SB398 - Out–of–State Health Care Practitioners – P
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John Hartline, Chair
Charlotte Davis, Executive Director

Testimony in Support of
Senate Bill 398 - Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization
Senate Education, Health, and Environmental Affairs Committee
March 03, 2022

The Rural Maryland Council supports Senate Bill 398 - Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization. This bill allows a health care practitioner who is not licensed in the State to provide behavioral health services via telehealth to a patient. The bill will allow Marylanders to have more access to behavioral health practitioners that certain parts of the State, specifically rural, are lacking. The bill will not only expand the number of behavioral health practitioners, but also allow patients who cannot travel to their offices to be able to access them virtually.

Rural Marylanders are often in worse health than that of their urban and suburban counterparts, and lack access to medical facilities and practitioners, especially specialty care such as mental health. SB-398 will allow more practitioners to provide behavioral services in the State, giving Marylanders who do not currently have access to behavioral health services the option of visiting with a practitioner from another state through telehealth. According to Mental Health America, in 2019, nearly 50 million (20 %) of adults in the U.S experienced a mental illness, and more than half of these adults go without treatment.

Allowing for more behavioral health options through telehealth will also help those who would have to travel far distances, or those who lack transportation, to have access to the services that they need for their mental health. Often in rural areas, an individual lives far away from any behavioral health practitioners, and possibly farther from the practitioner that meets their specific needs. If an individual must drive an hour to and from a practitioner's office, they are less likely to go because of the time and additional cost to get there. This leads to the individual not receiving the help they need to take care of their mental health. The Health Resources and Services Administration (HRSA) reports that more than 1.3 million Marylanders are in a mental Health Professional Shortage Areas (HPSA). That's over 1.3 million Marylanders that do not have access to the appropriate mental health care they need.

The Rural Maryland Council respectfully requests your favorable support of Senate Bill 398.

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.

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Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

March 3, 2022

The Honorable Paul G. Pinsky
Chair, Senate Education, Health, and Environmental Affairs Committee
2 West, Miller Senate Office Building
Annapolis, MD 21401

RE: SB 398 - Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization- Letter of Support

Dear Chair Pinksy and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of support on Senate Bill (SB) 398 - Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization. SB 398 authorizes a health care practitioner who is not licensed in Maryland to provide behavioral health services via telehealth to Marylanders. The practitioner will be held to the same standards of practice applicable to in-person health care settings in Maryland.

Throughout the COVID-19 pandemic, the use of telehealth services has soared, as people have increasingly turned to this method to receive care in their home. A new report from the U.S. Department of Health and Human Services found that massive increases in the use of telehealth helped maintain some health care access during the COVID-19 pandemic, with specialists like behavioral health providers seeing the highest telehealth utilization relative to other providers.[1] In 2020, telehealth visits comprised a third of total visits to behavioral health specialists, compared to 8 percent of visits to primary care providers and 3 percent of visits to other specialists. These findings prominently show an increased interest in seeking behavioral health care through telehealth.[2] The ability to provide telehealth services is directly related to the availability and number of healthcare practitioners able to provide these critical services.

SB 398 will increase access to behavioral health care services by allowing more health care practitioners to provide much needed behavioral telehealth services to Marylanders. By expanding this access to behavioral health care services, SB 398 will ensure all Marylanders can receive the care they need, in the most convenient and effective manner for them. Please also see the attached report from the Maryland Health Care Commission that provides additional information about the evolving telehealth landscape in Maryland and the nation as a whole.

[1] *New HHS Study Shows 63-Fold Increase in Medicare Telehealth Utilization During the Pandemic* https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic
[2] *Id.*

MDH is committed to increasing access to crucial behavioral health resources for all Marylanders, while reducing barriers to treatment. MDH respectfully requests a favorable report on SB 398. If you have any questions, please contact Heather Shek, Director of Governmental Affairs, at heather.shek@maryland.gov or (410) 260-3190.

Sincerely,

Dennis R. Schrader
Secretary

MARYLAND HEALTH CARE COMMISSION

Telehealth Policy Workgroup

February 2021

Andrew N. Pollack, MD, Chairman
Ben Steffen, Executive Director

MARYLAND HEALTH CARE COMMISSION

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Overview

During the global pandemic, telehealth emerged as a viable solution for prevention, diagnosis, and treatment to mitigate the spread of the Coronavirus Disease 2019 (COVID-19).[1, 2] A State of Emergency declared by Governor Larry Hogan on March 5, 2020 accelerated use of telehealth,[3] quickly moving it from the fringes to the forefront of health care delivery. Actions taken through State Executive Orders and federal waivers made telehealth adoption and use easier for health care providers (providers)[4] and consumers. These actions gave providers a mechanism to deliver safe and uninterrupted care virtually during the public health emergency (PHE).

In the fall of 2020, the Maryland Health Care Commission (MHCC) convened a *Telehealth Policy Workgroup* (workgroup) to discuss changes in telehealth policy implemented in response to the PHE. The workgroup consisted of about 70 participants representing a variety of stakeholder perspectives and interests. The workgroup discussed use of telehealth during the PHE and considered the permanence of certain expansion policies. The general opinion of the workgroup is that telehealth will remain a sought-after option to provide and receive health care post-PHE.

This report includes information about the evolving telehealth landscape in Maryland and the nation, key policy changes enacted during the PHE, and general findings from the workgroup. The information contained in this report is intended to inform stakeholders on the benefits, unintended consequences, and permanency concerns of extending policies beyond the PHE. The workgroup suggested that MHCC study the quality and cost of telehealth and its impact on access to care, alignment with new models of care, and consumer and provider satisfaction.

Telehealth Landscape

Telehealth is the delivery of health care services using electronic communications-based technologies. Technologies include real-time audio and video conferencing, the internet, store-and-forward applications (to transmit images, documents, pre-recorded messages, etc.), streaming media,[5] and wireless communications, such as mobile phones.[6] Telehealth is a convenient option for consumers to be screened and treated by a provider remotely when in-person interventions are not necessary. Services can include symptom consultations, chronic pain management, prescription refills, specialty care, and many others.[7]

Telehealth as a modality to delivering health care services has been slow to gain broad acceptance, unlike other industries, which enable consumers to manage their own digital transactions. Prior to the PHE, roughly 7 out of 10 consumers were interested in trying telehealth; use was uncommon with

[1] HIMSS, Healthcare IT News, *Telemedicine during COVID-19: Benefits, Limitations, Burdens, Adaptation*, March 2020. Available at: www.healthcareitnews.com/news/telemedicine-during-covid-19-benefits-limitations-burdens-adaptation.
[2] WebMD, *Will Telehealth Remain After COVID? Should It?* August 2020. Available at: www.webmd.com/lung/news/20200828/will-telehealth-remain-after-covid-should-it.
[3] The Office of Governor Larry Hogan, *COVID-19 Pandemic: Orders and Guidance.* Available at: governor.maryland.gov/covid-19-pandemic-orders-and-guidance/.
[4] For purposes of this report, a provider refers to a licensed individual who can perform and bill for telehealth services.
[5] Streaming media is media other than video and audio, such as live closed captioning and real-time text.
[6] Health Resources & Services Administration, *Telehealth Programs,* January 2021. Available at: www.hrsa.gov/rural-health/telehealth.
[7] The Joint Commission, *Quick Safety Issue 55: The Optimal Use of Telehealth to Deliver Safe Patient Care,* October 2020. Available at: www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-55/.

only around 1 out of 10 consumers being treated via telehealth.[8] Nationally, about 22 percent of primary care and specialty physicians had used telehealth to see patients before the PHE.[9] Just about 6 percent of consumers were aware their provider offered telehealth services.[10]

Historically, barriers inhibiting use of telehealth were largely attributed to telehealth restrictions on the location of the patient and distant site provider, technology costs and other implementation challenges, and reimbursement. An aging population, growth in chronic illness, and health and health care disparities as it relates to access, quality, and affordability are increasingly driving interest in telehealth.[11] The Centers for Medicare & Medicaid Services (CMS), some state Medicaid programs, and private payers are developing new care delivery and payment models with opportunities for telehealth, to the extent it encourages efficiencies in the system.[12] Use of telehealth in these new models is foundational to achieving better health outcomes, lower costs, and patient-centered care.[13]

Policy Changes – A Turning Point

COVID-19 created unprecedented demand for virtual care. Notably, telehealth use increased in the nation by more than 3,000 percent in 2020 compared to 2019.[14] In the span of a few weeks, providers implemented and scaled virtual care delivery to serve 50 to 175 times more patients via telehealth than they did before the PHE.[15] Consumer adoption of telehealth increased from 11 percent (in 2019) to 46 percent (by April 2020).[16] This shift is attributed to an alignment among payers in response to the PHE (and subsequent extensions), allowing changes in telehealth policies for short-term control of COVID-19. The policy changes empowered providers to quickly pivot their operations and adopt telehealth to minimize unnecessary exposure to the virus.[17]

Prior to the PHE, CMS policies were prescriptive in defining telehealth, limiting how it could be used, the settings and geographic areas where services could be delivered, and provider types that could deliver virtual care. All 50 states and Washington, D.C. provided some form of Medicaid reimbursement, and about 43 states and D.C. had laws governing private payer[18] reimbursement.[19] Coverage varied from state to state. The most commonly covered telehealth modality was real-time

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[8] Advisory Board, *10 Takeaways: Covid-19 Transformed Telehealth Overnight. What Does it Mean for the Future?* June 2020. Available at: www.advisory.com/blog/2020/06/10-covid-19-takeaways-june-11.
[9] American Well, *Telehealth Index: 2019 Physician Survey,* 2019. Available at: static.americanwell.com/app/uploads/2019/04/American-Well-Telehealth-Index-2019-Physician-Survey.pdf.
[10] Advisory Board, *Weekly Advisory: Telehealth, COVID-19, and the Watershed Moment for Digital Health*, June 2020. Available at: www.ppnhco.com/wp-content/Benefits/Advisory-Board-Telehealth-Notice-June-11-2020.pdf.
[11] Brookings, *Removing Regulatory Barriers to Telehealth Before and After COVID-19*, May 2020. Available at: www.brookings.edu/research/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/.
[12] Milliman, *Telehealth Under Alternative Payment Models*, September 2017. Available at: www.milliman.com/en/insight/telehealth-under-alternative-payment-models.
[13] Deloitte, *Realizing the Potential of Telehealth: Federal and State Policy is Evolving to Support Telehealth in Value-Based Care Models*, 2016. Available at: www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-realizing-the-potential-of-telehealth.pdf.
[14] HealthLeaders, *Telehealth Usage Rises with Increase of COVID-19 Cases,* January 2021. Available at: www.healthleadersmedia.com/innovation/telehealth-usage-rises-increase-covid-19-cases.
[15] McKinsey & Company, *Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?* May 2020. Available at: www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.
[16] *Ibid.*
[17] University of Minnesota Center for Infectious Disease Research and Policy, *COVID-19 Reveals Telehealth Barriers, Solutions*, May 2020. Available at: www.cidrap.umn.edu/news-perspective/2020/05/covid-19-reveals-telehealth-barriers-solutions.
[18] Certain laws require reimbursement be equal to in-person coverage; most laws only require parity in covered services and not reimbursement amount. Not all laws mandate reimbursement.
[19] Center for Connected Health Policy, *State Telehealth Laws & Reimbursement Policies*, 2020. Available at: www.cchpca.org/about/projects/state-telehealth-laws-and-reimbursement-policies-report.

audio and video; few states permitted audio-only. Many requirements have been relaxed or eliminated by both government[20] and private payers during the PHE. These include:

- Redefining telehealth to include audio-only telephone calls;
- Removing geographic and facility type restrictions;
- Waiving state-specific licensure provisions enabling interstate practice;
- Redefining what constitutes a treatment relationship between a provider and patient;
- Expanding eligible provider types that can deliver telehealth services;
- Allowing reimbursement for more services delivered via telehealth; and
- Reducing or eliminating cost-sharing.

