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Maine's 130th Session of the State Legislature- Special Session

Committee on Health Coverage, Insurance and Financial Services

May 6th Public Hearing(s), 2021 Telehealth Bills.

Note: Testimony w/timestamps as applicable can also be found here: http://legislature.maine.gov/ctl/HCIFS/05-06-2021?panel=0&time=0&sortdir=0&sortby=2 which is useful if interested in the youtube recording, which can be found here: https://www.youtube.com/watch?v=44SAGaRbGvg&t=1264s

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THE Allumbaugh AGENCY
Integrated Benefit Management

May 6, 2021

From: Joel Allumbaugh
President
The Allumbaugh Agency
Visiting Fellow
The Foundation for Government Accountability

RE: L.D. 649 & 1361

To the Distinguished Members of the Joint Standing Committee on Health Coverage, Insurance & Financial Services:

I come before you today in support of L.D. 649 & 1361, An Act To Expand and Promote Telehealth Services and An Act To Amend Telehealth Laws Regarding Out-of-State Telehealth Provisions.

I would like to take this opportunity to introduce The Allumbaugh Agency. We are a full-service employee benefit agency specializing in the design and administration of employee benefit plans. Our customers are Maine small businesses and their employees. I am also a Visiting Fellow with the Foundation for Government Accountability, a non-partisan, non-profit organization that strives to improve health care policy in the states and Washington, D.C.

I understand the committee will be reviewing a number of telehealth bills all with an aim toward expanding the availability of telehealth services in Maine. This is an important topic not just in Maine but throughout the country. The CDC reported a 50% increase in telehealth visits in just the first quarter of 2020 with 154% increase just in the last week of March.

The CDC further points out in its publication "Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic – United States, January-March 2020" that "telehealth can serve an important role in pandemic planning and response" and further "might continue to serve as an important modality for delivering care after the pandemic."

Expanding telehealth availability by reducing regulatory barriers is good public policy for Maine. Though you have a number of bills to consider with various approaches to expanding telehealth access I would encourage the committee to keep three primary goals central in your deliberations.

License Reciprocity is Key
In my experience as an insurance consultant, the biggest delay in bringing telehealth services to patients relates to the time involved with licensure. There is significant similarity in licensing requirements state to state that justify allowing providers licensed in good standing in their home state to see patients through telemedicine in

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THE Allumbaugh AGENCY
Integrated Benefit Management

Maine. In addition, there are adequate consumer protections in place as consumers can pursue medical malpractice suits at any time and the interstate aspect of telemedicine could bring access to federal courts.

Multiple Modes of Communication Should be Accommodated
The reality in Maine is that we have many rural areas with limitations not just related to access to care but also with broadband impacting access to various modes of communication. Flexibility for providers and patients to communicate in mutually acceptable ways is a practical solution to maximize access to care through telemedicine.

Payment Parity
I would encourage the committee to reject language that imposes payment parity for telehealth services as compared to comparable in-person services. Telehealth services have natural advantages in terms of efficiency and cost savings due to reduced physical infrastructure and provider flexibility. This enables not just improved access but opportunities to reduce the cost of care. Reimbursement for services should be determined between insurers and providers. Lower cost care also enables advantages to patients who are often paying lower or no co-pays for telehealth visits. Though well intentioned, payment parity will simply artificially inflate the cost of care.

I would also ask the committee to consider the interest and activity throughout the country to facilitate the growth of telehealth services. As states adopt similar laws throughout the nation, opportunities for Maine providers to grow their own practices through Telehealth represents additional opportunities for Maine to increase economic activity and attract medical professionals to our State. As providers supplement their practices with telehealth services, there could be opportunity to more effectively attract providers to rural parts of our state.

Thank you for your consideration. I urge you to improve access to health care for Maine residents by supporting the growth of telemedicine in Maine.

Respectfully Submitted,

Joel Allumbaugh
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Visiting Fellow, The Foundation for Government Accountability

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May 5, 2021

The Honorable Heather Sanborn
Chair, Maine Committee on Health Coverage, Insurance and Financial Services
Maine Senate
82 Frost Hill Road
Portland, ME 04103

The Honorable Denise Tepler
Chair, Maine Committee on Health Coverage, Insurance and Financial Services
Maine House of Representatives
13 Homeplace
Topsham, ME 04086

RE: ATA COMMENTS PENDING TELEHEALTH BILLS

On behalf of the American Telemedicine Association (ATA) and the over 400 organizations we represent, I am writing to comment on the telehealth bills pending before the committee. The ATA is the only national organization completely focused on advancing telehealth, and we are committed to ensuring that everyone has access to safe, affordable, and high-quality care whenever and wherever they need it. The practice of telehealth empowers the health care system to provide services to millions more patients every year in an efficient and efficacious manner. The ATA represents a broad and inclusive coalition of technology solution providers and payers, as well as partner organizations and alliances, working to advance industry adoption of telehealth, promote responsible policy, advocate for government and market normalization, and provide education and resources to help integrate virtual care into emerging, value-based modalities.

