JEWISH COUNCIL

WRITTEN TESTIMONY

Senate Bill 3 – Preserve Telehealth Access Act of 2021
And
Senate Bill 393 -- Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

Finance Committee
January 27, 2021

SUPPORT

Background: Senate Bills 3 and 393 (SB3 and SB393) would help countless low income, disabled, and older Marylanders by expanding access to telehealth services. Currently, due to the Covid-19 pandemic, several state restrictions on telehealth have been lifted. These bills would make those changes permanent, including expanding access to audio-only telehealth for Medicaid and commercial insurance plans, prohibiting Medicaid from limiting the delivery of telehealth based on the location of the client, and requiring private insurance plans to reimburse providers for telehealth services at the same rate as in-office care. In addition to these changes, SB393 includes three additional provisions. It would cover behavioral health and substance use treatment by peers and paraprofessionals, two key professional sectors of the mental health workforce. Second, this bill protects consumer choice, meaning a patient can choose between a telehealth and an in-person visit, and not be forced between one or the other. The final provision applies to Medicaid recipients, and provides that telehealth visits are reimbursed at the same rate as in-person visits.

Written Comments: The Baltimore Jewish Council (BJC) represents The Associated: Jewish Community Federation of Baltimore and all of its agencies and programs, including Jewish Community Services (JCS). JCS provides critical social services, including mental and behavioral health therapy, older adult care, and disabilities support. Due to the Covid-19 pandemic telehealth executive orders, JCS has continued to provide services to its clients. Specifically, the audio-only telehealth allowance has enabled the neediest clients, including those with disabilities, older adults, and low-income individuals without stable internet access to receive their much-needed services. SB3 and SB393 would allow these clients to continue to receive telehealth services after the pandemic is over. JCS has learned how invaluable telehealth services are to their clients, allowing clients to not have to rely on family, friends, Mobility and other public transit options to get them to their appointments. Telehealth services save time, money and stress and makes services more accessible for many clients.

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Member of the Jewish Council for Public Affairs

Baltimore Jewish Council is an agency of The Associated
The Associated
Jewish Federation of Baltimore

For these reasons, we urge a favorable report on SB3 and SB393, with a preference for SB393 due to its additional provisions.

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of The Associated: Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

Maryland Medical Assistance Program and Health Ins

Uploaded by: Mitchell, Laura

Position: FAV

Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services – SB 393
Senate Finance Hearing
January 27, 2021
FAVORABLE

Senator Kelley, Senator Feldman and members of the Senate Finance Committee, thank you for accepting testimony from me today on this very important, life saving bill. I am the mother of two adult sons and the grandmother to three, one of whom resides in Maryland. Telehealth services have been a lifeline for us in recent months and will continue to be critical in the future because of some of the changes COVID-19 brought about. Changes that will last far beyond the current crises.

Telehealth has also been a lifeline for other Marylanders as they access mental health (MH) and substance use disorder (SUD) care during the pandemic. Telehealth coverage must be expanded permanently in private and public insurance to help address the skyrocketing need for MH and SUD care as result of COVID-19 and as Maryland recovers from the pandemic.

I volunteer with several organizations and see the need for these services in each role. As the President of the Parkland Magnet Middle School PTSA at my grandson's school – a majority/minority school with a high FARMS rate –I am aware of at least five (5) students in the last year that have experienced significant MH crises which eventually led to suicidal ideation and/or suicide attempts because they were unable to access MH services sooner. Three years ago, a child at the school completed suicide so we are very attuned to the need for our students to have access to services. Several of the parents that I have assisted have had difficulty accessing care due to transportation challenges and other issues. Some, like myself, have secured appointments for care, only to spend the appointment time fighting technology to have a video call, when a simple phone/audio only appointment would have provided much more benefit. My grandson has been hospitalized twice in the last two years for suicidal ideation while we struggled to get appointments with counselors and psychiatrists that were close enough to home that he didn't have to miss two hours of school each week to drive to appointments or wait months for an appointment.

We moved to Montgomery County 4 ½ years ago from the Eastern Shore (Salisbury) so I am also very aware of the technology challenges that the more rural areas face with large proportions residents having no reliable internet access and very few providers available for in person services, thereby making MH and SUD services non-existent, particularly for pediatric patients. My 78-year-old mother still lives in Salisbury and essentially homebound, so she is only able to access MH services via audio only because, in her words, "the smart phone is smarter than me" so she is challenged to access care if video is a requirement and in person is not a real possibility for her. Even in Montgomery County, within the Rockville city limits on Comcast Cable, I often cannot maintain a connection if I turn on my camera so, even over Zoom (the most stable platform), we end up having audio only sessions just to stay connected in this urban area of the state.

I will also share with you that I have struggled with some issues of depression since the death of my 7-week-old granddaughter on August 18, 2016, the very day I moved to Rockville. At the time, my husband and I were raising our 14-year-old grandson due to his mother and father's (my youngest son) MH and SUD issues. I was trying to get him settled in a new home, new school, my husband had a new job, I had just resigned my City Council seat – a position I loved dearly – to move here and we did not know anyone in the area. So I threw myself into the PTA at his school and carried on with several other volunteer activities I did as a councilmember where feasible. I really just kept moving to outrun my feelings, in retrospect. In late 2019, I realized that I needed to seek counseling myself, but I also knew the challenges we had endured trying to access services for

my son and grandson and I wasn't up for that daunting task of finding care for myself. Last January, I took on that challenge and found a provider I was able to connect with. Two months later, COVID-19 hit. I was never a fan of telehealth and resisted it at first. But that being the only option at the time, we began making virtual appointments. I quickly realized that this was much better suited to my needs as some days – before COVID (BC) – I had to force myself to leave the house to go to the store or to an appointment with my therapist. As 2020 wore on (endlessly) I was hospitalized five (5) times for a chronic health condition and once for surgery. Each time I was able to get the support I needed and continue my treatment via audio only sessions. The Wi-Fi connections in the hospital made video appointments impossible and I would not have kept a video appointment in a hospital gown, or in my bed as I recovered from surgery. I would have missed many appointments and lost my slot with that provider if not for the ability to meet remotely and with audio only. I will also add that my chiropractor and primary care physician already receive a higher reimbursement rate for 15-20 minute appointments than my therapist does for a 50 minute appointment so the requirement for reimbursement rate parity is absolutely critical for video and audio only appointments. From my stories, I hope you can see how passage of this bill with have a tremendous impact on the Marylanders' access to mental health and substance use care. I am passionate about this issue because I can see that many of the issues – my health issues, proximity to providers for my grandson, son and mother – are not going away with COVID-19 and the silver lining of the pandemic it is that we have found that telehealth is an excellent, and in many cases the only, way for our family to access much needed care. These and other important points addressed in the bill are listed below.

The Coverage for Mental Health & Substance Use Disorder Telehealth Benefits bill (SB 393/HB 551) will improve access to life-saving MH/SUD treatment by:

- Authorizing patients to receive telehealth services in their **homes or wherever they are located** to maximize access to care while reducing financial barriers.
- Authorizing **audio-only/telephonic** telehealth to reduce health disparities associated with race, income, and place of residence, while progress is made to bridge the digital divide.
- Requiring payment for telehealth services **at the same rate** as in-person services to ensure that providers are fully reimbursed for the care they provide.
- Authorizing certified MH/SUD programs to be reimbursed for **peers and paraprofessionals** providing telehealth services, under supervision.
- Requiring reimbursement for remote patient monitoring (RPM) for patients with MH/SUD.
- Requiring plans to **comply with the Mental Health Parity and Addiction Equity Act** and eliminating barriers to MH/SUD telehealth services that are more restrictive than those for medical/surgical telehealth services.
- Protecting the **patient's right to consent** to receive services via the service mode they choose.

COVID-19 has increased the need for MH and SUD services in Maryland.

State and national data have demonstrated that the COVID-19 pandemic has exacerbated people's mental health conditions and substance use. Significantly more people are struggling with MH/SUD, and they are reaching out for professional help.

- The number of overdose deaths from drugs and alcohol in Maryland increased 12% in the first three quarters of 2020 compared to the same time period in 2019.
- Calls and online outreach to Maryland's 211 call center to connect residents with mental health resources increased by 353% in the fourth quarter of 2020 compared to 2019, and text volume increased by 425%.
- During late June 2020, 40% of adults in the U.S. reported struggling with mental health or substance use. Approximately twice as many adults reported suicidal ideation in 2020 compared to 2018.

- The proportion of children's mental health-related visits to the emergency department increased between 24%-31% in October 2020 compared to October 2019.
- Patients who survive COVID-19 have a significantly higher rate of being diagnosed with anxiety and mood disorders in the three-month period following their COVID-19 diagnosis than those with other diagnoses.

Black and brown communities are being hit the hardest by these dual public health crises of COVID-19 and MH/SUD, and access to care must increase in these communities.

- In Maryland, substance use fatalities among Black individuals increased 35% from 2017 to 2019 while reported data reflected a 10.8% decrease among white individuals, according to Opioid Operational Command Center.
- At the beginning of the pandemic, suicide rates increased dramatically among Black Marylanders.
- Black and brown individuals are reporting higher rates of suicidal ideation, adverse mental health symptoms, and alcohol or drug use during the pandemic than white individuals.
- Black patients with SUD who are diagnosed with COVID-19 have the highest rates of hospitalization and death across all populations.
- Even before the pandemic, overdose mortality rates have continued to increase for Black Americans, Asian Americans, Hispanic Americans, and American Indians, while the overall overdose death rate declined in 2018.

Telehealth has been essential for delivering MH and SUD care during the pandemic.

Utilization of telehealth for MH and SUD services has far exceeded that of any other health care condition and has remained high even as rates of telehealth have decreased for other types of services. Appointment "no-shows" dropped dramatically, and patients wish to continue using telehealth after the pandemic.

- In September 2020, U.S. telehealth claims were up almost 3,000% compared to September 2019, based on FAIR Health data. That month, mental health conditions accounted for over half (51.83%) of the telehealth claims , and any other diagnosis accounted for 3% or less of claims.
- According to the Community Behavioral Health (CBH) Association of Maryland's survey of 4,000 patients, more than 70% of respondents would continue using telehealth at least half the time after the pandemic. The top reasons clients wanted to continue to use telehealth, besides reducing the risk of COVID-19 exposure, include:
    - Appointment flexibility (61%)
    - Travel time (49%)
    - Transportation (39%)
    - Physical disability (25%)
    - Preference (16%)
    - Childcare (15%)
- The CBH survey also demonstrated that 75% of patients reported having the same or better therapeutic connection with their MH/SUD providers when using telehealth.
- Telehealth significantly reduces no-show rates and improves patient retention.

Audio-only telehealth is necessary to bridge the digital divide.

Patients primarily use audio-only telehealth because they lack access to reliable internet, sufficient data plans, appropriate devices, or technological literacy. Without audio-only telehealth visits, the most vulnerable patients (older, low-income, homeless persons) will lose access to care. Other patients rely on telephone visits with their MH and SUD providers because they lack privacy or safety in their homes.

- Across Maryland, 14.7% of the overall state population is underserved with respect to internet access.
- Approximately 425,000 Marylanders lack high-speed internet. Most of them live in rural communities, but almost a quarter of those who lack internet access live in urban areas where the cost is prohibitive.

The Maryland Addiction Directors Council (MADC)'s survey found that 87% of patients had a positive experience using audio-only telehealth with their SUD treatment provider most if not all of the time, with another 11% reporting a positive experience some of the time.

Thank you for your time and for all you do!

Laura Mitchell

- *Parkland MMS*: PTSA President
- *MCCPTA*:
    - DCC Area Vice President;
    - Chair, Operating Budget Committee
    - Chair, Substance Use Prevention Committee
    - Wheaton Cluster Coordinator
- *Alcohol and Other Drug Abuse Advisory Council (AODAAC)*: Voting Member
- *Opioid Intervention Task Force (OIT)*: Workgroup Member
- Montgomery County Suicide Prevention Alliance

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SB393 Testimony.pdf
Uploaded by: Nkongolo, LaToya
Position: FAV

Testimony of Work Life Behavioral Health and Professional Training owner
LaToya Nkongolo, LCSW-C, LCADC

Before the
Senate Finance Committee

Hearing on
SB393

January 27, 2021

Thank you, Chair and committee members for allowing me to testify at this important hearing. My name is LaToya Nkongolo, and I am a licensed clinical social worker, licensed clinical alcohol and drug counselor. My husband and I own Work Life Behavioral Health located in Glen Burnie, MD, in Anne Arundel County. Our clientele consists of individuals ages 4 and over receiving services, both in person and in home. Many live across the county in suburban and rural areas and many have limited access to transportation and internet services. Approximately 54% of our recipients of Medicaid/Medicare, approximately 31% have private insurance, and 15% self-pay for services. The COVID pandemic forced us to be innovative in the way we provide services to the nearly 1,000 Anne Arundel County residents who trust us with their mental health and substance use counseling services. As a result of the pandemic, we transitioned to telehealth in March 2020 both by audio and/or telephone. My hope is to offer you some insight into my daily practice experience as a telehealth provider. I would like to share how various populations are benefitted from teletherapy services:

School Aged Youth- Youth are consistently attending teletherapy sessions in the comfort of their own home without the hardship of parents adjusting their work schedules to accommodate in person sessions.