The Office for Civil Rights (OCR) also relaxed certain regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including allowable technologies for the provision of telehealth services (e.g., popular non-public facing applications like Apple FaceTime and Facebook Messenger video chat).[21] When consumers lack broadband internet or an internet-enabled device, audio-only is an alternative to delivering care, as long as a provider determines that care can be provided safely.[22] Audio-only is considered by some stakeholders as an essential modality, particularly in low-income and underserved communities.[23]

Trends

Nationally, telehealth claims[24] processed by private payers in 2020 ranged between 5 and 13 percent since March, compared to less than one percent the prior year.[25, 26] Payers statewide have reported a significant increase in the volume of somatic and behavioral telehealth claims during the PHE. The surge in virtual visits helped offset an estimated 60 to 70 percent decrease of in-person office visits after declaration of the PHE.[27] Social distancing guidance issued by the Centers for Disease Control and Prevention in February 2020, as well as stay at home orders and other restrictions issued by individual states, led to use of telehealth peaking in April 2020.[28] As states began to loosen restrictions in May and throughout the summer, telehealth usage declined.[29] Payers noted an uptick in telehealth throughout the fall as the number of COVID-19 cases increased.

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[20] The Secretary of the Department of Health & Human Services declared a PHE on January 31, 2020 and later authorized waivers and modifications under Section 1135 of the Social Security Act on March 13, 2020, retroactive to March 1, 2020.
[21] U.S. Department of Health & Human Services, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, March 2020. Available at: www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.
[22] See n. 11, *Supra.*
[23] Healio News, *Audio-Only Telehealth: A 'Crucial Option' During COVID-19 Pandemic,* May 2020. Available at: www.healio.com/news/primary-care/20200520/audioonly-telehealth-a-crucial-option-during-covid19-pandemic.
[24] FAIR Health defines a claim line as an individual service or procedure listed on an insurance claim.
[25] See n. 14, *Supra.*
[26] See Appendix A for monthly summary of claim lines in 2019 and 2020.
[27] Office of the Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic*, July 2020. Available at: aspe.hhs.gov/pdf-report/medicare-beneficiary-use-telehealth.
[28] Centers for Disease Control and Prevention, *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic – United States, January-March 2020*, October 2020. Available at: www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm.
[29] See n. 14, *Supra.*

Between March and October 2020, about 25 million Medicare beneficiaries (or 39 percent) received telehealth services.[30] Medicaid and CHIP beneficiaries received more than 35 million telehealth services between March and June 2020, an increase of 2,600 percent compared to the same period in 2019.[31] The volume of virtual visits is anticipated to level off somewhere around one-tenth to one-third of total visits as states continue to gradually reopen and some payers roll back coverage for telehealth (e.g., cost-sharing).[32, 33] In the wake of COVID-19, more health care leaders will elevate telehealth as a strategic priority.[34] Over time, demand for telehealth will significantly change the way health care is obtained, delivered, and reimbursed for virtual and in-person services.[35]

In Maryland, there have been up to sixfold increases in telehealth adoption for certain provider types. Data included in the table that follows was obtained from an environmental scan of providers before and during the PHE. Findings indicate rapid adoption of telehealth as providers quickly responded to meet patient needs during the PHE peak.

Maryland Telehealth Adoption Rates
June, 2020

Provider Type	*Pre-PHE (%)*	*During PHE (%)*
Physician Practices	11	70*
Nursing Homes	9	75
Home Health Agencies	27	53
Hospitals	87	98

Note: *Anecdotal data; hospital adoption was limited to select departments (e.g., tele-ICU) and was deployed across most specialties during the PHE.

Legislative Activity

The CMS has taken action to expand telehealth coverage in its 2021 Physician Fee Schedule,[36] making coverage permanent for 66 of the 144 telehealth services temporarily added for the duration of the PHE.[37, 38] The federal government is currently considering numerous bills aimed at further expanding telehealth coverage and reimbursement post-PHE. A particularly notable bill is the

[30] Centers for Medicare & Medicaid Services, *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients*, December 2020. Available at: www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.
[31] Centers for Medicare & Medicaid Services, *Trump Administration Drives Telehealth Services in Medicaid and Medicare*, October 2020. Available at: www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicaid-and-medicare.
[32] Healthcare IT News, *'Sleeping Giant' of Telehealth Awoke in 2020, and Here's Who Rose to the Challenge*, January 2021. Available at: www.healthcareitnews.com/news/sleeping-giant-telehealth-awoke-2020-heres-who-rose-challenge.
[33] McClelland Law Firm, P.A., *Health Insurers are Rolling Back Telehealth Coverage Due to COVID-19,* December 2020. Available at: mcclellandfirm.com/health-insurers-are-rolling-back-telehealth-coverage-due-to-covid-19/.
[34] KaufmanHall, *A New Approach to Telehealth Strategy: Planning for the Pandemic and Beyond*. Available at: www.kaufmanhall.com/ideas-resources/article/new-approach-telehealth-strategy-planning-pandemic-and-beyond.
[35] *Ibid.*
[36] Centers for Medicare & Medicaid Services, *Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021,* December 2020. Available at: www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1.
[37] These additions allow beneficiaries in rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services such as certain types of emergency department visits, therapy services, and critical care services. Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home. More information is available at: www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.
[38] These services were added using, for the first time, an expedited process (established by CMS in May 2020) that does not involve rulemaking.

Permanency for Audio-Only Telehealth Act[39] that would allow CMS to reimburse Medicare providers for certain audio-only visits.[40] Coverage for audio-only services has received a great deal of attention during the PHE, in part, for providing more equitable access to health care.[41, 42]

The Maryland General Assembly is considering legislation during the 2021 session to make certain regulatory waivers permanent.[43] Other states have introduced bills to make permanent many of the policies implemented during the PHE.[44] Four states[45] have already passed legislation. Changes include expanding eligible originating sites to a patient's home and schools,[46] redefining telehealth to include audio-only visits, and removing established in-person provider-patient relationship requirements.[47]

Workgroup Approach

Providers, payers, consumers, technology vendors, and State agencies[48, 49] met five times between September 2020 and January 2021.[50] Discussions centered on six telehealth policies deemed important by the workgroup given their ongoing relevance during the PHE.[51] A qualitative approach was used to gather the opinions and experiences among workgroup participants. Over 340 observations were categorized as a benefit, unintended consequence, permanency concern, or other consideration.[52] The workgroup's analysis of the data led to the identification of notable patterns in the data, which provided a framework of common themes that were used to formulate general findings.[53] Workgroup participants were not asked to endorse the general findings.

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[39] Congress.gov, *Permanency for Audio-Only Telehealth Act*, December 2020. Available at: www.congress.gov/bill/116th-congress/house-bill/9035/text?r=2&s=1.
[40] The Act is designed to permanently remove technological and geographic restrictions that, amongst other things, have inhibited the provision of telehealth services in rural areas where a lack of adequate broadband connectivity to support audio-visual technology can be a significant impediment to the expansion of telehealth technology. More information is available at: www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.
[41] JD Supra, *Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19*, December 2020. Available at: www.jdsupra.com/legalnews/executive-summary-tracking-telehealth-77278/.
[42] Research suggests that about 80 percent of seniors have a cell phone; however, only about 42 percent have a smartphone. Of these, there is uncertainty about how many feel confident in using all the capabilities of a smartphone. More information is available at: www.pewresearch.org/internet/2017/05/17/technology-use-among-seniors/.
[43] Numerous telehealth bills are being considered by the General Assembly. More information is available at: mgaleg.maryland.gov/mgawebsite/Legislation/Index/senate.
[44] Over 200 bills are pending in legislatures. More information is available at: www.medpagetoday.com/practicemanagement/telehealth/90849.
[45] States include Colorado, New Hampshire, Ohio, and Washington. More information is available at: www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.
[46] The practice of restricting telehealth reimbursement to rural or underserved areas is decreasing. Maryland and four other states (HI, MN, NC, SD) have telehealth geographic restrictions. Some restrictions are limited to certain specialties, such as mental health in Maryland.
[47] Federation of State Medical Boards, *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, January 2021. Available at: www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.
[48] See Appendix B for a copy of the Workgroup Participants.
[49] Over 90 stakeholders were included in the distribution list.
[50] Meeting information, materials, and recordings are available on MHCC's website. More information is available at: mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_telehealth_policy.aspx.
[51] The workgroup was requested to rank twelve telehealth policies by priority via an online survey.
[52] See Appendix C for a copy of the discussion tables.
[53] Thematic analysis is a qualitative research method for identifying, organizing, and categorizing observations to facilitate the discovery of significant themes within a data set.

Limitations

Workgroup participants represented the perspectives of their stakeholder category. Views expressed by the participants were not necessarily the official position of their employer organization. Differing viewpoints provided helpful insight in interpreting the observations. Divergent perspectives and varying levels of familiarity with telehealth may have possibly influenced the findings.

General Findings

Each telehealth policy contains proposed actions to inform policy decision making beyond the PHE. Certain elements of the general findings were deemed relevant across several policies.