The ATA has a longstanding position that state policies related to tech-enabled healthcare delivery should be modality neutral and enable a healthcare professional to practice as efficiently and effectively as possible. In short, government should not pick winners and losers in technology innovation; rather, it should set in place good public policy to encourage such innovation. This allows a practitioner to use their expertise, discretion, experience, and the standard of care to determine which delivery method will be the most effective for each unique patient. We urge the Committee to consider a truly technology neutral approach to defining "telehealth" – similarly to how LD1681 does.

As far as the rate of reimbursement for telehealth services is concerned, the ATA maintains that state policymakers should set rational guidelines that are both fair to the provider of such services and reflect the cost savings offered to the health care system by the effective use of telehealth technologies. In some instances, reimbursement parity may be appropriate while in other instances it may not be.

Lastly, the ATA believes that all healthcare practitioners should be included under the telehealth umbrella. The COVID-19 pandemic has shown that it is not just doctors and their patients who benefit from remote care, but also mental, oral, and other physical health providers and their patients. To that end,

the ATA encourages this committee to include all health care providers in any telehealth bill that moves forward.

Again, we thank you for your consideration of telehealth in Maine. We urge you and your colleagues to pass permissive telehealth policy in the interest of expanding access to affordable, quality health care across the state – particularly in rural and underserved communities. Please do not hesitate to let us know how we can be helpful in your efforts to advance common-sense telehealth policy in Maine. If you have any questions or would like to discuss further the telehealth industry's perspective, please contact me at kzebley@americantelemed.org.

Kind regards,

Kyle Zebley
Public Policy Director
American Telemedicine Association

Testimony Neither For Nor Against

LD 323 An Act Regarding Insurance Coverage for Telehealth Services
LD 333 An Act Regarding Telehealth
LD 649 An Act to Expand and Promote Telehealth Services
LD 849 An Act to Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures
LD 1007 An Act to Increase Availability of Health Care through Telehealth
LD 1194 An Act to Reduce Health Care Worker Shortages

Presented by Kimberly Cook
May 6, 2021

Community Health Options is Maine's only nonprofit CO-OP health insurance company. We are based in Lewiston and provide health insurance in the individual, small group and large group markets, as well as providing health plan administration for self-funded plans through Pioneer ASO. Health Options exists for the benefit of our members and our mission which is to provide affordable, high quality benefits that promote health and wellbeing.

Telehealth is an increasingly valuable tool in ensuring access to health care across Maine and its adoption rapidly accelerated as a result of the COVID-19 pandemic. We are pleased that our Members are utilizing telehealth to obtain medically necessary care in a manner that is safe and effective.

We understand there are instances in which audio only telehealth is the only medium available for conducting a telehealth visit. However, we also recognize that in-person health care services offer unique benefits that can warrant differences in reimbursement from telehealth services. There is inherent value in face-to-face visits between patients and providers that is not always replicable when services are provided from a distance. Reimbursement for telehealth services should be allowed to reflect this difference. The best way to ensure Mainers have access to this innovative service at a price reflecting its limitations is to allow carriers and providers to negotiate through the contracting process.

We encourage the Committee to limit the coverage mandate for audio-only telehealth to those services for which the Medicare Physician Fee Schedule allows for reimbursement of audio-only services.[1] This approach will ensure that patients are receiving, and being billed for, services that can appropriately be delivered via audio-only services.

We appreciate your consideration of these comments and hope you will provide carriers with the flexibility needed to ensure incentives remain for providers to offer in-person care.

[1] Medicare Physician Fee Schedule for Telehealth Services available at List of Telehealth Services for Calendar Year 2021 (ZIP)

Consumers for Affordable Health Care

Advocating the right to quality, affordable health care for every person in Maine.

Consumer Assistance HelpLine
1-800-965-7476

Statement of Kate Ende, Policy Director, Consumers for Affordable Health Care

In Support of:
LD 333, An Act Regarding Telehealth
LD 323, An Act Regarding Insurance Coverage for Telehealth Services
LD 849, An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures

Senator Sanborn, Representative Tepler and members of the Joint Standing Committees on Health Coverage, Insurance and Financial Services, thank you for the opportunity to provide this testimony in support of LD 333, 323, and 849, to maintain access to telehealth services.

My name is Kate Ende and I am the policy director at Consumers for Affordable Health Care (CAHC), a nonpartisan, nonprofit organization that advocates for Maine people to be heard, respected, and well-served in a health system that provides coverage, access and quality, affordable care to all.

As designated by Maine's Attorney General, CAHC serves as Maine's Consumer Assistance Program for health insurance and as such, we operate a toll-free confidential HelpLine staffed by trained experts in eligibility and enrollment in private and public health insurance coverage. We answer questions about eligibility, help people apply for and enroll in health coverage, including private Marketplace health plans, and assist with other issues using insurance and accessing care. It is from our experience assisting Mainers in navigating the health care and coverage systems that we offer the following comments.

We greatly appreciate the steps this Administration, including the Superintendent, have taken to help ensure people have access to the care they need during the pandemic, such as the emergency provisions related to telehealth. Over the past year, we have seen how the increased availability of telehealth has not only been useful in ensuring continued access and reducing risks associated with in-person care during the pandemic, but also in reducing barriers that existed prior to COVID-19.