Criminal Justice Population: We have seen an increase in services to those who are currently incarcerated, in addition to those who are in outpatient therapy to satisfy probation and parole requirements.

Geriatric Population: Myself and other therapists at Work Life offer in home therapy services to seniors and the disabled. Many of them have limited understanding of technology which was a concern. This population has benefitted from utilizing phone sessions as a means to remain consistent with treatment. Telehealth has eliminated the need for therapists to provide in home services which has decreased transportation time and allowed us to increase the number of clients we serve.

DSS Clients: Client who are required to receive counseling services have been able to comply this requirement while balancing work and other responsibilities.

Conclusion:

- The pandemic has forced us to use audio and/or visual technology which has shown to be a better way to make treatment more accessible to all.
- Telehealth has decreased barriers such as transportation, missed time from work and school.
- Telehealth has shown to decrease the cost of transportation services such as AAA Medicaid transportation and Medicare transportation.
- There been a reduction of missed appointments which has allowed patients to be more consistent with treatment and to transition to biweekly or monthly therapy sessions.
- Individuals in the criminal justice and child welfare systems are better able to meet the requirements of said systems while balancing work and family.

Thank you all for listening and for considering the critical need for clients to continue receiving the help they need through audio and/or visual teletherapy services.

SB393 - Maryland Medical Assistance Program and He
Uploaded by: Orosz, Samantha
Position: FAV

Statement of Maryland Rural Health Association

To the Finance Committee

January 27, 2021

Senate Bill 393 Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

POSITION: SUPPORT

Chair Kelley, Vice Chair Feldman, Senator Augustine, and members of the Finance Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 393 Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services.

MRHA supports this legislation expands the reimbursement of telehealth by Medicaid to include synchronous and asynchronous interactions, audio only service delivery, and Remote Patient Monitoring (RPM) services. It is essential to the health of all Marylanders to have access to equitable and quality behavioral health services during the COVID-19 pandemic.

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland.

Rural Maryland represents almost 80 percent of Maryland's land area and 25% of its population. Of Maryland's 24 counties, 18 are considered rural by the state, and with a population of over 1.6 million they differ greatly from the urban areas in the state.

Maryland law states that "many rural communities in the State face a host of difficult challenges relating to persistent unemployment, poverty, changing technological and economic conditions, an aging population and an out-migration of youth, inadequate access to quality housing, health care and other services, and deteriorating or inadequate transportation, communications, sanitations, and economic development infrastructure." (West's Annotated Code of Maryland, State Finance and Procurement § 2-207.8b)

And while Maryland is one of the richest states, there is great disparity in how wealth is distributed. The greatest portion of wealth resides around the Baltimore/Washington Region; while further away from the I-95 corridor, differences in the social and economic environment are very apparent. MHRA believes this legislation is important to support our rural communities and we thank you for your consideration.

Lara Wilson, Executive Director, larawilson@mdruralhealth.org, 410-693-6988

MAYSB - SB 393 FAV - Behavioral Health Telehealth.
Uploaded by: Park, Liz
Position: FAV

Maryland Association of Youth Service Bureaus

"Being here for Maryland's Children, Youth, and Families"

Testimony on SB 393
Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services
Finance Committee
January 27, 2021
POSITION: SUPPORT

The Maryland Association of Youth Service Bureaus (MAYSB) respectfully requests that you give SB 393 a favorable report, allowing providers to continue using Telehealth as an option in providing mental health and substance use services in Maryland.

Throughout the course of the COVID-19 pandemic, MAYSB mental health and substance use providers found that telehealth service options were a critical component of clients' engagement, care, stabilization, and recovery. Telehealth has proven itself as an integral method to maintaining consistent therapy and a quality connection to our clients. MAYSB providers have not only kept active clients but have admitted many new clients using a combination of in-person and telehealth services. Telehealth provided an instant method to continue seeing active clients during the initial phases of the crisis, helped avoid gaps in treatment, and provided timelier crisis 0maintain the integrity of services while providing our clients with options.

In addition to the above merits of telehealth, many providers have seen greater consistency with attendance, with reduced no-shows for appointments. Telehealth provides various scheduling options and an increased ability to offer same/next day sessions, giving clients more flexibility as they manage the new day to day challenges of remote work, virtual education, and potential exposures.

Looking forward, we know telehealth will allow for new ways to engage clients whose attendance was inconsistent, or who had difficulty getting to appointments due to transportation, schedule conflicts, or mental health issues impacting daily functioning. As an example, for someone who has an anxiety-related disorder, leaving home can be anxiety-producing. With telehealth, therapists can continue to work with the individual.

Telehealth has allowed resistant or medically compromised family members to engage in their child's treatment, providing a more comprehensive approach and outcome for families. It has also allowed for intervention with a client while in their environment. For people in some counties, the distance clients travel to appointments can be challenging. Many families do not have reliable transportation or the funds for fuel.

For all of these reasons, we respectfully ask you to support this bill.

Respectfully Submitted: Liz Park, PhD
MAYSB Chair
lpark@greenbeltmd.gov

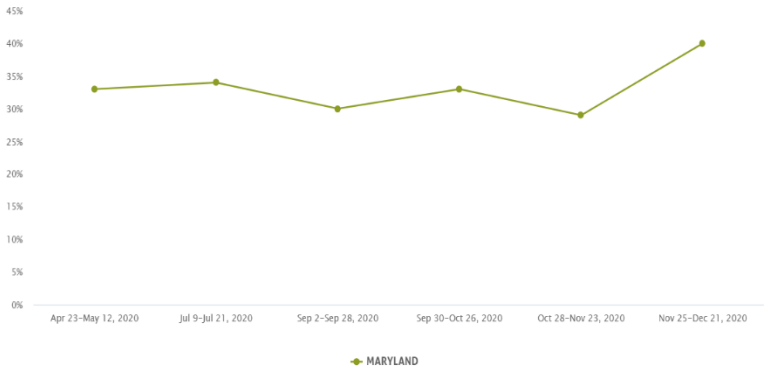
SB 393 Telehealth SUPP_ ACY.pdf
Uploaded by: Rock, Melissa
Position: FAV

EQUITY FOR ALL KIDS

ADVOCATES FOR CHILDREN AND YOUTH

To: The Honorable Chair, Senator Delores Kelley, and members of the Finance Committee
From: Melissa S. Rock, Birth to Three Strategic Initiative Director & Interim Managing Director
Re.: **SB 393: Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services**
Date: January 27, 2021
Position: **SUPPORT**

Advocates for Children and Youth (ACY) applauds Maryland's Department of Health (MDH) for their swift expansion of access to telehealth somatic and behavioral health services during the COVID-19 pandemic. Not only did the pandemic increase the medical needs of Marylanders statewide, the need for behavioral health support also increased exponentially. As stated in an MDH press release, "Maryland's crisis hotline saw a significant increase in volume in recent months, especially in text messages. From March 2019 to March 2020, text messages increased by 842 percent; 'chats' increased almost 84 percent; and calls increased almost 25 percent. Between February 2020 (1,619 calls) and March 2020 (2,345 calls), calls to Maryland 211 increased by 45 percent."[1] ACY has also seen a spike in children experiencing anxiety[2] and children experiencing depression.[3] (See tables below.)



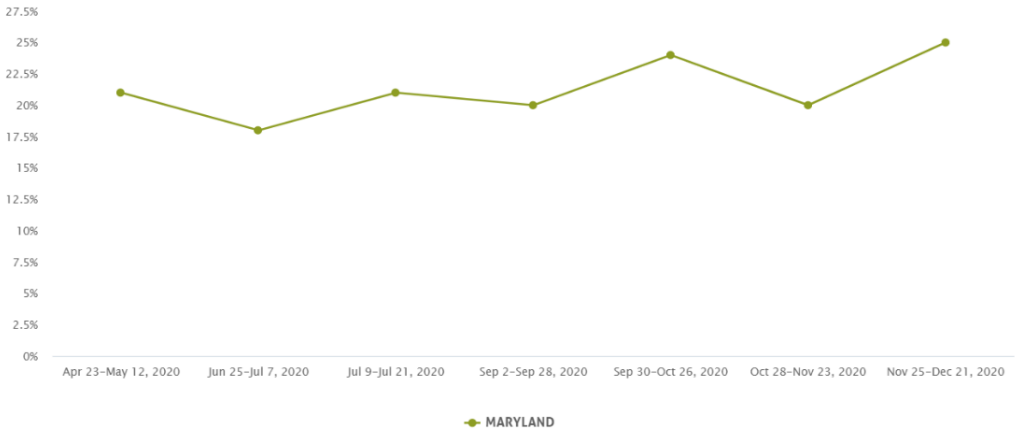
Adults Living In Households With Children Who Felt Nervous, Anxious Or On Edge For More Than Half Of The Days Or Nearly Every Day In The Past Week (Percent)

National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
A project of the Annie E. Casey Foundation

With the help of the increased ability to scan brains, we now know that 85% of brain development happens before a child turns 3 years old. That brain development is highly influenced by a young child's experiences. For children experiencing toxic levels of stress—like those children living in poverty, or exposed to violence, their brains do not develop at the same rate because of the impact on their bodies responding to that toxic stress.[4] However, a strong attachment to one primary caretaker can buffer the negative impacts toxic stress can have on brain development and ensure brain development progresses appropriately.[5] A parent can only provide that strong attachment to their children if they are receiving the behavioral health treatment they need.

[1] https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-launches-%E2%80%98MD-Mind-Health%E2%80%99.aspx
[2] https://datacenter.kidscount.org/data/line/10894-adults-living-in-households-with-children-who-felt-down-depressed-or-hopeless-for-more-than-half-of-the-days-or-nearly-every-day-for-the-past-week?loc=22&loct=2#2/22/false/2047,2042,2034,2033,2032,2028,2027,2002,1997,1996/asc/any/21182
[3] https://datacenter.kidscount.org/data/line/10893-adults-living-in-households-with-children-who-felt-nervous-anxious-or-on-edge-for-more-than-half-of-the-days-or-nearly-every-day-in-the-past-week?loc=22&loct=2#2/22/false/2047,2042,2034,2033,2032,2028,2027,2002,1997,1996/asc/any/21180
[4] https://developingchild.harvard.edu/guide/a-guide-to-toxic-stress/
[5] https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2016/05/Executive_Summary_FB2PBI.pdf

When clinically appropriate and permissible to a patient, telehealth eliminates a lot of barriers than exist for many Marylanders living in under-resources areas even when there is no global pandemic. For many families, transportation to medical and behavioral health is a barrier. While Medicaid transport is intended to eliminate that barrier, adults cannot bring their children with them when utilizing Medicaid transportation, and many of these parents do not have access to childcare. Telehealth also makes these appointments much less time consuming. For parents in low-wage jobs with limited access to paid time off, decreasing the time for appointments eliminates a significant barrier to receiving important treatment. **SB 393** will ensure that these telehealth expansions stay in place beyond the pandemic.



Adults Living In Households With Children Who Felt Down, Depressed Or Hopeless For More Than Half Of The Days Or Nearly Every Day For The Past Week (Percent)

National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
A project of the Annie E. Casey Foundation

There are some important ways **SB 393** expands upon SB 3- Preserve Telehealth Access Act of 2021. **SB 393 requires payment parity for behavioral health treatment for Medicaid providers** (rather than only private providers), which creates equity issues for Marylanders without the resources to obtain private insurance. **SB 393 also requires patients utilizing private insurance to consent** to their treatment being via telehealth rather than in person. We think it's essential that patients consent to their treatment being provided via telehealth services and that it is deemed clinically appropriate to receive the treatment via telehealth rather than in person.

ACY urges this committee to issue a favorable report on SB 393 to help eliminate many of the access barriers for somatic and behavioral health for families across Maryland.