Policy 1. Removing telehealth restrictions on originating and distant site locations

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Standardize the definitions of originating and distant site to recognize any setting where care can be delivered based on consumer needs and preferences for telehealth services, provider clinical judgement, and guidelines on health, safety, and security

- Expanding permissible care delivery sites for telehealth services helps address care access gaps in rural, vulnerable, and underserved populations

D. Assess the flexibility and financial impact on the Medicaid program

Policy 2. Permitting audio-only when the treating provider determines it to be safe, effective, and clinically appropriate

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Support greater State and federal telecommunications infrastructure investment in less-resourced communities and health care facilities to improve and ensure equitable access and use of telehealth

D. Assess the flexibility and financial impact on the Medicaid program

Policy 3. Removing telehealth restrictions on conditions that can be treated

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Develop a consumer education strategy to improve awareness of telehealth as an option and when telehealth services are appropriate

D. Adopt uniform telehealth use policies across all health care specialties including, but not limited to, somatic, behavioral health, and rehabilitation services to improve access and coordinated care

E. Assess the flexibility and financial impact on the Medicaid program

Policy 4. Removing telehealth restrictions on provider types

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Allow licensed health care providers to treat patients using telehealth within their scope of practice based on consumer needs and preferences for telehealth services, provider clinical judgement, and existing guidelines on health, safety, and security

- Expanding provider types helps address provider shortages and timeliness of care
- Broadened access reduces hospital readmissions and emergency department utilization

D. Assess the flexibility and financial impact on the Medicaid program

Policy 5. Reducing or waiving cost sharing for telehealth services through the end of the PHE or until December 31, 2021, whichever occurs last

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based
- Federal requirements on high-deductible plans may impact flexibility to make changes
- Differing cost sharing requirements for an in-office visit versus a telehealth visit may have disproportionate effects on payers and consumers

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after PHE ends or the data analysis concludes

C. Assess the flexibility and financial impact on the Medicaid program

Policy 6. Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal PHE

General Findings

A. Allow existing OCR telehealth enforcement discretion policies to sunset at the end of the PHE without State intervention, unless otherwise addressed through other OCR actions

B. Assess the use of non-HIPAA compliant technology on privacy and security

Conclusion

The MHCC has promoted telehealth adoption over the last 10 years. Throughout this time, uptake of telehealth was slower than anticipated. Proactive policy changes by payers supported and encouraged rapid adoption of telehealth during the PHE. The need to leverage available technology to improve value and efficiency in health care should continue to drive use of telehealth once the PHE ends. The workgroup stressed the importance of making telehealth part of an integrated care

delivery system post-PHE that considers unique characteristics of practices and evolving consumer expectations.[54, 55]

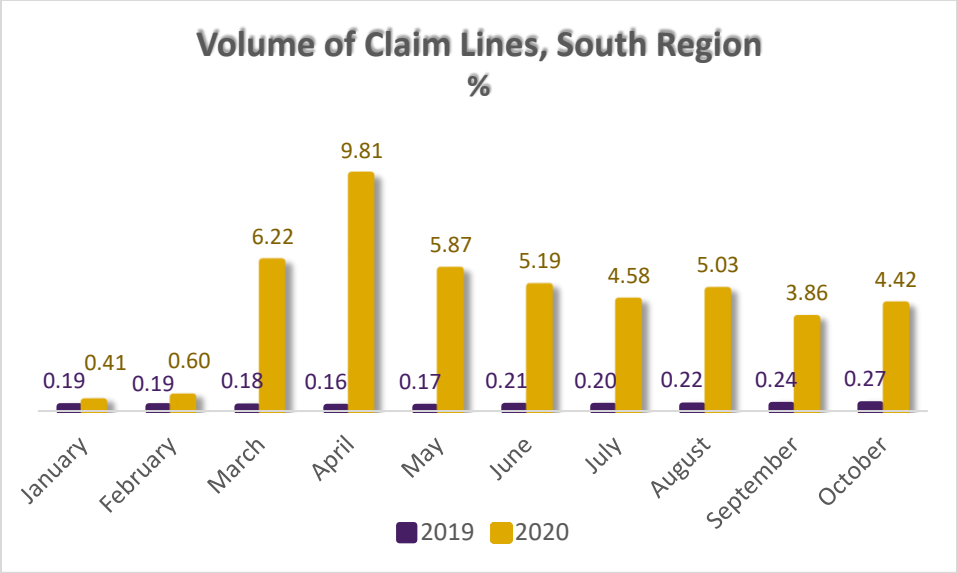
COVID-19 has been a natural experiment that will inform telehealth policy and research moving forward.[56] Important issues exist if telehealth is to expand after the PHE. Audio-only coverage and payment parity for all forms of telehealth are among the biggest areas of payer and provider disagreement. There is general agreement among the workgroup that an approach informed by data would be beneficial. The MHCC is planning to conduct an assessment of telehealth to examine value, cost, access, and quality of audio-only and video visits, and the comparative effectiveness of audio-only, video, and in-person visits.

Acknowledgements

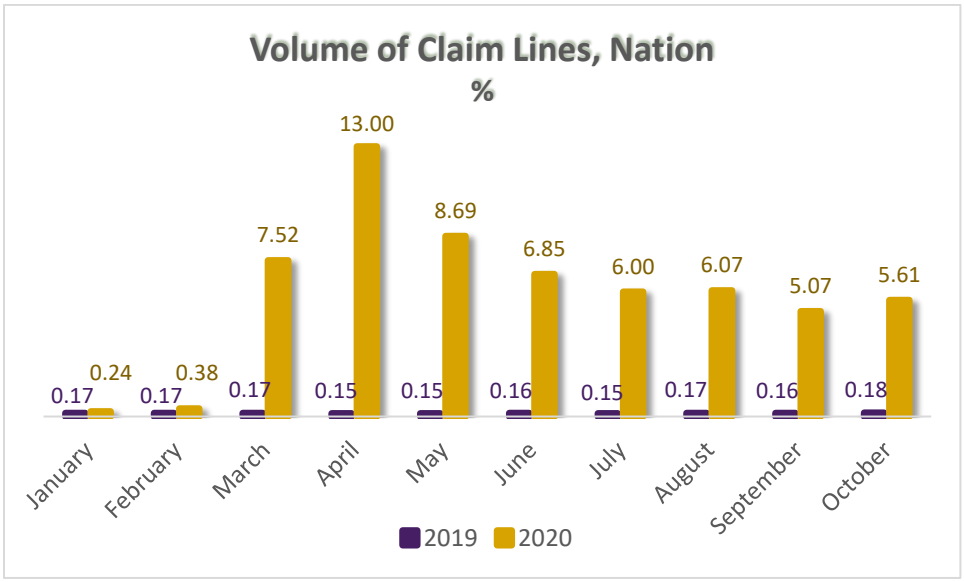
The MHCC appreciates the contributions made by workgroup participants and commends their dedication to advancing adoption and use of telehealth statewide. Stakeholders worked together laudably to meet the objectives of the workgroup.

[54] KaufmanHall, *Redesigning Care Delivery for a Post-COVID-19 World.* Available at: www.kaufmanhall.com/ideas-resources/article/redesigning-care-delivery-post-covid-world.
[55] Health Tech, *Telehealth Grew Wildly Popular Amid COVID-19. Now Visits are Plunging, Forcing Providers to Recalibrate*, September 2020. Available at: www.statnews.com/2020/09/01/telehealth-visits-decline-covid19-hospitals/.
[56] Health Affairs, *Establishing a Value-Based 'New Normal' for Telehealth*, October 2020. Available at: www.healthaffairs.org/do/10.1377/hblog20201006.638022/full/.

Appendix A. Volume of Telehealth Claims



Note: South Region includes AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV.



Source: FAIR Health Monthly Telehealth Regional Tracker

Appendix B. Workgroup Participants

Telehealth Policy Workgroup Participants *As of 01/07/21*			
#	**First Name**	**Last Name**	**Organization**
1	Vivian	Aguayo	Maryland Primary Care Program
2	Bimbola	Akintade, PhD	University of Maryland School of Nursing
3	Salliann	Alborn	Maryland Community Health System
4	Emily	Arneson	Kennedy Krieger Institute
5	Paul	Berman	Berman & Killeen, PA, Maryland Psychological Association
6	Arun	Bhandari, MD	Chesapeake Oncology Hematology Associates
7	Richard	Bloch	Maryland Podiatric Medical Association
8	Dave	Brennan	MedStar
9	Jennifer	Briemann	Maryland Managed Care Organization Association
10	Nicole	Brandt	The Peter Lamy Center on Drug Therapy and Aging
11	Alyssa	Brown	Maryland Department of Health, Office of Health Services
12	Rebecca	Canino	Johns Hopkins Medicine
13	Patrick	Carlson	Maryland Department of Legislative Services
14	Matthew	Celentano	League of Life & Health Insurers of Maryland
15	Ann	Ciekot	Public Policy Partners
16	Annie	Coble	Johns Hopkins University
17	Eric	Colchamiro	Government Affairs, Alzheimer's Association
18	Adam	Conway	Greater Baltimore Medical Center
19	David	Cooney	Maryland Insurance Administration
20	Jen	Crockett, MD	Kennedy Krieger Institute
21	Susan	D'Antoni	Montgomery County Medical Society
22	Sherry	Dai	CareFirst BlueCross BlueShield
23	Joe	Dematttos	Health Facilities Association of Maryland
24	Lori	Doyle	Community Behavioral Health Association of Maryland
25	Robyn	Elliott	Maryland Community Health System
26	Sarah	Feeny Price	Maryland Retailers Association
27	Peggy	Funk	Hospice & Palliative Care Network
28	Shannon	Gahs	Zektick
29	Donald	Goldberg	Teledoc
30	Laura	Goodman	Maryland Department of Health
31	Cathy	Grason, JD	CareFirst BlueCross BlueShield
32	Jessica	Grau	Maryland Health Benefit Exchange
33	Jim	Gutman	AARP – Maryland
34	Marina	Hardy	Taft Hardy & Associates
35	Brian	Hasselfeld, MD	Johns Hopkins Medicine
36	Ann	Horton	Maryland National Capital Homecare Association
37	Diana	Hsu	Maryland Hospital Association
38	Helen	Hughes, MD	Johns Hopkins University