NCADD-MD - SB 393 FAV - Telehealth - Behavioral He
Uploaded by: Rosen-Cohen, Nancy
Position: FAV

Senate Finance Committee
January 27, 2021

Senate Bill 393
Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

Support

NCADD-Maryland supports Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services.

Amid the COVID-19 pandemic, the pre-existing opioid overdose death fatality crisis has worsened. In Maryland, third-quarter data from the Maryland Department of Health shows a 14% increase in the number of opioid overdose deaths in 2020, over the same period the year before. The numbers were up even before the impact of the pandemic early last year. We have also seen a disturbing trend in the increasing numbers of Black Marylanders dying from overdoses.

What the pandemic has taught us is that telehealth is a life-saving tool in the delivery of health care services, including substance use disorder and mental health treatment. With the existence of a massive digital divide, the use of the telephone has been the only way tens of thousands of Marylanders have been able to access health care services. When the public emergency declarations are lifted, the digital divide will unfortunately still be with us. We therefore must continue the use of telehealth, including audio-only technology.

Surveys have shown both consumer satisfaction and efficacy. The Maryland Addiction Directors Council conducted a survey of clients that showed that 78% of those using telehealth had a positive experience either all of the time or most of the time. Specifically with the use of audio-only telehealth, 80% of respondents reported positive experiences all or most of the time.

The Behavioral Health Administration conducted provider surveys in the spring and again in the fall of 2020. The second survey results show the following important outcomes:

- No outpatient SUD respondent indicated an inability to provide telehealth in the second survey, compared to 25% in the first survey;

- 42% of programs reported individuals were keeping their treatment/service appointments more often at the time of the second survey compared to 36% in the first; and
- Outpatient SUD programs were twice as likely to indicate that individuals were taking their medications as prescribed more often (32%) in the second survey than in the initial survey 15%).

With the two guiding principles that telehealth should be used when clinically appropriate, and when preferred by the consumer, the use of telehealth should continue indefinitely. And with the myriad regulations and safeguards that already exist, there should be no hesitation to continue audio-only to ensure everyone has access to care.

We strongly urge a favorable report on Senate Bill 393.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

Spangler - Telehealth Testimony.pdf
Uploaded by: Spangler, Christina
Position: FAV

Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services – SB 393
Senate Finance Hearing
January 27, 2021
FAVORABLE

My name is Christina Spangler. I am a mother of four, full-time working resident of Charles County, Maryland. My oldest son (age 12) struggles with Bi-Polar disorder, severe non-verbal autism, epilepsy, and self-injurious behaviors. Because of these challenges, myself and two of my other children (ages 10 and 4) have been diagnosed with Post-Traumatic Stress Disorder.

Telehealth has been a leading contributor for my family's wellness. For myself, I have never been able to access the therapy needed to address my mental health needs. Taking leave from work, paying $30/hr for special needs child care, and additional time for travel are too many stressors to find a 40 minute therapy session beneficial. Now I am able to use my lunch break to attend mental health therapy in my own home. I wish to continue to use telehealth for my mental health services after the public health emergency is over because it removes the barriers that have previously prevented me from getting the care I need."

Living in Southern Maryland makes locating providers a challenge. Telehealth has allowed me to widen my options for providers. We have been able to secure a therapist for my 10-year-old son that he is able to connect with rather than just settling for the closest provider. His therapist has reported meeting virtually has provided him with a level of comfort and security meeting in a sterile office cannot provide. He has been opening up more during sessions, which is allowing them to work at a much deeper level. I would like for my son to continue to have the option to use telehealth after the COVID-19 so that he can keep making progress to his mental health."

Due to my oldest son's intense needs, there are no providers able to support our family outside of Kennedy Krieger Institute (KKI). A normal appointment begins with my mother waking up at 4:30am to drive to my home to sit with my other children. While Baltimore is roughly 70 miles from my home, it is typically a three-hour drive when factoring time for beltway traffic, construction, accidents, and time to find parking. The specialists are often running behind so we are forced to wait in an exam room until the provider is available. After our appointment, it is another 2-3 hour commute home filled with anxiety that I will not make it before school dismissal. Telehealth appointments save me an entire day off work, six hours in the car and my mother's time/travel all for what is typically a 20-minute medical appointment. Our more intensive services through KKI (which include the same mentioned stressors) have become immensely more valuable for our family when completed virtually. Video appointments have allowed my medical team to be inside my home. Rather than just my self-reporting of the layout of my home, or ways my son injurers himself, interacting with his siblings, our team can now see it in real-time. We now have a revised and more effective treatment plan now that they are able to see first-hand what the plan looks like being implemented outside of a sterile, distraction-free treatment room.

It is my hope that Care-First and Priority Partners will continue to reimburse telehealth appointments at the full-rate. Bringing our mental health care providers into our home through telehealth relieves endless stressors for my special needs family, and allows us to maximize the benefits of these medically necessary services.

I urge you to support SB 393. Thank you.

Christina Spangler
Maryland Coalition of Families
CSpangler@mdcoalition.org
Phone: 443-472-7918

SB 393 - Support - MPS WPS.pdf
Uploaded by: Tompsett, Thomas
Position: FAV

January 28, 2021

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: Support – SB 393: Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

Dear Chairman Kelley and Honorable Members of the Committee:

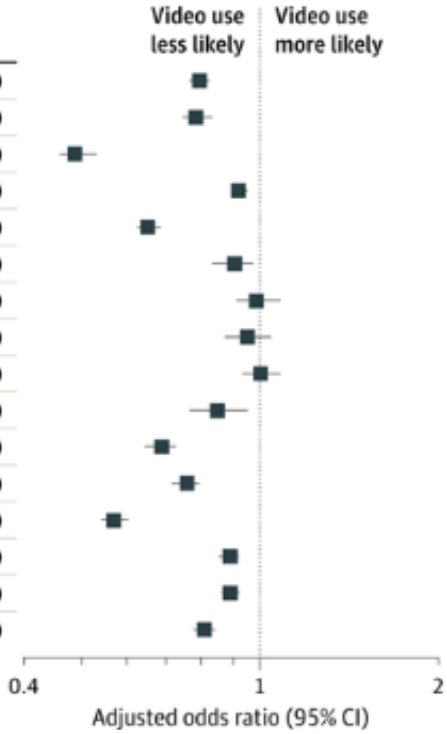
The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS & WPS support Senate Bill 393: Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services (SB 393). Ensuring patients continue to receive clinically safe and efficient care should be a priority for legislators as Maryland continues to grapple with the pandemic. Since the beginning of the pandemic, temporary flexibilities to deliver telehealth have provided continued access to care and have allowed clinics and private practices to stay open when they may have otherwise been forced to close. Furthermore, expanding coverage to telehealth has dramatically changed the way many of our doctors deliver psychiatric care. Our members have quickly adapted to telehealth and note that no-show rates have significantly decreased.

For patients who lack broadband access or video-only technology, the ability to reach patients over the telephone during the pandemic has been critical to ensuring continuity of care. A recent study found that despite the growth in telehealth this last year, lower video use was also observed among women (8% less likely), Black people (35%), Hispanics (10%), and low-income families (43% less likely for household income less than $50,000). Additionally, patients who are hesitant to see a physician face-to-face may feel more comfortable seeking care via audio-only telehealth.

The following chart shows the study's results:

Characteristic	Adjusted odds ratio (95% CI)
Aged 55-64 y vs <55 y	0.79 (0.76-0.82)
Aged 65-74 y vs <55 y	0.78 (0.74-0.83)
Aged >75 y vs <55 y	0.49 (0.46-0.53)
Female	0.92 (0.90-0.95)
Black vs White	0.65 (0.62-0.68)
Latinx vs White	0.90 (0.83-0.97)
Asian vs White	0.99 (0.91-1.08)
Other race/ethnicity vs White	0.95 (0.87-1.04)
Unknown race/ethnicity vs White	1.00 (0.93-1.08)
Non-English language	0.85 (0.76-0.95)
Medicaid vs commercial insurance	0.68 (0.64-0.72)
Medicare vs commercial insurance	0.75 (0.71-0.79)
Median household income <$50 000 vs >$100 000	0.57 (0.54-0.60)
Median household income $50 000-$100 000 vs >$100 000	0.89 (0.85-0.92)
Charlson Comorbidity Index score 1-2 vs 0	0.89 (0.86-0.92)
Charlson Comorbidity Index score ≥3 vs 0	0.80 (0.77-0.84)



We have already seen the tremendous gains in access to psychiatric care achieved by the temporary expansion of video and audio-only services, which will continue to be critical in the coming months.

MPS & WPS ask the committee for a favorable report of SB 393. If you have any questions with regards to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Joint Legislative Action Committee
of the Maryland Psychiatric Society and the Washington Psychiatric Society

CC-SB393-Telehealth.pdf
Uploaded by: Vaughan, Regan
Position: FAV

CATHOLIC CHARITIES | CHERISHING THE DIVINE WITHIN ALL

Senate Bill 393
Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services

Senate Finance Committee
January 27, 2021

Support

Catholic Charities of Baltimore strongly supports SB 393, which would improve access to behavioral health services by allowing patients to receive telehealth services from their homes, authorize audio-only telehealth, require payment for telehealth services at the same rate as in-person, reimburse for peer and paraprofessional provided telehealth services, and protect a patient's right to consent to receive services via the mode they choose.

Inspired by the gospel to love, serve and teach, Catholic Charities provides care and services to improve the lives of Marylanders in need. As the largest human service provider in Maryland working with tens of thousands of youth, individuals, and families each year, we recognize the importance of access to mental health and substance use services in a manner that best meets the clients' needs.

Each day, Catholic Charities staff interact with Marylanders facing challenges and difficulties, those challenges and difficulties have only escalated during the Pandemic. COVID-19 has laid to bare longstanding inequities in our systems, including inequitable access to behavioral health services. However, one area that has been a bright spot in an otherwise dark time is that many children, youth and adults were able to continue their therapy relationships through telehealth.

Catholic Charities provides a continuum of behavioral health services throughout Western and Central Maryland with outpatient clinics in Anne Arundel, Baltimore, Frederick, Harford and Allegany Counties, as well as, Baltimore City. We also offer school based behavioral health services in over 120 schools in the vicinity of the clinics. Prior to March of 2020, we offered limited telehealth services. Faced with a massive disruption in services due to COVID, we ramped telehealth services up to our new normal of 3,500 telehealth visits a week. Those appointments include not only therapy but also medication management and psychiatric rehabilitation program (PRP) services. Over the past 10 months, we have learned many lessons. We know that telehealth is not for everyone, but for many of our clients, telehealth has been a critical tool to reaching clients where they are. This story shared by one of our clinicians exemplifies our experience.

> Since the switch to telehealth, Jane[1] has been able to attend her appointment as scheduled. Not only does she seek therapy and medication management services, but all 3 of her children also seek several services (therapy, medication management and PRP services). By switching to telehealth, she saves money on gas, has less wear tear on her vehicle, and does not having to worry about having transportation to attend appointments in the office. Additionally, as a resident of Western Maryland Jane does not have to worry about traveling in inclement weather or having to have her children travel in various weather conditions to get to an appointment. She explained overall it is a lot less stress and "Zoom" has become part of her life. She also pointed out that it is a much smoother process to organize the family's schedule.

While no one would have recommended the abrupt switch we made from in-person services to telehealth, we now have a wealth of knowledge to gauge the appropriate usages of telehealth. SB 393 would ensure telehealth services can continue for all Marylanders after the Pandemic with the appropriate consumer protections. **On behalf of the individuals and families we work with, Catholic Charities of Baltimore appreciates your consideration, and urges the committee to issue a favorable report for Senate Bill 393.**

Submitted By: Regan K. Vaughan, Director of Advocacy

[1] The client's name was changed to protect her privacy.

Legal Action Center_SB 393 FAV 1.27.21_Ellen Weber
Uploaded by: Weber, Ellen
Position: FAV

Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services – SB 393
Senate Finance Hearing
January 27, 2021
FAVORABLE

Thank you for the opportunity to submit testimony in support of SB 393 which would make permanent the telehealth service delivery standards for mental health (MH) and substance use disorder (SUD) benefits in Medicaid and private insurance that have been available during COVID-19. Telehealth services, including audio-only service delivery, have been the lifeline for Marylanders during the pandemic. Continuation of these expanded telehealth standards in both Medicaid and private insurance will help address the skyrocketing need for MH and SUD services resulting from COVID-19 and help Maryland recover.

This testimony is submitted by the Legal Action Center, a non-profit law firm that uses legal and policy strategies to fight discrimination, build health equity and restore opportunity for people with substance use disorders, criminal records, and HIV or AIDS. The Center also leads the Maryland Parity Coalition, which issued Telehealth Recommendations in July 2020 to extend, beyond the public health emergency, the telehealth practices that Maryland Medicaid had adopted early in the pandemic to ensure access to and continuity of MH and SUD care. The Coalition's recommendations, endorsed by 36 state organizations, form the basis of SB 393 along with the extension of comparable standards to state-regulated private insurance.

SB 393 would adopt 5 essential standards to implement effective telehealth services for MH and SUD care:

- Authorize patients to receive telehealth services in their **homes or wherever they are located**.
- Authorize and require reimbursement for **audio-only/telephonic telehealth** delivered by licensed MH and SUD programs and licensed practitioners consistent with in-person service delivery.
- Require **reimbursement** for telehealth services (both audio-only and audio-visual) **at the same rate as in-person services (payment parity)**.
- Protect the **patient's right to consent** to receive services via the service delivery mode of their choice and retain current network adequacy standards that require member consent to count telehealth for satisfaction of Maryland's network adequacy metrics.
- Require health plans and Medicaid to comply with the **Mental Health Parity and Addiction Equity Act** so that authorization, utilization management, and reimbursement standards are comparable across MH, SUD, and medical/surgical services.

Other states have adopted these same standards for MH, SUD and other health services in Medicaid and private insurance on a permanent basis. We urge Maryland to build on our telehealth lessons over the past 10 months and do the same to meet the dire need for MH and SUD treatment and ensure continuity of care, post-pandemic.

I. Substance Use Disorders and Mental Health Conditions: Increased Demand for Treatment and Reliance on Telehealth Service Delivery for Care

COVID-19 has traumatized Marylanders, negatively affecting their health and creating significant economic and social hardship. Communities of color have experienced the harsh and disparate impact of COVID as well as mental health and substance use problems. Data reveal higher rates of alcohol and drug use, anxiety, and depression, overdose deaths and suicide across all populations. The need for treatment has never been greater.

- Overdose deaths from alcohol and drug use increased 12% in Maryland for the first 3 quarters of 2020 compared to 2019.
- Suicide rates among Black individuals in Maryland doubled during the initial COVID peak (March – May 2020) compared to Black suicide rates in 2017-2019, while suicide rates among whites dropped by one-half of the white suicide rate in 2017-2019 during March through July.
- Providers in Maryland's Public Behavioral Health System reported in the fall of 2020 that patients receiving MH and SUD services indicated more concerns or challenges with suicidal ideation, substance use and both housing and homelessness than in the spring of 2020 and reported ongoing and high levels of anxiety, depression and loneliness. (Univ. of Maryland Baltimore, "The Effects of COVID-19 on Individuals Receiving Behavioral Health Services and Supports in Maryland: Follow-up Survey" (Nov. 2020) at 17-18) (hereafter "BHA Survey").
    - As evidence of the need for treatment, the Behavioral Health Administration (BHA) has found that more "new" individuals were seeking MH and SUD services (p. 6, 29) and more individuals were keeping their treatment/service appointments more frequently than in spring 2020. (BHA Survey at 10, 29).
- Parents in Maryland have reported their children are experiencing increased rates of anxiety and depression over the period of mid-July to mid-December 2020: 40% of adults reported living with children experiencing anxiety and 25% reported their children experienced depression. (Annie E. Casey Foundation: Kids Count Data Center)
- Calls and online outreach to Maryland's 211 call center to connect residents with mental health resources increased by 355% in the fourth quarter of 2020 compared to 2019 and text volume increased by 425%.
- Patients who survive COVID have a significantly higher rate of being diagnosed with anxiety and mood disorders in the 3-month period following their COVID diagnosis than those with other diagnoses.

Telehealth services have been essential for the delivery of MH and SUD care to Marylanders over the past 10 months and has far exceeded the level of service delivery for other health conditions.

- Lt. Governor Rutherford has highlighted the role of telehealth in "lifting barriers" to MH and SUD services during the pandemic and has called for "**continued expansion of the use**

of telehealth to reduce barriers to service delivery…[and] in particular…the authorization of audio-only telehealth services." (Commission to Study Mental and Behavioral Health in Maryland 2020 Report at p. 3 and Recommendation 10 at 21).

- BHA's Survey has found that telehealth succeeded in delivering MH and SUD care by: (1) removing the need to travel, (2) providing easier access to treatment and (3) increasing client participation in treatment. (Report at 20, 29). Over one-third of respondents (35%) offered the unsolicited observation that telehealth has "increased patient engagement, decreased no-shows, and increased access for new clients who otherwise may not receive treatment." (BHA Survey at 26).
- In commercial insurance, the utilization of telehealth for MH care has far exceeded that for any other health condition during the pandemic. FAIRHealth data for the region in which Maryland is located (southern region) show that utilization of telehealth services for MH **jumped 30 percentage points from 12.5% of claims in Oct. 2019 to 42.8% of claims in Oct. 2020;** the second most frequently billed condition – acute respiratory conditions – accounted for only 5.3% of telehealth claims. Two of the top 5 CPT codes billed were for psychotherapy. Nationally, over 51% of telehealth claims were for MH services in October 2020.

Post-pandemic, the increased need for MH and SUD care will be long-lasting. Telehealth, if properly regulated and reimbursed, will help fill long-standing gaps in access to and availability of MH and SUD treatment in rural and medically underserved areas in Maryland. **No insurance carrier has satisfied the state's network adequacy requirements for MH and SUD services, in full, for the past 3 years.** Telehealth services, if properly reimbursed, could expand MH and SUD service to those who choose this mode of service delivery.

II. SB 393 Would Authorize Telehealth Services to Meet the Needs of Marylanders with MH and SUDs.

SB 393 would ensure that individuals in both Medicaid and private insurance gain access to effective MH and SUD services through the adoption of 5 key standards.

A. Expand Originating Sites to Include the Patient's Home or Wherever the Patient is Located

Maryland's commercial insurance standards do not limit the location at which patients must receive health services care, while state Medicaid regulations limit the "originating site" of services for most health conditions to designated health facility or other settings. COMAR §§ 10.09.49.02, 10.09.49.06. The pandemic has demonstrated the value of patients receiving care in their home or other setting in which they can have a private counseling session. This expansion has allowed patients and providers to have greater flexibility in setting appointment times, has removed the stigma associated with visiting a MH or SUD program or practitioner's office, and can reduce the "triggers" for drug use that may be associated with neighborhoods in which SUD programs are located. It has also allowed individuals who are homeless or not safe in their home to gain access to essential care at locations in which they can have confidential conversations. While many patients

with MH and SUDs benefit from and need direct interaction with peers and practitioners through in-person services, "talk therapy" is uniquely well-suited for remote service delivery, consistent with the individualized treatment plan developed by the patient and provider.

With the elimination of transportation, childcare costs, and travel time, and the ability to reduce time away from work, providers report that patients enter and engage more consistently in treatment. *See* BHA Survey at 20 and 29. Indeed, Healthcare for the Homeless found a lower rate of "no-show" appointments for patients with telehealth appointments than for those with in-clinic appointments (17.9% v. 18.5%) from April to December 2020 and, more significantly, a sharp reduction in the patient "no-show" rate for in-clinic appointments (25%) for the same period in 2019. (Data on file with Legal Action Center). Finally, providers have reported the therapeutic value of seeing patients in their home or living environment via audio-visual telehealth: it has enabled them to more effectively adjust a patient's treatment plan and, as appropriate, engage family members in family therapy. **Removal of originating site requirements in Medicaid will lower barriers to care and improve treatment participation.**

B. Authorize and Require Reimbursement of Audio-only Telehealth

Equity in access to health care delivery is not possible without coverage of and reimbursement for audio-only telehealth. Approximately 36% of Marylanders lack access to high speed internet, as defined by the Federal Communication Commission standard, according to the Maryland Task Force on Rural Internet, Broadband, Wireless and Cellular Service. (p. 6). Many other residents lack the technological literacy to use audio-visual telehealth; others cannot afford the cost of internet plans, computers and smart phones needed for audio-visual services. As noted in the BHA Survey, the greatest telehealth challenges that public health system patients have experienced are: (1) access to internet connectivity; (2) access to hardware; and (3) the ability to use telehealth technology. (BHA Survey at 21, 29). "Access to telehealth" was among the services or supports most needed by public health system patients, second only to "continuation of service." (BHA Survey at 18). While Maryland must devote resources to ensure that all Marylanders have access to audio-visual telehealth, if preferred for service delivery, patients in need of MH and SUD care cannot wait for the digital divide to be bridged. **For this reason, the Lt. Governor's Mental and Behavioral Health Commission has recommended the permanent authorization of audio-only telehealth for behavioral health care.**

Apart from digital access barriers, audio-only telehealth also meets the therapeutic needs more effectively for some patients. Individuals with eating disorders and other mental health conditions are often more comfortable and willing to get care when they do not need to look at themselves – or their provider – on a screen. Providers who use audio-visual telehealth often have patients look away from their screens, as needed, to enable them to work on sensitive issues. MH and SUD providers who have relied on audio-only telehealth during the pandemic have observed that the care delivered through audio-only and audio-visual telehealth is the same. Practitioners have needed to develop different skills and strategies to deliver effective care, but the "talk therapy" is the same service.

Audio-only telehealth is an effective mode of service delivery for many individuals with MH and SUD conditions because the treatment relies primarily on verbal communication and support. Post-

pandemic, patients and providers will determine the appropriate service delivery mix on an individual basis, and audio-only telehealth will be an important option for some. Accordingly, **after 10 months of care delivery through audio-only telehealth, the failure to authorize coverage and reimbursement of this service delivery tool would disrupt care for countless Marylanders and re-erect barriers to care.** As described below, 7 states authorize audio-only telehealth for Medicaid and 6 states authorize this delivery mode in private insurance on a permanent basis.

C. Require Payment Parity for MH and SUD Care in Both Medicaid and Private Insurance.

Pre-pandemic, Maryland Medicaid reimbursed audio-visual telehealth for MH and SUD treatment at the same rates as in-person visits, because it considers audio-visual telehealth service to be the same service as an in-person visit. During the pandemic, Maryland Medicaid has also reimbursed audio-only visits at the same rate as an in-person visit. For private insurance, no statute establishes a statutory standard for reimbursement of telehealth services, and private carriers have continued to have discretion in telehealth reimbursement during the pandemic.

SB 393 would require payment parity across all service delivery modes – audio-only telehealth, audio-visual telehealth and in-person services – for both Medicaid and private insurance. This standard will ensure that practitioners are paid fully for the services they deliver and have the resources and financial incentive to continue to deliver or invest in both audio-only and audio-visual telehealth. The cost of care delivery for MH and SUD programs and practitioners is the same regardless of the service delivery mode: the key costs points are personnel, fixed-site buildings, telehealth and communications technologies, none of which change when a practitioner delivers an audio-only or audio-visual telehealth service. Permitting lower reimbursement rates that do not cover the full cost of delivering care via audio-only telehealth will make it impossible for MH and SUD practitioners to offer that service and will preclude them from investing in the therapeutic innovation and technology that would make service delivery most effective for their patients.

Payment parity is essential to ensure continuity of care post-pandemic and ensure equity for those who cannot access or afford audio-visual telehealth. As noted below, most states authorize payment parity in Medicaid, 7 of which require payment parity for audio-only as well as audio-visual on a permanent basis. Fifteen (15) states require payment parity in private insurance, 5 of which also include audio-only at payment parity on a permanent basis.

Concerns have been raised that services delivered via audio-only telehealth may be billed inappropriately. While neither carriers nor Maryland Medicaid has offered support for that concern (and data from Optum on telehealth billing/reimbursement during the pandemic do not appear to be available), billing standards and audit practices should address these concerns. Providers are required to deliver services consistent with state regulatory standards that establish the length and intensity of services, and they must deliver and document services consistent with billing codes to submit and receive reimbursement. The same service codes and standards exist regardless of the service delivery mode, and carriers and Medicaid have the same audit authority for audio-only telehealth as other service delivery modes. Finally, programs have implemented effective

identification verification practices to verify patient identity for audio-only communications. **No evidence exists that payment parity for audio-only services will generate fraudulent billing**.

D. Ensure Patient Choice for Service Delivery Mode and Retain Existing Network Adequacy Standards that Require Patient Consent to Count Telehealth Services for Satisfaction of Network Adequacy Metrics.