#	First Name	Last Name	Organization
39	Jim	Hummer	Lorien Health Services
40	Neal	Karkhanis	League of Life & Health Insurers of Maryland
41	Elizabeth (Pam)	Kasameyer	Maryland Department of Health, Medicaid Planning
42	Niharika	Khanna, MD	University of Maryland Medical System
43	Danna	Kauffman	Shwartz, Metz and Wise, P.A.
44	John	Kornack	Amwell
45	Beverly	Lang	Nurse Practitioner Association of Maryland, Inc.
46	Christopher	Langhammer, MD	University of Maryland Medical System
47	Sonia	Lawson, PhD	Maryland Occupational Therapy Association
48	Cailey	Locklair Tolle	Maryland Retailers Association
49	Kathleen	Loughran	Amerigroup
50	Kelvin	Lucas	Maryland Department of Legislative Services
51	Daniel	Mansour, PharmD	Peter Lamy Center on Drug Therapy and Aging
52	Dan	Martin	Maryland Behavioral Health Coalition
53	Pam	Metz	Schwartz, Metz and Wise, P.A.
54	Michael	Paddy	Maryland Insurance Administration
55	Sarah	Peters	Husch Blackwell Strategies
56	Gene	Ransom	MedChi, The Maryland State Medical Society
57	Maansi	Raswant	Maryland Hospital Association
58	Sharon	Ringley	Chief of Staff for Delegate Kelly
59	Deb	Rivkin	CareFirst BlueCross BlueShield
60	Tricia	Roddy	Maryland Department of Health
61	Magaly	Rodriguez de Bittner, PharmD	University of Maryland School of Pharmacy
62	Lindsay	Rowe	Maryland Department of Legislative Services
63	Dawn	Seek	Maryland National Capital Homecare Association
64	Dan	Shattuck	Barbara Marx Brocato & Associates
65	Lisa	Simpson	Maryland Department of Legislative Services
66	Deborah	Steinberg	Maryland Parity at 10 Coalition
67	Jackie	Stone	Kennedy Krieger Institute
68	Oleg	Tarkovsky	CareFirst BlueCross BlueShield
69	Allison	Taylor	Kaiser Permanente
70	Tequila	Terry	Health Services Cost Review Commission
71	Jennifer	Thomas, PharmD	Maryland Pharmacists Association
72	Jim	Trumble, MD	Peninsula Regional Medical Center
73	Michael	Udwin, MD	CareFirst BlueCross BlueShield
74	Ellen	Weber	Maryland Parity at 10 Coalition
75	Joe	Winn	UnitedHealthcare
76	Steve	Wise	Schwartz, Metz and Wise, P.A.
77	Jennifer	Witten	Maryland Hospital Association
78	Ben	Wolff	Maryland Department of Health, Office of Health Services

Appendix C. Policy Discussion Tables

DRAFT: 010721

1: Removing telehealth restrictions on originating sites	
BENEFITS **Providers** • Expands ability to offer telehealth • Avoiding unnecessary utilization (e.g., hospital/emergency room, SNF admissions) • Reduced no-show rates • Increased opportunity to use remote patient monitoring for high-risk patients and chronic care management • Supports care coordination and transitions between care settings with more immediate follow-up • Improves access to interprofessional team care (e.g., social worker, pharmacist) and communication • Potential decreased costs associated with "brick and mortar" facilities • Increases ability to quickly respond to acute non-emergent situations • Allows timely treatment/therapy adjustments when viewing patient in their natural environment • Preservation of protective personal equipment • Ability to assess patients' home environment **Payers** • Greater access and engagement for members • Supports care delivery at the lowest cost setting and potential for reduced health care costs (e.g., Medicaid transport costs) **Consumers** • Expands access to care and flexibility in seeking services • Mostly comfortable with technology • Consumer choice/preference and comfort to receive services where they want (e.g., minimize stigma for seeking certain services) • Increases patient engagement, self-management, and satisfaction in their health care • Increases the potential for health equity • Reduces barriers to care (e.g., financial, transportation, childcare, debilitating conditions, time off work, etc.) • Promotes infection control and public safety	**UNINTENDED CONSEQUENCES** **Providers** • Potential risks to privacy and security of PHI in some circumstances • The ability to accurately diagnose • The impact on patients due to reduced regulatory oversight of providers • Potential loss of local providers/services • Concerns over increases of fraud allegations • Potential lack of comfort with technology and communicating virtually with patients **Payers** • Overutilization of health services • Potential for delivery of partial care **Consumers** • Access and communication barriers for certain populations due to age, socioeconomic status, technology literacy, vision/hearing impairments, etc. • Duplication of services, virtually and in-person • Possibility of pressure to have a telehealth visit against one's preference

PERMANENCY CONCERNS

Providers

- Uneven opportunity across providers due to technology access and infrastructure challenges (e.g., broadband internet, data)
- Addressing challenges of patient engagement in care; no clear pathway to address health literacy and digital divide issues
- Ability to adapt to rapidly changing guidelines

Payers

- Alignment across payers in defining originating site (e.g., home is anywhere) and reimbursement policies
- Impact on Total Cost of Care Model is unknown
- Need to assess metrics pertaining to quality, cost, utilization, and patient outcomes to understand impact
- Facility fee concerns

Consumers

- Infrastructure and technology challenges could impede access, particularly for underserved communities
- Ensuring comfort and appropriate use of the technology
- Need to assess patient satisfaction data to inform policy and training programs

OTHER

Providers

- Consider removing originating site restriction requiring staff to be on site to bill facility fee
- Monitor federal efforts to permit expansion of originating sites

Payers

- Consider CMS guidance and Medicare policies on originating site and payer alignment
- Monitor and analyze quality and cost data to inform policy and advance positive health outcomes

Consumers

- Need for parallel in-person and telehealth pathways
- Continued need for financial support and opportunities (e.g., grants) without geographic restrictions to improve technology infrastructure

Non-Specific

- Inclusion of telehealth training in provider education, accreditations, and certifications
- Determination of what constitutes an originating site

PRIMARY THEMES

- The need to rely on providers' clinical judgment and consumers' preferences to determine appropriateness
- Removing geographic and originating site restrictions promotes greater access to care, particularly for underserved populations
- Broader use of telehealth can assist in reducing the total cost of care
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion
- A concern that policy changes may be implemented prematurely and will require modification when sufficient data is collected and appropriately analyzed
- Gaps remain (e.g., lack of technology, digital literacy, and access to high-speed internet) that need to be addressed to close health disparities for rural, underserved, and vulnerable communities

Removing telehealth restrictions on originating sites

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
  - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Modify the definition of originating site to recognize any patient setting where care can be delivered based on consumer needs and preferences, and provider clinical judgement and guidelines on health, safety, and security
  - Expanding permissible care delivery sites for telehealth services helps address care access gaps in rural, vulnerable, and underserved populations

2: Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate	
BENEFITS **Providers** • Supports care management and continuity (e.g., chronic care management, follow ups, behavioral health, medication therapy management) • Supports care delivery during public health emergencies (e.g., COVID-19, natural disaster, etc.) • Increases ability to quickly respond to acute non-emergent situations • Expands opportunities to provide patient education • Provides an option to deliver care when audio-video connection is not accessible or feasible **Consumers** • Allows flexibility to receive services that aligns to their preferences • Greater likelihood for equitable access to care, particularly for vulnerable populations or patients with limitations (e.g., technology, broadband internet, digital literacy, unstable housing) or when other options (e.g., video visits, in-person) are not available • Ease of access, particularly for older populations and individuals with limited access to technology	**UNINTENDED CONSEQUENCES** **Providers** • Increased risk for siloed care/lack of documentation within the EHR if not integrated into care delivery workflows (e.g., video visits and in-person) • Potential for duplication of services • Increased risk for missed diagnoses and miscommunication • May impede provider adoption of video visits **Payers** • Understanding implications of services provided outside a regulated space • Potential confusion on appropriate use requirements and uneven reimbursement policy across payers, insured and self-insured business • Potential for billing of new, additional, or duplicate services • Potential increase of fraud and abuse **Consumers** • Unaware of financial liability for associated services • Potential to create inequities for patients only able to access audio-visual care • Potential risks to privacy/confidentiality of visit in certain situations (e.g., domestic violence cases) • May limit provider/consumer engagement during the visit
PERMANENCY CONCERNS **Providers** • Defining reimbursement levels for audio only services (e.g., payment parity based on provider time or technology used – audio-only; audio and video; audio, video, and RPM) • Determining services appropriate and effective for audio only • Lack of guidelines on appropriate uses and processes (e.g., verifying patient identity) resulting in greater risk of liability • Potential standard of care issues and practice workflow challenges (e.g., standardizing documentation of audio-only visit within EHRs) • Impact of prior authorization on access **Payers** • Challenging to formulate reimbursement policies (e.g., length of call, visit type, duplicity/coordination of services, who initiates call) and alignment across payers • Establishing guidelines for determining appropriate services once data from PHE is collected and analyzed • Long-term effect on care quality, cost, and outcomes unknown	**OTHER** **Providers** • Need for parity in payment with services provided by telehealth **Payers** • Consider a time-limited phase out approach to allow adequate adoption and use of telehealth by providers and consumers • Need time to conduct an impact evaluation of audio only services during the PHE on utilization, access, quality, safety, and efficacy **Consumers** • Need for policies to remain patient-centric **Non-Specific** • Use should be based on patient and provider preferences and clinical judgement • Permit audio only services due to necessity (e.g., rural facilities with lack of broadband internet) • Consider MTM comprehensive and targeted review services as reimbursement model

- Demand beyond PHE is unknown
- Determination of quality metrics

Consumers

- Educating consumers on appropriate uses
- How to address language and physical barriers (e.g., hearing and eyesight)
- Need for clarification on copayments/coverage

PRIMARY THEMES

- Provides an alternate and easily accessible modality to render care and seek treatment based on provider judgment and consumer preference
- Helps address health care inequities, especially for underserved and underrepresented populations
- Addresses challenges associated with adopting health information technology for resource-limited providers
- Variations exist in determining a method and rationale for payment parity with in-person visits
- Considering audio only as a time-limited transition service to live-visual encounters when statewide access to broadband internet and other needed technology is achieved
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Balancing expanded access to care and the potential for health, safety, and security concerns

Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
    - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Support greater State and federal telecommunications infrastructure investment in less-resourced communities and health care facilities to ensure greater access and use of telehealth
    - Many rural areas lack sufficient broadband internet to support widespread adoption of telehealth