Use of telehealth services during the pandemic has confirmed that individual patient/client choice is essential to ensure the most effective service delivery. BHA's Survey identifies among the telehealth successes that nearly half (47%) of respondents reported "individuals' [patient] satisfaction with telehealth." On the other hand, more than one in four respondents reported "discomfort using telehealth," "lack of privacy," and "difficulty of engaging clients" (both adults and children). (BHA Report at 20-21). One-third of respondents identified the reason clients are leaving treatment is client inability to use telehealth and client unwillingness to use telehealth. (BHA Report at 15). **Post-pandemic, patients and providers will choose the most effective service delivery model based on the individual's circumstances, and they – not carriers – should have full control over that choice.** SB 393 will protect a patient's right to choose their service delivery and not allow a carrier to require a member to use telehealth services in lieu of in-person care.

Patient willingness to use telehealth services is also needed to translate the promise of expanded access into reality. Telehealth expansion has improved access to MH and SUD care during the pandemic for those who reside in underserved communities with, for example, a limited number of psychiatrists or other practitioners who treat children, adolescents and patients with specific MH conditions. However, **such expansion will not amount to actual treatment if a patient does not wish to use telehealth.** For this reason, Maryland's network adequacy standards authorize carriers to use a telehealth appointment so satisfy their network adequacy obligations **only if the patient consents** to telehealth services. COMAR § 31.10.44.06(B). We believe this is the correct standard and should not be revised to allow carriers to count telehealth services without the patient's consent, as proposed by the Maryland Insurance Administration (MIA) in its network adequacy regulatory revision process.

In our view, many telehealth coverage and reimbursement issues for private insurance must be resolved in this and future legislative processes before an assessment of whether this network adequacy standard should be revised. For example, absent the adoption of audio-only coverage and payment parity on a permanent basis, the availability of telehealth services for many would be drastically reduced. Second, little public data exist on the covered health benefits for which, and the geographical areas in which, carriers would deliver telehealth. **No carrier other than CareFirst has reported using telehealth services to satisfy appointment wait time metrics in the 3 years preceding the pandemic, even though state law permits telehealth to be used in this way.** While carriers have certainly increased telehealth service delivery during the pandemic (at varying rates), the public has not seen data on the level of services by health condition, patient demographics, or geographical region.

A full understanding of the cause of network deficiencies for MH and SUD services is also required before removing member consent as a condition of network adequacy satisfaction. **No**

carrier has satisfied Maryland's network adequacy metrics for MH and SUD service in full for any of the 3 reporting years, and carriers have failed consistently to inform the MIA of their efforts to contract with providers, which is essential to identify the source of network deficiencies. To the extent gaps exist because of low reimbursement rates or credentialing barriers, the expansion of telehealth at a similarly low reimbursement rate will not result in increased services on the ground. **Consumers will lose important rights under Maryland law, Ins. § 15-830, to receive services from a non-network provider when the network is not sufficient, if carriers can represent that an in-network telehealth service is available, notwithstanding a patient's discomfort or unwillingness to use telehealth care.** Thus, a full understanding of the source of network gaps is essential before a revision to the current regulatory standard that allows carriers to count telehealth services **only if** the patient consents.

Importantly, Massachusetts has considered this precise issue in the context of its telehealth expansion. The state has adopted a provision stating that Medicaid plans and commercial insurance plans "shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request." Mass. Gen. Law ch. 118E § 79(b); Mass Gen. Law ch. 175 § 47MM(b) (2020). **SB 393 would preserve the patient's right to access appropriate in-person or telehealth services for MH and SUD treatment under the State's current network adequacy standard.**

E. Require Private Health Plans and Medicaid to Comply with the Mental Health Parity and Addiction Equity Act.

Standards related to reimbursement, utilization management – including prior authorization requirements – and any other requirement that could limit access to telehealth services for MH and SUD benefits are subject to the Mental Health Parity and Addiction Equity Act (Parity Act). The MIA has identified violations of the Parity Act by state-regulated health plans in reimbursement rate setting and credentialing, and Maryland Medicaid regulations currently require prior authorization for MH and SUD telehealth services (COMAR § 10.09.49.09(E)(4)), while not imposing this same standard for somatic care. Telehealth standards for MH and SUD benefits must be comparable to and imposed no more stringently on MH and SUD benefits than on medical/surgical benefits. SB 393 will ensure that private plans and Medicaid assess telehealth standards for compliance with the Parity Act to prevent discriminatory coverage policies.

III. State Adoption of Audio-Only Telehealth and Payment Parity Standards

Like Maryland, many state legislatures are examining telehealth delivery standards to ensure the continuation of service delivery post-pandemic. An examination of state standards for audio-only and payment parity requirements in Medicaid and private insurance, both pre-pandemic and in response to expanded service delivery during the pandemic, (Attachment 1) reveals important trends:

- 3 states – Colorado, Massachusetts, and New Hampshire – have enacted legislation that requires coverage of audio-only telehealth and payment parity for telehealth services in both Medicaid and private insurance.

- 3 states – New York, Ohio, and Oregon – and the District of Columbia require coverage of audio-only telehealth and payment parity in Medicaid alone.
- 2 states – Delaware and Georgia – require coverage of audio-only telehealth and payment parity in private insurance alone, and the District of Columbia requires coverage of audio-only (and does not address payment parity).
- Most states require payment parity in Medicaid for telehealth, as defined by those states.
- 10 states – Arkansas, California, Hawaii, Minnesota, New Jersey, New Mexico, North Dakota, Vermont, Virginia, and Washington – require payment parity in private insurance for telehealth, as defined by those states.

Massachusetts is unique insofar as it authorizes payment parity for **MH and SUD benefits delivery** via telehealth on a permanent basis in both Medicaid and private insurance (including audio-only) while limiting payment parity for other health care conditions to 2 years.

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The expansion of telehealth services is an important tool to improve access to MH and SUD care to the extent patients and providers agree that it is an appropriate service delivery mode. **We urge a favorable report on SB393 to ensure appropriate standards for the implementation of telehealth service delivery of MH and SUD care in Maryland on a permanent basis.**

Thank you for considering our views.

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ATTACHMENT 1

Legal Action Center: State Survey Telehealth Standards: Audio-Only and Payment Parity

States	Medicaid		Private Insurance	
	Audio-Only	**Payment Parity[1]**	**Audio-Only**	**Payment Parity**
Alabama				
Alaska		Yes[2]		
Arizona				
Arkansas		Yes[3]		Yes[4]
California		Yes[5]		Yes[6]
Colorado	Yes[7]	Yes[8]	Yes[9]	Yes[10]
Connecticut				
Delaware		Yes[11]	Yes[12]	Yes[13]
District of Columbia	Yes[14]	Yes[15]	Yes[16]	
Florida				
Georgia			Yes[17]	Yes[18]
Hawaii		Yes[19]		Yes[20]
Idaho		Yes[21]		
Illinois				
Indiana		Yes[22]		
Iowa		Yes[23]		
Kansas		Yes[24]		
Kentucky		Yes[25]		
Louisiana		Yes[26]		
Maine		Yes[27]		
Maryland		Yes[28]		
Massachusetts[29]	Yes[30]	Behavioral Health permanently and other services for 2 years[31]	Yes[32]	Behavioral Health permanently and other services for 2 years[33]
Michigan		Yes[34]		
Minnesota		Yes[35]		Yes[36]
Mississippi		Yes[37]		
Missouri		Yes[38]		
Montana				
Nebraska		Yes[39]		
Nevada		Yes[40]		
New Hampshire	Yes[41]	Yes[42]	Yes[43]	Yes[44]
New Jersey		Yes[45]		Yes[46]
New Mexico		Yes[47]		Yes[48]
New York	Yes[49]	Yes[50]		
North Carolina		Yes[51]		

North Dakota				Yes[52]
Ohio	Yes[53]	Yes[54]		
Oklahoma				
Oregon	Yes[55]	Yes[56]		
Pennsylvania				
Rhode Island				
South Carolina		Yes[57]		
South Dakota		Yes[58]		
Tennessee		Yes[59]		
Texas		Yes[60]		
Utah		Yes[61]		
Vermont		Yes[62]		Yes[63]
Virginia				Yes[64]
Washington		Yes[65]		Yes[66]
West Virginia				
Wisconsin		Yes[67]		
Wyoming		Yes[68]		

[1] This chart cites to Medicaid statutes, regulations, manuals, or websites that explicitly require payment parity for telehealth. Federal Medicaid regulators (Centers for Medicaid and Medicare Services) view telehealth as a mode of service delivery, rather than a separate service, and do not require States "to submit a (separate) SPA [State Plan Amendment] for coverage or reimbursement of telemedicine services, if they decide to reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations." Telemedicine, Medicaid.gov, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html. No such State Plan Amendments were found in this review. Therefore, it is likely that more, if not all, state Medicaid programs reimburse telehealth services at the same rate as in-person services.

[2] Alaska Dep't. of Health & Social Services, Division of Public Health, Telehealth in Alaska & Telemedicine, http://dhss.alaska.gov/dph/HealthPlanning/Pages/telehealth/default.aspx.

[3] Ark. Code §§ 23-79-1602(a)(2), 23-79-1602(d)(2).

[4] Ark. Code § 23-79-1602(d)(2).

[5] Cal. Dep't. of Health Care Services, Telehealth Frequently Asked Questions (Sept. 23, 2020), https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx.

[6] Cal. Ins. Code § 10123.855(a)(1).

[7] Colo. Rev. Stat § 25.5-5-320(1).

[8] Colo. Rev. Stat. § 25.5-5-320(1) – (2.5).

[9] Colo. Rev. Stat. § 10-16-123(4)(e).

[10] Colo. Rev. Stat § 10-16-123(2)(b)(I).

[11] Del. Health & Social Services, Division of Medicaid & Medical Assistance, Delaware Medical Assistance Program, Practitioner Provider Specific Policy Manual § 16.4.1.5 (Aug. 2019)

https://www.matrc.org/wp-content/uploads/2019/08/DE-Provider-Manual.pdf?9b3fb7&9b3fb7.
[12] Del. Code §§ 3370(a)(4), 3571R(a)(4).
[13] Del. Code §§ 3370(e), 3571R(e).
[14] D.C. Fiscal year 2021 Budget Support Act of 2020, Telehealth Reimbursement Amendment Act of 2020, Sec. 5042 (Oct. 1, 2020), https://lims.dccouncil.us/downloads/LIMS/45028/Meeting4/Enrollment/B23-0760-Enrollment17.pdf.
[15] D.C. Code § 31-3863.
[16] D.C. Fiscal year 2021 Budget Support Act of 2020, Telehealth Reimbursement Amendment Act of 2020, Sec. 5042 (Oct. 1, 2020).
[17] Off. Code of Ga. Ann. § 33-24-56.4(b)(6).
[18] Off. Code of Ga. Ann. § 33-24-56.4(f).
[19] Haw. Rev. Stat. § 346-59.1(b).
[20] Haw. Rev. Stat. § 431:10A-116.3(c).
[21] *See* CMS, State Medicaid & CHIP Telehealth Toolkit, Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version: Supplement #1 61 (Oct. 14, 2020), https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.
[22] Ind. Health Coverage Programs, Provider Reference Module, Telemedicine and Telehealth Services 10 (Feb. 6, 2020, https://www.in.gov/medicaid/files/telemedicine%20and%20telehealth%20services.pdf.
[23] Iowa Admin. Code § 441.78.55.
[24] Kan. Dep't. of Health & Environment, Division of Health Care Finance, Kansas Medical Assistance Program, Fee-for-Service Provider Manual 33 (Jan. 2020), https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Gen%20benefits_19203_19079.pdf.
[25] Ky. Rev. Stat. § 205.5591(5).
[26] La. Dep't. of Health, Professional Services Provider Manual, Chapter Five of the Medicaid Services Manual 153 (Nov. 6, 2020), https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf.
[27] MaineCare Benefits Manual, 10-144 ch. 101 § 4.07-1(A) (June 15, 2020), https://www.maine.gov/sos/cec/rules/10/ch101.htm.
[28] Md. Health Care Commission, Reimbursement for Telehealth Services (Mar. 2019), https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Telehealth_Reimbursement_Flyer_20200330.pdf.
[29] Massachusetts also includes requirements that Medicaid plans and commercial insurance plans "shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request." Mass. Gen. Law ch. 118E § 79(b); Mass Gen. Law ch. 175 § 47MM(b) (2020), https://malegislature.gov/Bills/191/S2984.
[30] Mass. Gen. Law ch. 118E § 79(a) – (b) (2020).
[31] Mass. Gen. Law ch. 118E § 79(g) (behavioral health services); Mass. Ch. 260 of the Acts of 2020 § 68 (all other services, but only for two years), https://malegislature.gov/Bills/191/S2984.
[32] Mass Gen. Law ch. 175 § 47MM(a) – (b) (2020).

[33] Mass. Gen. Law ch. 175 § 47MM(g) (behavioral health services), Mass. Ch. 260 of the Acts of 2020 § 68 (all other services, but only for two years), https://malegislature.gov/Bills/191/S2984.
[34] Mich. Medicaid Provider Manual, § 6.22.A, http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.
[35] Minn. Stat. § 256B.0624(3b)(a).
[36] Minn. Stat. § 62A.672(b)(3).
[37] Miss. Admin. Code tit. 23 part 225 ch. 1, Rule 1.5(B) (Aug. 1, 2020), https://www.sos.ms.gov/adminsearch/ACCode/00000608c.pdf.
[38] Mo. Rev. Stat. § 208.670(2).
[39] Neb. Rev. Stat. § 71-8506(1) – (2).
[40] Nev. Rev. Stat. § 422.2721(1),
[41] N.H. RSA 167:4-d, III(e) (2020).
[42] N.H. RSA 167:4-d, III(b) (2020).
[43] N.H. RSA 415-J:2, III (2020).
[44] N.H. RSA 415-J:3, III (2020).
[45] N.J. Rev. Stat. § 30:4D-6k(7)(a).
[46] N.J. Rev. Stat. § 26:2S-29(a).
[47] N.M. Admin. Code § 8.310.2.12(M).
[48] N.M. Stat. Ann. § 59A-22-49.3(I) (2019).
[49] N.Y. Pub. Health Art. 29-G § 2999-CC(4) (2020), https://legislation.nysenate.gov/pdf/bills/2019/S8416.
[50] N.Y. Pub. Health Art. 29-G § 2999-DD(1). However, reimbursement of audio-only telehealth is contingent upon federal financial participation. *Id.*
[51] N.C. Division of Medical Assistance, Medicaid and Health Choice Clinical Coverage Policy No. 1H, Telemedicine and Telepsychiatry 15 (Jan. 1, 2018), https://files.nc.gov/ncdma/documents/files/1-H.pdf.
[52] N.D. Century Code § 26.1-36-09.15(3).
[53] Ohio Admin. Code § 5160-1-18(A)(3)(b)(i) (2020).
[54] Ohio Admin. Code §§ 5160-1-18(E)(4), (8).
[55] Or. Admin. Rule § 410-120-1990(1)(b) (effective Jan. 1, 2021), as amended by DMAP 64-2020, available for download at https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=275177.
[56] Or. Admin. Rule § 410-120-1990(6)(b) (effective Jan. 1, 2021), as amended by DMAP 64-2020.
[57] S.C. Department of Health and Human Services, Physicians Services Provider Manual 215 (July 1, 2020), https://provider.scdhhs.gov/internet/pdf/manuals/Physicians/Manual.pdf.
[58] S.D Medicaid, Billing and Policy Manual, Telemedicine Services 12 (Jan. 2021), https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Telemedicine.pdf.
[59] Tenn. Code Ann. § 56-7-1002(f).
[60] Tex. Code tit. 4 § 531.0217(d).
[61] Utah Code § 26-18-13.5(3).
[62] 8 Vt. Stat. Ann. § 4100k(a)(2)(A), 4100k(i)(2).
[63] 8 Vt. Stat. Ann. § 4100k(a)(2)(A).
[64] Va. Code § 38.2-3418.16(D).

[65] Rev. Code Wash. § 74.09.325(1)(b)(i); Washington Apple Health (Medicaid), Physician-Related Services/Health Care Professional Services Billing Guide 88 (Feb. 1, 2020), https://www.hca.wa.gov/assets/billers-and-providers/physician-related-servs-bg-20200201.pdf.
[66] Rev. Code Wash. § 48.43.735(1)(b)(i) (2020).
[67] Wis. Stat. 49.45(61)(e)(1).
[68] Wyo. Dep't. of Health, Division of Healthcare Financing, "CMS 1500 ICD-10" 121 (Jan. 1, 2018), https://wymedicaid.portal.conduent.com/manuals/Manual_CMS1500_1_1_18.pdf.

MADC Support for SB 393.pdf
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Position: FAV

Senate Finance Committee
January 27, 2021

Senate Bill 393
Maryland Medical Assistance – Coverage & Reimbursement of Telehealth Services

Support

Maryland Addiction Directors Council (MADC) supports Senate Bill 393 to expand coverage for telehealth services under Maryland Medicaid. MADC advocates for SUD and dual recovery providers across the State including agencies providing over 1,000 residential beds in Maryland.

With the Covid pandemic and the State of Emergency in March 2020, MADC providers implemented telehealth treatment. Group treatment, individual treatment and case management was delivered using telehealth. Group and individual sessions for all ASAM levels of care continued to be delivered under COMAR regulations. The State of Maryland sets all the regulations for who can deliver the service, how many minutes the service must last to be billable, what content can be included in the treatment and the clinical documentation (note writing) that must occur.

While the State of Maryland temporarily reduced some of the weekly hours required for more intensive treatment during the State of Emergency, other COMAR regulations remain in effect for billable services. An example of Maryland service reductions is as follows:

- high intensity residential treatment (ASAM 3.5) is usually 36 hours of treatment services per week. The State temporarily reduced these weekly treatment hours from 36 hours to 28 hours per week in recognition of the difficulties Covid presented for treatment delivery. Post pandemic, MADC would not advocate for reduced services to continue, but instead require delivery of the normal 36 service delivery hours per week.

For outpatient services many patients do not have access to chrome books or other equipment that is needed for audio-visual services. Their cell phones are not able to provide audio-visual services. Providers use audio-only for these patients. Telehealth/audio only sessions have the same requirements as face-to-face treatment services. Both must be pre-authorized by Medicaid. This means the client must meet ASAM clinical criteria. Face-to-face services and telehealth/audio-only have the same requirements for treatment delivery including

length of service, who can deliver the service and the content of the service in order to be billable.

In June 2020 MADC surveyed 400 clients using telehealth across the State in residential and outpatient treatment. Over 80 % expressed satisfaction with individual and group sessions delivered by virtual telehealth and audio only services. Telehealth is a tool that has made treatment access easier for clients. It opens access flexibly to patients and we believe has increased client engagement in outpatient services. Our goal is to augment services for clients while maintaining quality.

The costs are the same for all service delivery methods. The overwhelming cost component of care is personnel. Overwhelmingly, clinicians and counselors are engaged in services via telehealth for the same length of session as face-to-face treatment. COMAR regulations requiring pre-authorization, who can deliver the service, length of service, service content and documentation, broadly quality of care standards under COMAR do not change for telehealth services.

For patients in residential care, while high-intensity SUD residential treatment (3.5) services have a temporary reduction in weekly hours due to Covid, clients must receive care in a licensed residential facility (not their home) as per COMAR. The residential facility is providing telehealth via agency IT equipment in the residential unit. Hence programs have the same costs for the residential setting regardless of how the therapeutic services are delivered.

Much of SUD and outpatient mental health treatment is structured into a fee for service or bundled daily billing rate. Requirements for pre-authorization for Medicaid services do not change. This means there is a clear COMAR definition for the length of the service, who can deliver the service and what quality standards and content must be included in the services. Bundled daily rates in SUD tightly restrict additional Medicaid billing while fee for service billing must meet COMAR standards. Telehealth does not change or open up new/different billing or amend existing COMAR billing requirements in SUD.

MADC supports SB 393 to make permanent the telehealth expansion. COMAR regulations remain the same for these services while clients receive quality care.

Sincerely,

Kim Wireman

Kim Wireman, LCSW-C, LCADC
Board Member

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Senate Finance Committee
January 27, 2021

Senate Bill 393
Maryland Medical Assistance – Coverage & Reimbursement of Telehealth Services

Support

Powell Recovery Center, Inc. supports Senate Bill 393 to expand coverage for telehealth services under Maryland Medicaid. Powell has provided life-saving addiction and dual recovery treatment since 1994 in Baltimore City. All Powell clients are in the public health system with Medicaid or uninsured funding. Approximately 85% of Powell clients present seeking treatment for fentanyl dependence.

With the Covid pandemic and the State of Emergency in March 2020, Powell implemented telehealth treatment. HIPAA compliant technology along with 54" TV sets (already in the units), Chromebooks and tablets were supplied to each residential unit. Group treatment, individual treatment and case management was delivered using telehealth. Initially the clinicians and counselors were located at Powell's treatment campus and provided telehealth from this location. With the increasing severity of the pandemic, the clinicians and counselors were provided with Chromebooks and deliver telehealth from their home. From April 2020 when telehealth was implemented, virtual weekly supervision, case conferences and trainings for counselors and clinicians focused on delivering telehealth services.

Group and individual sessions for all ASAM levels of care continued to be delivered under COMAR regulations. By this I mean the State of Maryland sets all the regulations for who can deliver the service, how many minutes the service must last to be billable, what content can be included in the treatment and the clinical documentation (note writing) that must occur.

While the State of Maryland temporarily reduced some of the weekly hours required for more intensive treatment during the State of Emergency, other COMAR regulations remain in effect for billable services. An example of Maryland service reductions is as follows:

- high intensity residential treatment (ASAM 3.5) is usually 36 hours of treatment services per week. The State temporarily reduced these weekly treatment hours from 36 hours to 28 hours per week in recognition of the difficulties Covid presented for treatment delivery. Post pandemic, I would not advocate for reduced services to continue, but instead require delivery of the normal 36 service delivery hours per week.

Powell Recovery Center, Inc.
14 South Broadway
Baltimore, MD 21231
(410) 276-1773

For our outpatient services many patients do not have access to chrome books or other equipment that is needed for audio-visual services. Their cell phones are not able to provide audio-visual services. We use audio-only for these patients. Telehealth/audio only sessions have the same requirements as face-to-face treatment services. Both must be pre-authorized by Medicaid. This means the client must meet ASAM clinical criteria. Face-to-face services and telehealth/audio-only have the same requirements for treatment delivery including length of service, who can deliver the service and the content of the service in order to be billable.

In June 2020 Maryland Addiction Directors Council surveyed 400 clients using telehealth across the State in residential and outpatient treatment. Over 80 % expressed satisfaction with individual and group sessions delivered by virtual telehealth and audio only services. Telehealth is a tool that has made treatment access easier for clients. It opens access flexibly to patients and we believe has increased client engagement in outpatient services. Our goal is to augment services for clients while maintaining quality.

The costs are the same for all service delivery methods. The overwhelming cost component of care is personnel. Overwhelmingly, clinicians and counselors are engaged in services via telehealth for the same length of session as face-to-face treatment. COMAR regulations requiring pre-authorization, who can deliver the service, length of service, service content and documentation, broadly quality of care standards under COMAR do not change for telehealth services.

For patients in residential care, while high-intensity SUD residential treatment (3.5) services have a temporary reduction in weekly hours due to Covid, clients must receive care in a licensed residential facility (not their home) as per COMAR. Hence programs have the same costs for the residential setting regardless of how the therapeutic services are delivered.

Much of SUD and outpatient mental health treatment is structured into a fee for service or bundled daily billing rate. Requirements for pre-authorization for Medicaid services do not change. This means there is a clear COMAR definition for the length of the service, who can deliver the service and what quality standards and content must be included in the services. Bundled daily rates in SUD tightly restrict additional Medicaid billing while fee for service billing must meet COMAR standards. Telehealth does not change or open up new/different billing or amend existing COMAR billing requirements in SUD.

Sincerely,

Kim Wireman

Kim Wireman, LCSW-C, LCADC
President/CEO

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14 South Broadway
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Maryland Hospital Association- SB 393- Maryland Me
Uploaded by: Witten, Jennifer
Position: FAV

Maryland
Hospital Association

January 27, 2021

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Support- Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 393. As COVID-19 led many Marylanders to stay home, hospitals and doctors rushed to embrace the long-available but underused tool of telehealth—delivering health care remotely to keep both patients and providers safe. Emergency federal and state waivers freed hospitals and health systems to quickly ramp up telehealth. These services are universally supported by patients and by hospital caregivers. They recognize that beyond times of crisis telehealth broadens access to care, improves patient outcomes and satisfaction, and helps chip away at health inequities.

In particular, telehealth supports the estimated one in five Marylanders with behavioral health and substance use disorders (BH/SUD), which disproportionately affect underserved racial and ethnic communities. Hospitals occupy a unique position within the behavioral health care system, since they are often the first contact with providers for individuals with BH/SUD. In treating the whole person, hospitals address both physical and behavioral health conditions.