3: Removing telehealth restrictions on conditions that can be treated	
BENEFITS **Providers** • Reduces avoidable hospital admissions and emergency department utilization • Enables remote patient monitoring (e.g., for mental health and other targeted medication adherence, chronic care management) and rapid interventions when needed • Relies on providers' clinical judgment • Holds telehealth visits to same outcome measures as in-person visits • Promotes more coordinated and interprofessional care • Allows consistency across payers **Payers** • Potentially reduces costs associated with avoidable hospital admission and emergency department utilization **Consumers** • Allows for more immediate and expanded access to care • Creates a consumer-centered system of care that accommodates patient needs and preferences (e.g., reduces travel and scheduling challenges, convenience) • Greater coordination of services, particularly if comorbidities are present • Promotes access to specialty care, especially for high-risk patients	**UNINTENDED CONSEQUENCES** **Providers** • May reduce care efficacy of certain services • Potential risks to patient safety (e.g., certain symptoms may be missed without in-person physical exam) • Lack of data to determine which conditions can be effectively treated using telehealth **Payers** • Risk of overuse, potential for duplicate services resulting in an increase in health care costs • Potential negative impact on health care quality • Possibility of additive rather than substantive services **Consumers** • Confusion could occur when treatment plan is verbal • Patient dissatisfaction with care services resulting in complaints/dissatisfaction • Confusion around benefit coverage and out-of-pocket costs
PERMANENCY CONCERNS **Providers** • Malpractice concerns due to increased liability • Lack of condition-specific telehealth processes • Re-engineering practice workflows to support the effective use for new conditions • Support needed to conduct certain services within the home **Payers** • Lack of standards around appropriateness of care • Lack of data to determine the impact on access, cost, and quality **Consumers** • Increased demand on primary care providers could hinder access/availability	**OTHER** **Providers** • Prior authorization for behavioral health services may limit access • Barriers significantly differ depending on geographical location of patients • Alignment for conditions appropriate via telehealth and payer reimbursement • Some conditions and treatments may be limited by federal laws (e.g., medication assisted treatment) • Need updated provider training (education and professional **Payers** • Compliance oversight **Consumers** **Non-specific** • Need for ongoing data collection and analysis to assess policies and ensure they support positive health outcomes • Compliance with federal anti-discrimination laws (e.g., Mental Health Parity and Addiction Equity Act, American with Disabilities Act)

PRIMARY THEMES

- Fosters timely and coordinated care and may lead to improved patient outcomes and decreased avoidable hospital admissions and emergency department utilization
- Requires consumer education to promote understanding and awareness of the role of telehealth and how to navigate the technology
- Lessening prior authorization requirements for behavior health to expand access, promote patient safety, and avoid adverse outcomes
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion

Removing telehealth restrictions on conditions that can be treated

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
  - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Educate consumers on telehealth and services that are appropriate to receive via telehealth
  - Develop a consumer education strategy to increase awareness of appropriate care that can be provided via telehealth
- Adopt uniform behavioral health telehealth use policies that improve access
  - Harmonize payer behavioral telehealth access policies to enable timely and coordinated care and improved patient outcomes

4: Removing telehealth restrictions on provider types

BENEFITS

Providers

- Supports interprofessional team care, especially if providers are in different locations
- Helps address workforce shortages and funding limitations, especially for specialists (e.g., behavioral health providers)
- Increased timeliness and continuity of care
- Provides flexibility in staffing models (e.g., use of non-licensed or certified staff)
- Allows consistency across payers

Consumers

- Increased access to a broader range of provider types
- Reduces challenges associated with scheduling and travel
- Promotes care consistency
- Greater potential to address social determinants of health
- Supports consumer choice

UNINTENDED CONSEQUENCES

Providers

- Potential impact on patient safety (e.g., certain symptoms may be missed without in-person physical exam)
- Provider avoidance of telehealth due to lack of comfort
- Ensuring adequate provider training
- Potential decline of established patient-provider relationship and continuity of care (e.g., patients see different provider for each visit)

Payers

- Over or underutilization due to the lack of treatment guidelines

Consumers

- Potential confusion on what is covered

PERMANENCY CONCERNS

Providers

- Lack of existing reimbursement for certain provider types (e.g., pharmacists, home health, etc.)
- Potential for wide-range variation in provider determination as to the appropriate service delivery method
- Level of accountability
- Equity in decision making (e.g., discretion)
- Need for coordination among care team

Payers

- Need more data on value, cost, access, and quality
- Lack of standards to determine medically appropriate provider types
- Payment constraints in setting service rates for Medicaid (e.g., lack of flexibility in lowering rate to FQHCs for telehealth services)

Consumers

- Lack of quality measure ratings available to assess provider effectiveness in virtual visits

OTHER

Providers

- Restrictions should align with scope of the license
- Consider federal and State policies related to use of compacts and implications for practicing across borders
- Trust in providers' clinical judgement

Payers

- Need a method to address quality concerns/complaints

Consumers

- Need for education on seeking care from appropriate providers

PRIMARY THEMES

- Helps address geographic barriers and workforce shortages
- Concern among payers on the potential financial impact of expanded services and a limited Medicaid budget
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Increases potential for health equity, consumer choice, and access to health professionals
- The need for provider training on virtual care delivery and consistency in guidelines

Removing telehealth restrictions on provider types

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
    - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Allow licensed health care providers to treat using telehealth within their scope of practice based on consumer preference, provider clinical judgement, and existing guidelines on health, safety, and security
    - Expanding provider types helps address provider shortages
    - Broadened access reduces hospital readmissions and emergency department utilization

5: Reducing or waiving cost sharing for telehealth services through the end of the public health emergency or until December 31, 2021, whichever occurs last

BENEFITS

Providers

- Incentivizes flexibility in providing care
- Reduces risks associated with COVID-19 positive or presumed positive patients from presenting in-person for care

Increases stability and continuity of care

Payers

- Increased timeliness of care may reduce the risk of deferred/delayed care and increased costs to the health care system

Consumers

- Addresses access to care issues
- Supports financial equity in care, especially for those whose employment has been disrupted
- Greater likelihood that consumers will seek care rather than deferring
- Decreases exposure to COVID-19 and other infectious diseases
- Promotes care continuity and management

UNINTENDED CONSEQUENCES

Providers

- Potential confusion on reimbursement and covered services resulting from variation in coverage across payers (e.g., COVID-19 related services vs. unrelated services, audio only vs. video visits)

Payers

- Potential for inappropriate utilization of telehealth
- May promote and incentivize use of telehealth over in-person visits
- Lack of clarity on which plans must comply

Consumers

- Nuances in payer policies could create confusion on final billed amount (e.g., out-of-network providers, self-insured plans)
- A risk that higher cost-sharing for in-person visits (compared to telehealth) could create inequities in care delivery

PERMANENCY CONCERNS

Providers

- Differing reimbursement structure than in-person visits
- Financial impact on providers due to lost revenue
- Abrupt discontinuation of telehealth when financial benefit stops

Payers

- Potential for overutilization of services and duplicative services
- Funding – Medicaid

Consumers

- Risk that quality of care will be negatively impacted as the volume of virtual care increases system wide

OTHER

Providers

- Consider comparable or commensurate compensation to in-person visits

Payers

- Defer on making a policy recommendation until more data is gathered and analyzed
- The need for flexibility to be nimble and innovative in addressing PHE

Consumers

- Applying copayments in the same manner as in-person visits after PHE ends
- The need to address co-payments collection for those without credit cards
- Coverage options when in-network providers are not adequate or available

PRIMARY THEMES

- May increase access to care and reduce health implications associated with deferred care
- Educate consumers on appropriate conditions for a telehealth visit
- Supports equitable access to care for underserved populations
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed

Reducing or waiving cost sharing for telehealth services through the end of the public health emergency or until December 31, 2021, whichever occurs last

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
    - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
    - Federal requirements on high-deductible plans may impact flexibility to make changes
    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Differing cost sharing requirements for an in-office visit versus a telehealth visit may have disproportionate effects on payers and consumers

6: Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal public health emergency

BENEFITS

Providers

- Lessens privacy and security concerns
- Improves the quality of telehealth encounters
- Increased likelihood technology integration exists with electronic health records
- Fewer workflow challenges

Payers

- Reduces risk of unauthorized access to a patient's protected health information

Consumers

- Ensures adequate protection around privacy and security
- Builds consumer confidence in the use of telehealth

UNINTENDED CONSEQUENCES

Providers:

- Adopting telehealth will require a financial investment in the technology

Consumers

- Potential barrier to access (e.g., patients not allowed to manually send symptoms/vitals to providers, or broadband internet limitations)
- Applications are not always user friendly and may require downloading multiple technology solutions
- Limitation on patient choice

PERMANENCY CONCERNS

Providers

- Costs to invest in a HIPAA-compliant telehealth solution, particularly for small practices
- Solution integration challenges with EHRs
- Addressing barriers to implementation, particularly for those serving underserved communities

Payers

- The risk that payers could be held accountable for technology adoption choices of providers by OCR

Consumers

- Can limit use if applications are oversized
- Burnout by "yet another application" to download
- Challenges in becoming familiar with multiple telehealth solutions

OTHER

Providers

- Consider relaxation of HIPAA-compliant technology under certain circumstances (e.g., documented emergency situations)
- Lack of interoperability for technology that is not HIPAA-compliant
- Need for support in navigating telehealth technology vendor market
- Consider audio only reimbursement or alternative technology options when HIPAA-compliant technology is not feasible/accessible
- Consider reimbursement for services delivered via patient portals, secure messaging, etc.

Payers

- Use caution in adoption legislation that may hinder the evolution of telehealth technology
- Monitor OCR guidance

Consumers

- Need for easy-to-use technology

PRIMARY THEMES

- The utility of non-public facing applications during the public health emergency does not offset the risks to privacy and security
- Allowable communication options include practice patient portals and secure messaging
- Costs to invest in HIPAA-compliant telehealth infrastructure may stunt provider adoption
- Addressing implications on consumer access and satisfaction

Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal public health emergency

DRAFT – GENERAL FINDINGS

- Allow existing OCR telehealth enforcement discretion policies to sunset at the end of the PHE without State intervention
    - Assess the impact of non-HIPAA compliant technology usage on privacy and security during the PHE

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SB 398 - Out - of - State Health Care Practitioner

Uploaded by: Jake Whitaker

Position: FAV

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TTY USERS CALL VIA MD RELAY

SB 398 - Out - of - State Health Care Practitioners - Provision of Behavioral Health Services via Telehealth - Authorization
Position: Favorable
March 3, 2022
Keiffer J. Mitchell, Jr., Chief Legislative Officer
Jake Whitaker, Deputy Legislative Officer

Dear Chair Pinsky, Vice Chair Kagan, and Members of the Committee,

Senate Bill (SB) 398 increases the number of health care practitioners available to deliver behavioral health services to patients in Maryland. Licensed out-of-state health care practitioners, who are in good standing with their state licensing authority and adhere to Maryland laws governing practice standards, would be permitted to deliver behavioral health services via telehealth to Maryland patients.

Several Maryland health occupations boards have already joined interstate compacts, including the Board of Physicians, Board of Nursing, and Board of Professional Counselors and Therapists. This bill is aimed at providing Maryland patients with access to out-of-state providers whose respective out-of-state licensing entity has chosen not to participate in an interstate compact. For example, neighboring states like Virginia and Pennsylvania are not members of the Counseling Compact. SB 398 will allow Maryland patients to receive behavioral health services from counselors in states like Virginia and Pennsylvania whose respective licensing authorities are not currently participating in the Counseling Compact.

SB 398 will improve patient access to health care practitioners in Maryland communities that are experiencing behavioral health practitioner shortages. During the COVID-19 pandemic, the demand for behavioral health services via telehealth has only increased. The COVID-19 pandemic created additional challenges for individuals with substance use disorders and increased the need for expanding access to mental health and substance use disorder treatment services. Overdose deaths in Maryland and across the United States have increased since the beginning of the pandemic. Increasing the number of available health care practitioners is a critical step in ensuring that Maryland will be poised to serve the mental health and substance use disorder treatment needs of Marylanders moving forward.

Since taking office, Governor Hogan and Lieutenant Governor Rutherford have remained committed to addressing the heroin and opioid epidemic, including expanding access to critical behavioral health and substance use disorder treatment services. SB 398 is another important step in eliminating barriers to behavioral health services in Maryland.

For these reasons, we respectfully request a favorable report on SB 398.

13a - X - SB 398 - EHEA - OOCC - LOS.pdf
Uploaded by: State of Maryland (MD)
Position: FAV

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OFFICE OF THE GOVERNOR
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CROWNSVILLE, MARYLAND 21032

March 3, 2022

The Honorable Paul G. Pinsky
Chair, Senate Education, Health, and Environmental Affairs Committee
2 West, Miller Senate Office Building
Annapolis, MD 21401

RE: SB 398 – Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization- Letter of Support

Dear Chair Pinsky and Committee Members:

The Opioid Operational Command Center (OOCC) is submitting this letter of support for Senate Bill (SB) 398 - Out-of-State Health Care Practitioners- Provision of Behavioral Health via Telehealth Authorization.

At a time of increasing strain on the behavioral health workforce, increasing the number of practitioners who provide behavioral health services via telehealth can help meet the demand in areas with little-to-no provider capacity.

SB 398 will expand access to behavioral health care by authorizing out-of-state practitioners to provide services via telehealth, while requiring practitioners to be held to the same standards of practice that apply to in-person care in the State of Maryland. This flexibility in service provision is necessary at a time when overdose deaths are at historic highs. Expanded access to health care through telemedicine will especially benefit traditionally underserved areas, such as Maryland's rural areas, which often lack access to behavioral health services due to the relatively few number of providers within large geographical areas.

The need for additional behavioral health capacity is a message that OOCC hears frequently from individuals across Maryland. For example, the OOCC recently completed our Maryland Stop Overdose Strategy (SOS) Regional Town Hall series, through which we traveled across the state to learn directly from community members about what is working and what is not related to the state's response to the opioid and overdose crisis. A consistent theme that we heard from individuals in nearly every region of the state was a lack of adequate behavioral health services for individuals struggling with a substance use disorder.

Although challenges with the provision of behavioral health services exist statewide, they are especially prevalent in Western Maryland and on the Eastern Shore, where large geographic areas, coupled with few providers, present significant challenges for those seeking immediate care for behavioral health conditions. Having adequate, low-barrier treatment capacity that is

available for when someone is ready and willing to seek care for a behavioral health condition is, therefore, critical.

With the increased need for behavioral health services at a critical moment for addressing the overdose crisis, we urge a favorable report for SB 398. Thank you for your time and consideration. If you would like to discuss this further, please contact OOCC Deputy Director Marianne Gibson at 443-381-4377 or marianne.gibson@maryland.gov.

Sincerely,

Robin E. Rickard
Executive Director
Opioid Operational Command Center

SB398.TeleHealthBehav.22.pdf
Uploaded by: Virginia Crespo
Position: FAV

Maryland Retired School Personnel Association

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Phone: 410.551.1517 ● Email: mrspa@mrspa.org
www.mrspa.org

Senate Bill 398
In Support Of
Out-of-State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth - Authorization
Senate Education, Health, and Environmental Affairs Committee
Hearing: March 3, 2022 at 1:00 p.m.

The Maryland Retired School Personnel Association requests a favorable report on SB 398 Out - of - State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth - Authorization.

This bill is vital for residents of the state of Maryland who have Health Practitioners outside the state. For the elderly this is most important to be able to access Telehealth with their doctor whose practice may be in Pennsylvania, West Virginia, Delaware, or Virginia. Telehealth is the wave of the future and has been crucial during the time of this pandemic. In the future this would help those who do not have transportation to see the doctor out of state.

The pandemic has laid bare the need for greater access to behavioral health services for all Marylanders and shown the importance of access to telemedicine now and in the future. Easy access to behavioral health care and treatment is essential to one's overall health. Please support this bill for all who need to use telehealth for a doctor out of state.

On behalf of the almost 13,000 members of the Maryland Retired School Personnel Association, we urge a favorable report on SB 398.

Sincerely,

George D. Denny, Jr.
President

Virginia G. Crespo
Legislative Aide

MAJ -SB398- FWA - OOS Practicioners.pdf
Uploaded by: Josh Howe
Position: FWA

MARYLAND ASSOCIATION FOR JUSTICE

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info@mdforjustice.com

SB 398

Out–of–State Health Care Practitioners –

Provision of Behavioral Health Services via Telehealth – Authorization

Favorable with Amendments

The Maryland Association for Justice (MAJ) envisions a fair and impartial legal system that protects the rights and safety of all people. The Maryland Association for Justice is dedicated to improving and protecting the civil justice system through legislative advocacy and the professional development of trial lawyers.

SB 398 authorizes a health care practitioner who is not licensed in Maryland to provide behavioral health services via telehealth to a patient in the State.

MAJ has concerns with language regarding "venues for a civil action initiated against an out of state practitioner" outlined in §1-1005, new part (B)(6), beginning on page 3, lines 18 – 25.

As drafted the venue for civil action is currently limited to the patient's county of residence or any county in the state in accordance with §6-201 of the Courts and Judicial Proceedings Article.

§6-201, with regards to civil actions, states

> "Subject to the provisions of § 6-202 and §6-203 of this subtitle and unless otherwise provided by law, a civil action shall be brought in a county where the defendant resides, carries on a regular business, is employed, or habitually engages in a vocation. In addition, a corporation also may be sued where it maintains its principal offices in the State."

MAJ respectfully ask that the committee amend §1-1005, new part (B)(6) to include "AND § 6-202" after §6-201 on line 25 of page 3. Including § 6-202 would permit additional venues for specific actions including:

- Action against a corporation which has no principal place of business in the State -- Where the plaintiff resides;
- Tort action based on negligence -- Where the cause of action arose;
- Action for damages against a nonresident individual -- Any county in the State;
- Action against a person who absconds from a county or leaves the State before the statute of limitations has run -- Where the defendant is found;

MAJ asserts that this amendment brings the proposed provisions in line with Maryland's current and "in-person" malpractice tort provisions.

(OVER)

Beginning on Page 3, Line 23 of SB 398 insert and remove the following:

(6) VENUE FOR A CIVIL OR ADMINISTRATIVE ACTION INITIATED AGAINST AN OUT–OF–STATE HEALTH CARE PRACTITIONER BY THE DEPARTMENT, A HEALTH OCCUPATIONS BOARD IN THE STATE, OR A PATIENT WHO RECEIVES BEHAVIORAL HEALTH SERVICES VIA TELEHEALTH FROM THE HEALTH CARE PRACTITIONER SHALL BE LOCATED IN:

(I) THE PATIENT'S COUNTY OF RESIDENCE; OR

(II) IN ANY OTHER COUNTY IN THE STATE WHERE VENUE MAY BE ESTABLISHED UNDER § 6–201 AND § 6–202 OF THE COURTS ARTICLE.

MAJ respectfully urges a Favorable with Amendments Report

SB 398 Out of State BH Telehealth- Letter of Conce
Uploaded by: Erin Dorrien
Position: UNF

Maryland
Hospital Association

March 3, 2022

To: The Honorable Paul G. Pinsky, Chair, Senate Education, Health & Environmental Affairs Committee

Re: Letter of Concern – Senate Bill 398 – Out-of-State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization

Dear Chair Pinsky:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 398. The COVID-19 pandemic required a complete rethinking of how health care is delivered and accessed. One major change has been greater access to virtual care. Telehealth visits at one Maryland health system skyrocketed from eight patients a day to more than 1,200 during the public health crisis.

Telehealth services during the pandemic were universally supported by patients and by hospital caregivers. MHA strongly supports the continued use of intra and interstate telehealth, especially in specialties with provider shortages such as behavioral health. However, SB 398 does not contain critical safeguards needed to ensure Marylanders receive the best care possible from out-of-state practitioners.

Our primary concern is patient safety. SB 398 completely bypasses Maryland's health occupations boards. While there is room for the boards to modernize and reduce administrative burden on qualified health care professionals, the boards still play an important role in investigating and sanctioning bad actors. Completely removing the boards' oversight would unnecessarily put patients at risk.

MHA supports the intent behind SB 398 to build on lessons learned from COVID-19 waivers that allow interstate telehealth usage, but the bill provisions do not adequately address the scope of the undertaking. To effectuate meaningful and sustainable change, we encourage legislators to consider multiple routes to mutual recognition, including licensure reciprocity, additional compacts, and regional partnerships for telehealth beyond existing health professional compacts.

For these reasons, we urge an ***unfavorable*** report on SB 398.