Telehealth helps BH/SUD patients overcome the stigma of treatment. SB 393 would remove originating site restrictions, which means patients can receive treatment—within state and federal prescribing guidelines—for these conditions in an environment where they feel safe. Additionally, the bill removes distant site restrictions, granting flexibility that improves access. When patients cannot access behavioral health services in their community due to workforce gaps, they turn to hospitals as safety nets. In many instances, their needs would be better managed at a lower level of care. Even if hospitalization is the appropriate level of care at the time, it is difficult to discharge patients without appropriate community behavioral health providers. Telehealth can alleviate some of those bottlenecks in community health services and improve treatment options for all Marylanders with BH/SUD conditions.

For these reasons, we urge a *favorable* report.

For more information, please contact:
Maansi Raswant, Vice President, Policy
Mraswant@mhaonline.org

SB393_Coble.Hopkins.SWA.pdf
Uploaded by: Coble, Annie
Position: FWA

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

SB 393
Favorable with Amendments

TO: The Honorable Delores G. Kelley, Chair
Senate Finance Committee

FROM: Annie Coble
Assistant Director, State Affairs, Johns Hopkins University and Medicine

DATE: January 27, 2021

Johns Hopkins supports with amendments **Senate Bill 393 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.** SB 393 has important provisions to ensure continued access to telehealth services including allowing reimbursement for audio-only telehealth and includes protections, prioritizing patient choice in the determination of network adequacy for carriers. However, amendments should be considered to address the redundancies to codifying language that exists in COMAR and the authority that is granted to the Maryland Insurance Administration over the managed care organizations.

Johns Hopkins has prioritized expanding the use of the telehealth for the last several years. The COVID-19 pandemic has exacerbated the need for and provided an opportunity to prove the value of telehealth. Since the beginning of the pandemic in March 2020, Johns Hopkins Medicine has completed over 700,000 telemedicine visits. Across the institution, approximately 19% of those visits (or more than 130,000 visits in the last 10 months) have been completed through audio-only or telephone modalities. Based on October data, 84% of behavioral health visits were delivered via telehealth throughout the pandemic.

While current regulations allow appointments available through telehealth to be used when calculating wait times for network adequacy standards, codifying this methodology in statute could have downstream impacts with regards to availability of face to face care. This bill does establish new important patient protections in the network adequacy calculations. As stated, telehealth is currently allowed to be considered when calculating wait times for network adequacy standards, but current rules do not consider whether the patient has the capability or desire to use telehealth. Without considering patient consent the true level of accessibility and availability of services for patients is distorted. Patient choice is an important part of delivering quality care and should not be discounted.

One provision of this bill that requires further review is the authority that is granted to the Maryland Insurance Administration over the Medicaid managed care organizations. The Maryland Department of Health currently maintains the authority and flexibility over the MCOs and this bill removes some of that flexibility. This provision should be carefully considered before approving.

Telehealth has become an essential tool in providing healthcare. Senate Bill 393 allows Marylanders to continue to access this tool in an equitable and fair way but additional considerations need to be granted to certain components for the legislation. For those reasons and more, Johns Hopkins urges a **favorable with amendments report on Senate Bill 393 Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.**

2021 MCHS SB 393 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FWA

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 393 - Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth Services**

Hearing Date: **January 27, 2021**

Position: **Support with Technical Amendment**

Maryland Community Health System (MCHS) is in strong support of *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services.* We would appreciate consideration of a technical amendment which we have described at the end of this testimony Telehealth has become an essential component of health care services provided across the spectrum of practitioners. The bill ensures the stability and sustainability of our health care system beyond the pandemic.

Consumer-Centered: "As an FQHC, we have to meet people where they are." [i]

Telehealth is transformative because it places the consumer in the center of the health care system. Consumers can choose how to engage their providers, through telehealth or in-person services, just as long as the care is clinically appropriate. Consumer engagement is reflected in falling no-show rates. For example, one of our FQHCs experienced a two-thirds reduction in no show rates in a five-month period ending in July 2021 in comparison to the prior year. When consumers keep appointments, this means they are getting the care needed to improve their health outcomes.

Senate Bill 393 Protects Consumer Access

The pandemic has accelerated the adoption of a hybrid model where providers offer both in-person and telehealth services to meet the needs of their patients. The legislation protects health care access by ensuring this model is sustainable after the public health emergency:

- **Ensuring Continuity of Care through Audio-Only Services:** As one of our providers reported, "We treat a lot of patients. If they are poor, if they are old, we may not be able to find out what's going on with them without a phone." By providing for continued reimbursement for

audio-only services, the bill supports our patients who have the fewest resources, including access to broadband and transportation;

- **Bringing Health Care to the Consumer:** Before the pandemic, there were some Medicaid restrictions on the location of the patient. Generally, patients had to be at a clinical site to receive telehealth services rather than at home. This rule is a vestige from when telehealth was primarily used for primary care providers to consult with specialists. With the pandemic, Medicaid has waived those restrictions, and the bill ensures this flexibility will continue beyond the pandemic;

- **Sustaining the Health Care System with Reasonable Rates:** FQHCs, like many providers, plan to provide both in-person and telehealth services in the future. To sustain this hybrid model, reimbursement rates for telehealth must be equitable. Providers spend the same amount of time with a patient whether the visit is in-person or telehealth. While telehealth visits do not require physical space, they involve clinical preparation for the visit as well as enhanced technological and administrative support to interact with the patient; and

- **Supporting Parity for Behavioral Health Services:** Although the federal parity law has been in place since 2008, we are still struggling to ensure coverage for behavioral health and somatic services is the same. The bill supports more accountability for compliance with federal parity requirements.

We would note that the bill's definition of telehealth for Medicaid does not include dental. Medicaid's current telehealth policies include dental services, so we would ask for a technical amendment to make this bill consistent with current policies:

On page 4 in line 31 insert "<u>, DENTAL,</u>" after "SOMATIC"

We ask for the Committee's full support of this legislation. We also note that there may be some valuable provisions on other telehealth bills, particularly SB 393, which focuses on the need to ensure parity for behavioral health services. We are committed to working with the Committee and other stakeholders as you review this bill and related telehealth legislation.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

5850 Waterloo Road, Suite 140, Columbia, Maryland 21045
410-761-8100

[i] A practitioner who serves transgender individuals at an FQHC

2021 MDAC SB 393 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FWA

Maryland Dental Action Coalition

10015 Old Columbia Road, Suite B-215
Columbia, Maryland 21046
www.mdac.us

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance - Coverage and Reimbursement of Telehealth**

Hearing Date: **January 27, 2021**

Position: **Support with Amendment**

The Maryland Dental Action Coalition (MDAC) strongly supports *Senate Bill 393 – Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth.* The bill recognizes that telehealth can improve access to all types of services. We request one technical amendment to add dental to the Medicaid definition of telehealth, as this is consistent with Medicaid's current policy:

On page 4 in line 31 insert "<u>, DENTAL,</u>" after "SOMATIC"

Since the beginning of the pandemic, the Maryland Medical Assistance Program has reimbursed for tele-dentistry using a procedure code established by the American Dental Association. Medicaid covers dental services for all enrolled children, dually eligible adults under the age of 65, and pregnant women. This summer, Medicaid is expected to add postpartum dental coverage.

Through telehealth during the pandemic, dentists have been able to provide remote consultations and then follow-up with in-person services as necessary. The pandemic will accelerate the implementation of telehealth to address access issues by:

- Connecting patients in remote areas to specialists. This is particular critical in rural areas;
- Providing emergency consults and diverting patients from emergency rooms; and
- Allowing dentist to provide consults to patients who face mobility and transportation issues.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

Optimal Oral Health for All Marylanders

SB393_BH Telehealth_SWA.pdf
Uploaded by: Taylor, Allison
Position: FWA

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

January 27, 2021

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 393 – Support with Amendments

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente supports SB 393, "Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services." However, we ask that the Committee consider some amendments, detailed below.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 775,000 members. In Maryland, we deliver care to over 450,000 members.

Kaiser Permanente has been offering telehealth services since 2013 and quickly expanded our existing and already robust virtual care services to provide thousands of video, audio, and secure email visits daily during the coronavirus pandemic. Prior to the pandemic, approximately 85 percent of our appointments were completed in person and about 15 percent were virtual. In the early months of the pandemic, the balance shifted to nearly 90 percent virtual services, and today we are providing approximately 50 percent of care through telehealth, about half through video visits and half through audio-only telephone visits. Chart 1 below shows the how the proportion of telehealth and in-person visits has shifted over time.

Incidentally, as the visit types shifted during the pandemic, member satisfaction saw its largest single quarter increase and highest overall level ever. We closely track member satisfaction, a metric that includes care experience and primary and specialty care access. Chart 2 below illustrates this increase.

Kaiser Permanente supports SB 393 overall because it removes restrictions on access to telehealth services for both Medicaid enrollees and commercial members. In particular, we

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

support the changes that remove the originating site requirement and expand the types of providers eligible to provide telehealth services in the Medicaid program. Also, while we support explicit coverage of audio-only telehealth, we do not believe the legislature should mandate specific payment levels for these services.

We ask the Committee to consider the following comments and amendments:

- **Health – General 15-103(a)(2)(xv).** Kaiser Permanente supports the changes to this section that remove the originating site requirement for all health care services in the Medicaid program.

- **Health – General 15-141.2(a)(4).** The definition of "health care provider" includes all individuals who are licensed, certified, or otherwise authorized to provide health care under the Health Occupations Article. It also includes mental health and substance use disorder programs. This definition would expand the types of providers who are able to deliver care via telehealth. KP supports this expansion.

- **Health – General 15-141.2(a)(7).** The definition of telehealth includes "audio-only delivery between a health care practitioner and patient using telecommunications technology," "store and forward communications," and "remote patient monitoring services."
    - KP supports the inclusion of audio-only in the definition. The language used to describe audio only services differs from that in SB 3/HB 123, so we would suggest alignment between the two bill.
    - KP believes that "store and forward communications" would already be covered as asynchronous interactions.

- **Insurance 15-139(a)(2).** As in the Medicaid statute, the definition of telehealth in the Insurance Article includes "audio-only delivery between a health care practitioner and patient using telecommunications technology," "store and forward communications," and "remote patient monitoring services."
    - As noted above, KP supports the inclusion of audio-only in the definition. The language used to describe audio only services differs from that in SB 3/HB 123.
    - As noted above, KP believes that "store and forward communications" would already be covered as asynchronous interactions.
    - KP generally supports the use of remote patient monitoring but does not support the inclusion of this term in the definition of telehealth in the Insurance Article and so offer the amendment below.

      On page 8, in line 29, after "**TECHNOLOGY;**" insert "**AND**"; in lines 30 and 31, after "**COMMUNICATIONS;**" strike:

      "**AND**

      (IV) REMOTE PATIENT MONITORING SERVICES".

- **Insurance 15-139(d)(1)(ii).** This subparagraph requires an entity to reimburse certain services appropriately provided through telehealth "on the same basis and at the same rate as if the health care service were delivered by the health care provider in person." Kaiser Permanente supports appropriate reimbursement levels for all services but recognizes that that might not mean parity on all services for all types of telehealth appointments when compared with in-person care. We recommend that the statute be silent on reimbursement levels, and to that end offer the amendment below.

  On page 6, in line 25, strike the colon; in line 25, strike "**(I)**" and in line 27, strike "**AND**"; strike lines 28-30 in their entirety.

- **Insurance 15-139(h)(1) and (2).** Kaiser Permanente objects to this language as it appears to interfere with the ability of a provider to determine the most appropriate venue for providing a health care service. To that end, we recommend the language be removed and offer the amendment below.

  On pages 10-11, strike beginning with the colon in line 28 on page 10 down through "**(3)**" in line 1 on page 11; in lines 4 through 7, strike "**(I)**", "**(II)**", "**(III)**", and "**(IV)**", respectively, and substitute "**(1)**", "**(2)**", "**(3)**", and "**(4)**", respectively.

- **Insurance 15-139(h).** Kaiser Permanente has been working closely with the MIA on changes to the regulations on network adequacy and believe the regulatory forum is the better space to continue that work. To that end, we recommend that this subsection be removed from the bill.

  On pages 10 and 11, strike beginning with line 28 on page 10 down through line 7 on page 11.