For more information, please contact:
Erin Dorrien, Vice President, Policy
edorrien@mhaonline.org

Sheppard Pratt written testimony SB398HB421 telehe
Uploaded by: Jeffrey Grossi
Position: UNF

Sheppard Pratt

Written Testimony

Senate Education, Health and Environmental Affairs Committee
House Health and Government Operations Committee

SB398 / HB421 Out–of–State Health Care Practitioners –
Provision of Behavioral Health Services via Telehealth – Authorization
February 8, 2022

Position: OPPOSE

Sheppard Pratt thanks the Maryland General Assembly for your longstanding leadership and support of mental and behavioral health providers in Maryland. This testimony outlines the Sheppard Pratt **opposition of SB398 / HB421 Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization**. It is our hope that the Maryland General Assembly will NOT 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. We thank the General Assembly and Governor for expanding telehealth during the pandemic but expanding beyond Maryland providers is not the right step at this time.

Sheppard Pratt asks that you **oppose this proposed telehealth expansion to out-of-state providers** for the following reasons**:**

1. **This is a safety issue.** Out-of-state providers need to have the same restrictions that are placed upon Maryland practitioners by other states. For example, the ability to emergency petition if deemed necessary. The providers entering Maryland must be licensed to practice Maryland in order to ensure proper vetting and oversight. This legislation doesn't even begin to address the long-term coordinated care required for behavioral health outpatient services or the local knowledge to address wraparound services which are often required.

2. **This is an equity issue for current in-state providers**. Maryland should be doing all we can to support our in-state providers by ensuring parity for mental health and addiction services. The State should begin by requiring commercial payors and Medicaid to fully support the expanded telehealth services into permanency and assist with telehealth access for all Marylanders. Behavioral health providers in Maryland continue to suffer through an Optum transition, workforce depletion, and reimbursement that does not meet the cost of care. This legislation will place additional strains on providers and will ultimately constrict an in-state continuum of care.

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

Sheppard Pratt

3. **This legislation addresses an unproven issue**. Following the resolution of the equity issue, the General Assembly should compel the Maryland Department of Health to conduct a study to document access difficulties including whether provider supply needs to be supplemented with out-of-state providers.

4. **This is a duration issue**. The expansion to out-of-state providers should mirror current federal legislation which limits the interstate telehealth expansion to the current emergency order duration. A justifiable step tied to a specific timeline and event restricting certain access and availability.

With the onset of the pandemic and increasing challenges with in-person crisis screenings, Sheppard Pratt successfully launched our Virtual Crisis Walk-In Clinic. Swiftly pivoting from an in-person walk-in clinic (which we still continue to provide), we expanded our crisis services to telehealth—offering psychiatric triage and referrals to our other virtual and in-person care options through a secure, online platform. The Virtual Crisis Walk-In Clinic is available to any individual living in Maryland who needs urgent psychiatric care. Licensed therapists and clinicians schedule follow up virtual or in-person appointments for therapy and/or medication management or recommend inpatient admission once the assessment has been conducted. Our ten outpatient locations throughout the State also shifted to provide both tele-therapy and tele-psychiatry services during the pandemic. Sheppard Pratt has seen an increased demand for services AND has been able to meet that demand by hiring additional Maryland licensed staff. We have also continued to provide virtual addiction services, partial day programs and intensive outpatient programs.

This virtual expansion equated to thousands of individuals who have been able to access the care they desperately needed—many of whom had previously been hindered by location, lack of transportation, or other common barriers. In fact, this service has eased burdens on emergency departments across the State at a time when all available beds are needed for our acute care patients.

It is vitally important that Marylanders have easier access to the quality mental health and addiction services they deserve. This bill, however, does not ensure quality services will be brought to Maryland nor are we certain that it addresses a meaningful service gap.

Sheppard Pratt urges the committee's unfavorable report on this legislation.

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.

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

MATOD - SB 398 UNF - BH Telehealth Out-of-State.pd
Uploaded by: Joshua Grollmes
Position: UNF

c/o IBR/REACH Health Services
2104 Maryland Avenue
Baltimore, MD 21218

(410) 752-6080

www.matod.org

Senate Education, Health, and Environmental Affairs Committee
March 3, 2022

Opposition to Senate Bill 398
Out-of-State Health Care Practitioners - Provision of Behavioral Health Services via Telehealth - Authorization

The Maryland Association for the Treatment of Opioid Dependence (MATOD) respectfully opposes SB 398. Our mission is to promote high-quality, effective medication assisted treatment for opioid addiction, so individuals, families, and communities can lead healthy lives in recovery and without stigma.

While MATOD appreciates the intent of the legislation to improve access to behavioral health through the use of telehealth, we believe this approach will both disadvantage consumers of services in Maryland as well as the community-based programs providing services.

Currently, telehealth allows flexibility in meeting clients where they are, both in terms of their treatment plan, and where they physically are. Out-of-state providers would not be able to offer clients an in-person option, and client choice is important for any of us, especially for people starting their journey to recovery.

With regard to providers, the bill would allow for out-of-state practitioners to practice telehealth in Maryland, but would not address the issue of Maryland providers being able to provide telehealth services over state lines.

We believe there are other avenues in the pursuit of greater access to behavioral health services. The state needs to invest in the pipeline of people entering the fields of counseling and social work. Tuition assistance and loan repayment programs within the Maryland Higher Education Commission have not been expanded in at least 15 years. Promoting the establishment of multi-state compacts with the health occupations boards where they currently do not exist would also allow for the use of telehealth services by providers from other states who we know meet the standards we have in Maryland.

We ask for an unfavorable report.

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.

MPA Testimony 2022 - Oppose - SB398 - Out-of-State

Uploaded by: Pat Savage

Position: UNF

MARYLAND
PSYCHOLOGICAL ASSOCIATION

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February 28, 2022

Senator Paul Pinsky
Chair, Education, Health, and Environmental Affairs Committee
11 Bladen Street
Annapolis, MD 21401

SB 398 Out-of-State Health Care Practitioners – Telehealth
Position: **OPPOSE**

Dear Senator Pinsky and Members of the Committee,

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, would like to ask the Committee to **OPPOSE SB 398**.

MPA recognizes the need for ensuring that Maryland's citizens have affordable access to needed mental health services. However, SB 398 is overly broad and does not provide an effective solution.

This legislation allows licensed health care practitioners in other states to practice into Maryland via telehealth with very few restrictions. Practitioners in a distant state would be allowed to practice via telehealth into Maryland even if the distant states' licensure requirements were less stringent and protective than Maryland's laws. For example, a licensed psychologist in Maryland must possess a doctoral degree; other states, however, allow psychologists to practice independently with a Master's degree and far less experience and training. In addition, the legislation provides no specified mechanism for the public to report complaints about the out-of-state practitioner. Do they report complaints to the distant state's licensing Board? Does the public report complaints to the local Maryland licensing Board? Unless these protective mechanisms are specified in detail with agreements between Maryland and the distant state, **Maryland would be allowing out-of-state practitioners to provide behavioral health treatment to Maryland's citizens with no oversight.**

In addition, the Maryland legislature passed two laws last year which allow for the interstate practice for licensed psychologists and licensed professional counselors. PSYPACT, for psychologists, is already operational, and the interstate compact for licensed professional counselors should soon be operational. Both compacts require strict coordination between member compact states with significant protections for each state's citizens.

For these and other reasons, the MPA urges you to **OPPOSE SB 398**.

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

Sincerely,

Linda McGhee
Linda McGhee, Psy.D., JD
President

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

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

2022 LCPCM SB 398 Senate Side.pdf
Uploaded by: Scott Tiffin
Position: UNF

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee:	**Education, Health, and Environmental Affairs Committee**
Bill Number:	**Senate Bill 398**
Title:	**Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization**
Hearing Date:	**March 3, 2022**
Position:	**Oppose**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) opposes *Senate Bill 398 – Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization.* This bill would authorize an out-of-state behavioral health care practitioner to provide telehealth services to a patient located in the state.

Last session, Maryland became one of the first states to pass the Interstate Licensure Professional Counselors Compact. We expect that enough states will pass the compact for it to go into effect, which will greatly increase the ability of LCPCs to provide services across state lines. The compact has several important patient safety provisions that Senate Bill 398 is missing. For example, the compact sets minimum education standards for participating providers and creates a process for states to share disciplinary records.

Additionally, we have serious concerns with conflicting provisions between these two bills, as the compact legislation includes the following section, specific to telehealth practice across state lines:

SECTION 7. COMPACT PRIVILEGE TO PRACTICE TELEHEALTH.

A. MEMBER STATES SHALL RECOGNIZE THE RIGHT OF A LICENSED PROFESSIONAL COUNSELOR, LICENSED BY A HOME STATE IN

ACCORDANCE WITH SECTION AND UNDER RULES PROMULGATED BY THE COMMISSION, TO PRACTICE PROFESSIONAL COUNSELING IN ANY MEMBER STATE THROUGH TELEHEALTH UNDER A PRIVILEGE TO PRACTICE AS PROVIDED IN THE COMPACT AND RULES PROMULGATED BY THE COMMISSION.

B. A LICENSEE PROVIDING PROFESSIONAL COUNSELING SERVICES IN A REMOTE STATE UNDER THE PRIVILEGE TO PRACTICE SHALL ADHERE TO THE LAWS AND REGULATIONS OF THE REMOTE STATE.

If Senate Bill 398 were to pass, we believe that professional counselors in other states wishing to provide telehealth services in Maryland would be able to bypass the compact. If this were to occur, the Board would not have the same access to interstate disciplinary data that is managed in real-time under the compact; nor do we know what authority Maryland's licensing board would have to investigate complaints and work with other state boards when complaints are made.

Thank you for your consideration of our testimony, and we would urge an unfavorable report. If we can provide any further information, please contact Scott Tiffin at stiffin@policypartners.net or 443-350-1325.

2022 MOTA SB 398 Senate Side.pdf
Uploaded by: Scott Tiffin
Position: UNF

Maryland Occupational Therapy Association

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

Committee: Education, Health, and Environmental Affairs Committee

Bill Number: Senate Bill 398

Title: Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization

Hearing Date: March 3, 2022

Position: Oppose

The Maryland Occupational Therapy Association (MOTA) opposes *Senate Bill 398 – Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization*. This bill allows out-of-state providers to provide behavioral health services in Maryland via telehealth. There is no clear definition of behavioral health services and we are concerned that it could cover the services of occupational therapists.

Last session, Maryland took the important step of joining the Occupational Therapy Licensure Compact. This compact will allow occupational therapists to provide services between member states. Unlike Senate Bill 398, the compact sets clear expectations and guidelines for member states and participating providers. For example, the compact includes a process of boards in different states to conduct joint investigations, which is not included in Senate Bill 398. Although we recognize the importance of interstate practice, we believe that Senate Bill 398 lacks the many patient protections that exist in the compact.

We ask for an unfavorable report. If we can provide any further information, please contact Scott Tiffin at stiffin@policypartners.net.

SB0398_UNF_MedChi_Out-of-State HC Practitioners -

Uploaded by: Steve Wise

Position: UNF

MedChi

The Maryland State Medical Society

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www.medchi.org

TO: The Honorable Paul G. Pinsky, Chair
Members, Senate Education, Health, and Environmental Affairs Committee
The Hogan-Rutherford Administration

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

DATE: March 3, 2022

RE: **OPPOSE** – Senate Bill 398 – *Out-of-State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **opposes** Senate Bill 398.

Senate Bill 398 would allow a practitioner who is not licensed in Maryland to provide telehealth services to a patient located here. The legislation requires that a person who practices telehealth here hold a valid license in another state and consent to the jurisdiction of the relevant Maryland health occupations board, but not be fully licensed here. While we appreciate the Hogan Administration trying to resolve an important issue that has arisen with the explosion in telehealth usage, we believe that any remedy should require full licensure here in Maryland. The answer to this issue lies in expeditious licensure, not excusal from licensure.

This Committee recently took action to extend until 2030 the Interstate Medical Licensure Compact ("Compact") that allows physicians to more easily become licensed in multiple states. See House Bill 180. Under the Compact, a physician has a home state where they reside that is their principal state of licensure. The physician may then obtain expedited licensure in other member states. Over 700 physicians from out of state have become licensed in MD using this approach. Once qualified, half of all Compact applicants receive their license in 7 days or less.

A license is the key to ensuring that the Board of Physicians can take action against a physician who violates the law, and most importantly one who is not following the appropriate standard of care. Without a license, the Board has no jurisdiction over that individual, and we believe this is true regardless of the language in Senate Bill 398 regarding consent to jurisdiction. And again, the Compact squarely addresses this – a physician who is subjected to discipline in one Compact state can quickly be disciplined

in another.

Finally, under the legislation, there is no requirement that Maryland practitioners receive reciprocal treatment from other states. So, while it helps other practitioners who want to practice in Maryland, it does not help Maryland practitioners who want to practice in other states. The Compact by its very nature ensures such reciprocity.

For these reasons, we would urge the Committee to oppose Senate Bill 398.

For more information call:
J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Christine K. Krone
410-244-7000

SB 398 - Oppose - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: UNF

February 17, 2022

The Honorable Paul Pinsky
Senate Education, Health, & Environmental Affairs Committee
2 West - Senate Office Building
Annapolis, MD 21401

RE: Oppose – SB 398: Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization

Dear Chairman Pinsky 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 strive 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 oppose Senate Bill 398: Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization (SB 398). Instead of taking bold steps to ensure parity for mental health and addiction services, SB 398 presents another hackneyed proposal that creates a different standard of care for mental health treatment than somatic health treatment. Every time the State has attempted this in the past, MPS/WPS's patients have suffered and discriminatory practices were fostered.

MPS/WPS has great concerns that out-of-state mental health practitioners might practice in a way that is not lawful here; for example, an out-of-state mental health practitioner may engage in conversion therapy or a psychologist may prescribe medication. An out-of-state mental health practitioner also may be unfamiliar with Maryland's mandatory reporting requirements or involuntary treatment laws. Similarly, an out-of-state mental health practitioner may not know how to carry out an emergency petition across state lines, the delay of which could be catastrophic for the individual or the community. Finally, SB 398 is eerily silent as to how such an out-of-state practitioner can attest that he/she even knows these laws and where liability can be attributed in cases of a bad outcome.

Simply put, psychiatric patients are better served when their psychiatrist practices in their community. This ensures that the proper standards of care are followed. Local psychiatrists know the availability of community resources and wrap-around services; the strengths,

weaknesses, and capacities of local hospitals; local crisis intervention resources; and last, but not least, local mental health laws. Finally, a local psychiatrist can collaborate with a patient's other local physician(s) more easily.

For all the reasons stated above, MPS/WPS ask for an unfavorable report on SB 398. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

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

13b - X - SB 398 - EHEA - MHCC - LOI.pdf
Uploaded by: Maryland State of
Position: INFO

MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

March 3, 2022

The Honorable Paul G. Pinsky
Chair, Senate Education, Health, and Environmental Affairs Committee
2 West, Miller Senate Office Building
Annapolis, MD 21401

RE: SB 398 - Out-of-State Health Care Practitioners – Provision of Behavior Health Services via Telehealth - Authorization

Dear Chair Pinsky and Committee Members:

The Maryland Health Care Commission (MHCC) is submitting this letter of information on Senate Bill (SB) 398 *Out-of-State Health Care Practitioners – Provision of Behavior Health Services via Telehealth – Authorization*.

SB 398 authorizes a health care practitioner who is not licensed in the State to provide behavioral health services via telehealth to a patient in the State under certain circumstances; and generally relating to telehealth and the provision of behavioral health services by out-of-state health care practitioners.

Interstate health occupation compacts have gained acceptance as a method to allow health care practitioners to provide services to consumers in other states, while assuring states that consistent oversight continues. Compacts allow for a less onerous and time-consuming process for physicians and other health care practitioners to obtain licenses in multiple states. Though a compact enables full licensure, one of the recent goals is to increase access to care through telehealth. During the 2021 legislative session, the Maryland General Assembly passed Senate Bill 571, *Interstate Licensed Professional Counselors Compact* (SB 571). SB 571 includes the privilege to practice telehealth, providing the individual is licensed by their home state. Maryland now participates in five (5) interstate compacts:

- Professional Counselors Compact
- Nurse Licensure Compact (NLC)
- Interstate Medical Licensure Compact (IMLC physicians)
- Physical Therapy Compact
- Psychology Interjurisdictional Compact

Compacts provide a pathway for health care practitioners to move seamlessly from one state to another through where participating states recognize another state's license.[1]

One limitation of compacts is that they may have little impact until a significant number of states have joined. Maryland is only the second state (Georgia being the other) to join the Professional Counselors Compact. The other four (4) compacts that Maryland is a part of have considerably broader state participation. Thirty (30) states participate in the Interstate Medical License Compact, thirty-three (33) states participate in the Nurse Licensure Compact, and twenty-six (26) states participate in the Psychology Interjurisdictional Compact.

SB 398 enables an out-of-state health care practitioner to provide telehealth without participating in a compact. Passage would enable Maryland residents to gain access to out-of-state practitioners without the constraints of an interstate compact. This legislation could negatively impact State monitoring of health care practitioners providing behavior health services using telehealth. The effect on consumers protections is unclear due to the limited ability of Maryland Health Occupation Boards to effectively investigate complaints and discipline out-of-state health care practitioners who violate State requirements.

Maryland Health Occupation Boards are responsible for several aspects of licensing health care professionals, including the determination of provider qualifications and scope of practice, and ensuring that licensure protects consumers. An important aspect of compacts is that it clearly outlines the reciprocal performance requirements that impact on performance. Setting the bar for out-of-state health care practitioners at licensing could lead to unintended consequences related to quality and cost.

If you would like to discuss this further, please contact Tracey DeShields, Director, Policy Development and External Affairs, Maryland Health Care Commission at tracey.deshields2@maryland.gov.

Sincerely,

Andrew Pollack
Chair, MHCC

Ben Steffen
Executive Director, MHCC

[1] American Counseling Association available at: www.counseling.org/news/updates/2021/05/19/maryland-becomes-second-state-to-sign-interstate-counseling-compact-into-law.

cc: The Honorable Carl Anderton. Jr.
The Honorable Joseph C. Boteler
The Honorable Jason C. Buckel, House Minority Leader
The Honorable Brian Chisholm
The Honorable Jefferson L. Ghrist
The Honorable Mike Griffith
The Honorable Wayne A. Hartman
The Honorable Kevin B. Hornberger
The Honorable Seth A. Howard
The Honorable Jay A. Jacobs
The Honorable Nicholaus R. Kipke
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March 3, 2022

To: The Honorable Paul G. Pinsky
Chair, Education, Health, and Environmental Affairs Committee

From: The Office of the Attorney General's Health Education and Advocacy Unit

Re: Senate Bill 398 (Out–of–State Health Care Practitioners – Provision of Behavioral Health Services via Telehealth – Authorization): Concern

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports the goal of expanding access to behavioral health services for Marylanders, but is concerned by the apparent lack of patient safeguards and consumer protections in Senate Bill 398. We believe these deficits must be corrected before Maryland authorizes the delivery of healthcare services, including behavioral health services, via telehealth by out-of-state providers, which is why the HEAU is supporting House Bill 670 (no cross-file), which calls for a study of all interstate telehealth services ("Requiring the Maryland Health Care Commission, in consultation with certain State agencies and stakeholders, to study ways that interstate telehealth can be expanded to allow State residents to use telehealth to receive health services from out-of-state practitioners; and requiring the Commission to submit a report on its findings and recommendations to the Senate Finance Committee and the House Health and Government Operations Committee on or before December 1, 2023"). We believe a comprehensive study is required to ensure access to care doesn't compromise quality of care, or the State's ability to address violations of laws established to protect Marylanders. A comprehensive study will allow for a thoughtful way to correct the deficits we have spotted in this bill, and to identify and correct other potential risks for patients inherent in the delivery of healthcare services by out-of-state providers.

Currently, a provider delivering health care services through telehealth must be licensed, certified, or otherwise authorized by law to provide health care services in the

State if the health care services are being provided to a patient located in the State. A web of patient safety, financial, privacy, consumer protection, and other regulatory safeguards protect Maryland patients as a result. This bill would allow a provider who is not licensed in the State of Maryland to provide behavioral health services via telehealth to a patient located in the State.

We are concerned that behavioral health services are not defined; that states have variable laws regarding the licensing and regulation of a variety of licensees who are allowed to deliver behavioral health services and the bill does not address the issue of conflicts of laws between the laws of Maryland and other states; we have the same concern regarding billing and collection of fees for services, and the enforceability of our consumer protections for health insurance enrollees in disputes with out-of-state providers or with their carriers relating to claims; lack of clear language including consent to the jurisdiction of administrative tribunals;; and limitations on the scope of authority of Health Occupations boards in Maryland.

While we are unsure how many Maryland law protections patients would lose if Senate Bill 398 becomes law, our concern is heightened because this is not a compact bill which would typically preserve or build in necessary safeguards, increasing the need for a comprehensive study.

cc: Sponsor