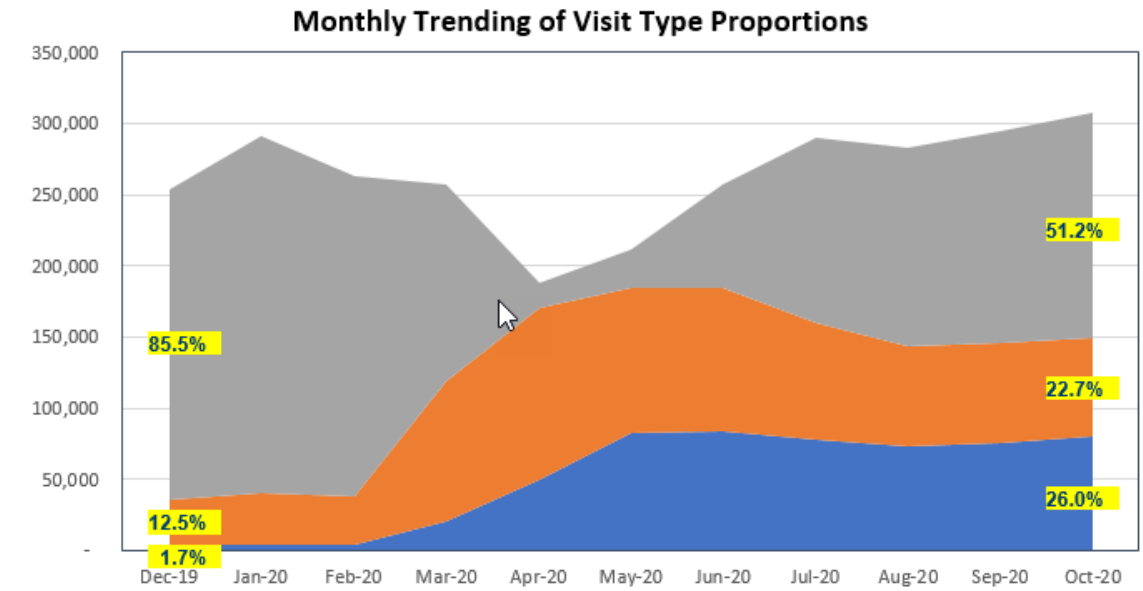
Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor

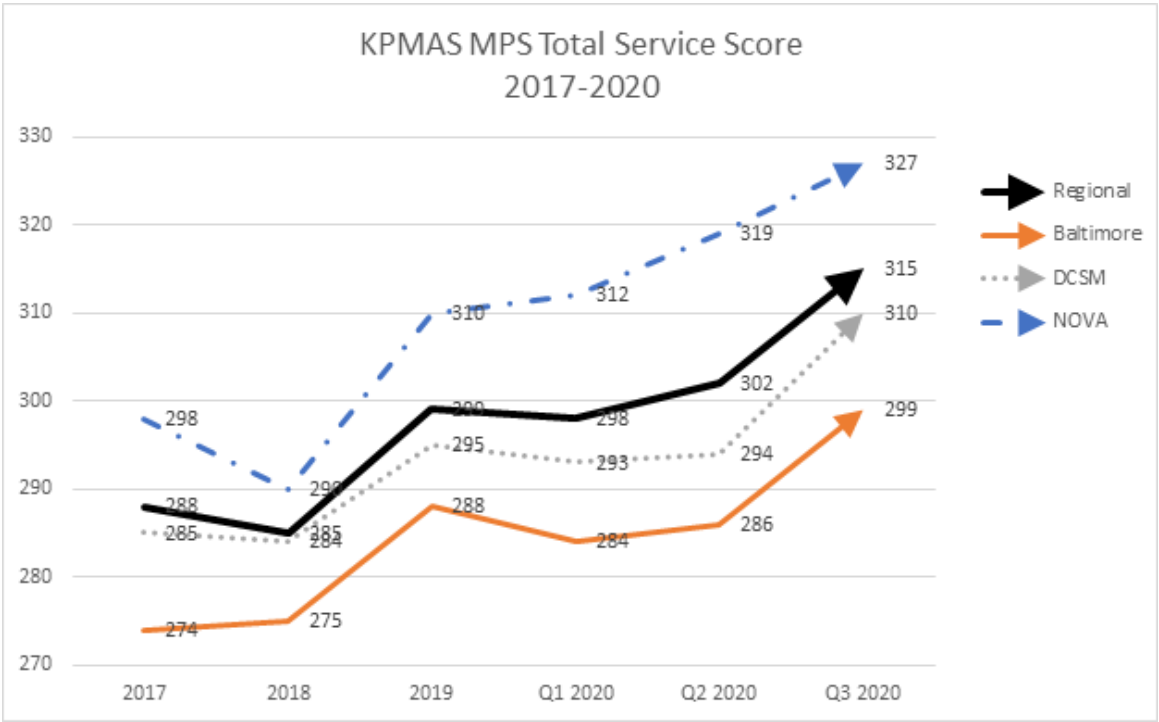
Allison Taylor, MPP JD
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

Chart 1: Volume of In-person, Video, and Audio-only Visits, Dec 2019-Oct 2020



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Office	217,945	251,108	225,016	138,456	17,256	27,244	71,875	130,534	139,124	149,854	157,406
Telephone	31,800	35,616	33,505	97,707	120,271	100,947	101,648	81,811	70,379	69,672	69,810
Video	4,258	4,614	4,635	20,920	49,937	83,157	83,272	78,207	73,229	75,697	80,005

Chart 2: Member Satisfaction, 2017-Q3 2020



SB393.UNFAVORABLE.MDRTL.LBogley.pdf
Uploaded by: Bogley, Laura
Position: UNF

Opposition Statement SB393/HB551
By Laura Bogley-Knickman, JD
Director of Legislation, Maryland Right to Life

We Strongly Oppose SB393/HB551

On behalf of our pro-life members across the state, I strongly oppose SB393 as written. While "telehealth" is a worthwhile goal for Maryland, "**teledeath**" must be expressly excluded from all telehealth policy.

As written, this bill could be used to kill not to heal. It could force Maryland taxpayers to fund the remote administration of lethal drugs that are intended to end human life, including **abortion-inducing drugs like** mifepristone (common brand name Mifeprex) and lethal drugs used in **Physician Assisted Suicide (PAS)**.

FDA guidelines maintain that the distribution and use of mifepristone, the drug commonly used in chemical abortions, must be under the supervision of a qualified healthcare provider because of the drug's potential for serious complications including, but not limited to, uterine hemorrhage, viral infections, pelvic inflammatory disease, loss of fertility and death.[1]

But the abortion industry is pressuring the FDA to remove these safety restrictions- leaving women to fend for themselves. They brazenly promote abortion inducing drugs as "DIY abortions." They want to convince women that these abortions are safe, easy, and nearly painless. They want to expand telemedicine to distribute more abortion pills, faster, so providers can dispense these drugs en masse, putting profits before patients. They even abandon women with complications to emergency rooms, refusing to deal with or even monitor the consequences of this dangerous drug.

The Maryland Medical Assistance Program and the **Maryland Children's Health Program** are two primary programs used for publicly funded reimbursements to abortion providers in Maryland. Taxpayers should not be forced to fund abortions or subsidize the billion dollar private abortion industry. A 2019 Marist poll showed that 54% of Americans oppose the use of tax dollars to pay for abortion.

Funding restrictions are constitutional

Furthermore government funding restrictions on abortion are constitutional. The Supreme Court in *Harris v. McRae (1980)*, ruled that the government may distinguish between abortion and other procedures in funding decisions -- noting that "*no other procedure involves the purposeful termination of a potential life*" -- and affirmed that *Roe v. Wade* did not create a government funding entitlement.

We respectfully recommend that you heed the FDA's existing safety restrictions on remote distribution of abortion drugs and issue an unfavorable report on this bill. Thank you.

[1] As of March 2020, the FDA reported 4,480 adverse events after women used Mifeprex/mifepristone for abortions (Mifeprex/mifepristone --- outcome: abortion/abortion induced). Among these events were 24 deaths, 1,183 hospitalizations, 339 blood transfusions, and 256 infections (including 48 "severe infections").

MMCOATelehealthPolicyRecommendationsFINAL01042021.

Uploaded by: Briemann, Jennifer

Position: INFO

BEYOND COVID-19

Telehealth Policy in Maryland's HealthChoice Program

Prepared by

Maryland Managed Care Organization Association

January 2021

MMCOA

MARYLAND MCO ASSOCIATION

Telehealth: Past, Present, and Future

The COVID-19 pandemic gave rise to a sharp increase in the number of Medicaid HealthChoice members accessing care through telehealth services. However, even before the novel coronavirus, telehealth utilization was growing. Following Governor Hogan's March 5, 2020 State of Emergency declaration, the Secretary of Health temporarily expand the definition of a telehealth originating site to include a participant's home or any other secure location as approved by the participant and the provider for purpose of delivery of Medicaid-covered services. This declaration applies to services delivered to a Medicaid member via Fee-For-Service (FFS) or through a HealthChoice Managed Care Organization (MCO). This regulatory expansion ensured that Medicaid members could access health care services in their own home or other secure location while mitigating possible exposure to COVID-19. This, along with numerous other flexibilities granted to MCOs to ensure the continued care of our members, has enabled those enrolled in the Medicaid HealthChoice program the ability to access quality care while the State of Emergency remains in effect. These expansions will remain in effect until further notice by Maryland Department of Health, but now is the time to begin thinking about what the delivery of telehealth services will look like post-COVID-19. As policymakers begin these discussions, special consideration needs to be given to the unique needs of Marylanders served by HealthChoice MCOs, including technological, transportation, geographic, and translation/linguistic concerns.

Willingness to Use Telehealth Services

In 2019, only 11% of consumers were likely to use telehealth services. In 2020, that number now stands at 76%.

McKinsey COVID-19 Consumer Survey, April 27, 2020

Barriers to Health Choice Telehealth Delivery

According to a 2019 Pew Research Center survey, only 56% of households with an income of less than $30,000/year have internet access, compared to 94% of households with an income of $100,000/year or more.

Pew Research Center, 2019

Recommendations for State Telehealth Policy

When developing and implementing policies governing the delivery of telehealth services post-COVID-19 State of Emergency, the Maryland Managed Care Organization Association (MMCOA), comprised of the nine MCOs serving the 1.5 million Marylanders enrolled in the HealthChoice Program, respectfully requests that the considerations listed below be incorporated into those policies.

- MMCOA supports the ongoing collection and analysis of clinical data as telehealth policy is developed to ensure that implemented policies result in positive health outcomes for HealthChoice members.
- MMCOA supports the elimination of "originating site" requirements, allowing reimbursement via telehealth delivery.
- MMCOA supports retaining and strengthening certain regulatory flexibilities and oversight surrounding audio-only delivery of telehealth services, provided that the delivery is clinically appropriate and that MCOs and health care providers have discretion in determining effectiveness of this modality, given the medical needs of the patient and the services delivered.
- MMCOA supports retaining certain flexibilities that allow providers to be reimbursed for telehealth services, if the services delivered are within the provider's scope of practice and that the provider maintains a current, valid, and unrestricted license.
- MMCOA supports the reinstating of technology standards that require providers to use HIPAA-compliant technology in the delivery of telehealth services, a requirement that was relaxed by the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) during the federal Public Health Emergency. To ensure patient privacy and system interoperability, resulting in safer delivery of care and better patient outcomes, delivery platforms must be HIPAA-compliant.
- MMCOA supports the Maryland Department of Health, in collaboration with MCOs and other stakeholders, to develop tools and processes by which fraud can be detected in the delivery of telehealth services.
- MMCOA supports allowing telehealth visits, as described in the policy recommendations above, to be counted as services provided to meet HEDIS requirements for health plans as currently permitted by NCQA.

MMCOA: A partner to our members, policymakers, and the State of Maryland

The Maryland MCO Association (MMCOA) is the trade association for Maryland's managed care organizations. The Association consists of nine member MCOs, and our aim is to educate Marylanders about the unique role that MCOs play in controlling costs and providing excellent health care. We do this by advocating for a more effective, integrated, and comprehensive Medicaid program to ensure access to affordable high-quality health care for all Medicaid enrollees.

Our Members

Aetna Better Health

Amerigroup Maryland, Inc.

Jai Medical Systems

Kaiser Permanente - Mid-Atlantic States

Maryland Physicians Care

MedStar Family Choice, Inc.

Priority Partners MCO, Inc.

UnitedHealthcare of the Mid-Atlantic, Inc.

University of Maryland Health Partners/CareFirst BlueCross BlueShield

Community Health Plan Maryland