Through our HelpLine, we have heard from consumers in rural areas of the state, many with limited access to transportation, who have had to travel significant distances to service centers such as Bangor and Portland for their care or treatment. Delaying medical care when in-person care is not available or accessible can have harmful consequences for a person's health. We support measures that will make it easier for people to safely access the medical care and prescription drugs they need, including expanding availability of telehealth services, when medically appropriate, to populations who do not have high-speed internet or other technology needed for a video telehealth appointment.

Telehealth is a valuable tool that can help reduce barriers to many types of care and improve access for people living in rural areas, who have limited transportation, or for other reasons prefer or need to receive care outside of an in-person encounter with their provider. However, the decision to use telehealth rather than in-person care, when deemed to be a medically appropriate option, should remain the choice of the patient. This is why, in addition to issues regarding reimbursement rates and cost-sharing under health plans, we recommend that the Committee also consider potential impacts on provider networks.

Carriers offering managed care plans must provide reasonable access to health care services for their members. Maine also requires carriers that offer prescription drug benefits to maintain a reasonably adequate network of pharmacies. While not exactly the same, mail-order pharmacies, like telehealth, can be useful in reducing geographic or transportation barriers in some instances, but are not always the best way to deliver services or an appropriate alternative to in-person retail pharmacies.
For this reason, Maine prohibits mail order pharmacies from being considered when determining the

adequacy of a carrier's retail pharmacy network. A similar safeguard should be adopted for telehealth providers: providers that only provide care within the geographic service area of the plan via telehealth should not be included for the purposes of determining the adequacy of a provider network or the accessibility of services under a health plan. This will ensure telehealth services are used only as a tool to increase access to care, and not as a means of limiting availability of in-person care. Such a safeguard is particularly important in rural areas where access to many types of care is already limited and would be further reduced if health plans were permitted to use narrower in-person provider networks. Individuals should be able to access telehealth care when it is medically appropriate, and they choose to do so, but should continue to have the option to go to their local health center or receive in-person care from the independent providers serving their community.

People should have the ability to access telehealth services whether or not they have a high-speed internet connection and without having to pay more the service than if had been provided in-person. Increasing the availability of telehealth services will help ensure more people in Maine are able to access the care they need when they need it, which is why we urge you to support these bills.

Thank you.

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May 6, 2021

Oral Testimony on LD#s 1007, and 1681

Senator Sanborn, Representative Tepler, and members of the Health Coverage, Insurance and Financial Services Committee. My name is Michael Dixon, and I will be testifying regarding several LDs you are hearing today, both in this group and in the last group. I am fairly new to testifying, but want to start by saying I have observed several committee hearing sessions, so have a great deal of appreciation regarding the important work you are doing, and of how demanding that work can be. I want to assure you that since I will be presenting on several bills, I will strive to not repeat myself, but rather to present different testimony each time I speak with you. My cumulative testimony will explain why I am in favor of this committee reporting out a bill that extends the availability of Telehealth services past the current public health emergency with an "Ought To Pass" recommendation.

I have been providing mental health services in Maine since 1974, for most of that time as a Maine-licensed psychologist. At this point in my career, I am mostly retired, and I have a very small part-time practice. Since the pandemic hit, I have not taken on any new patients, but have worked with a very small number of long-term individual patients, mostly using a HIPAA-compliant audio-visual platform, under the emergency telehealth provisions. I am one of the professional licensees who will be allowed to continue to practice using telehealth delivery by the current bills in hearing. Additionally, for the past couple of years I have been serving on the Maine Psychological Association's Legislative Committee. So, I am providing this testimony both as a provider of telehealth psychotherapy services and as a member of that committee.

Early on when the pandemic hit, and I needed to switch from in-person to telehealth delivery, I had to work with my patients on resolving technology issues so we could use the

platform, but it was a small price to pay. Not only did it allow me and my patients to stay safe, but it proved to be a very efficient system that saved on travel time. Based on my experience and research, I became convinced of the benefits of telehealth for patients who are elderly, low-income, reliant on others for transportation, and/or live n rural settings that are far away from available service providers. So I am very pleased that this Committee is taking up bills that will extend the availability of telehealth services to Maine residents, including through the use of telephone only services when that is the only viable option, even after the public health emergency ends. The bills that are being considered will ensure that telehealth services are permitted and covered equitably by patient funding sources. The parity of reimbursement feature is very important in making sure that telehealth services will continue to be available to Maine residents, since reimbursement previously has been less generous for telehealth services, even those that are equivalent to in-person services in terms of quality of care, expertise, and time required to provide.

As an aside, I will add that other bills being considered during the 130th while not directly dealing with Telehealth are important to realizing its full promise, including bills that extend broadband availability throughout the State, which will be a game-changer, not only for telehealth, but more generally for how Maine and Mainers do business, and bills, such as LD 592, that make sure that MaineCare reimbursements are competetive with medicaid reimbursements in other states.

Also there is another bill being heard today by this committee I would like to mention, LD 863. 863 will further improve telehealth options for Maine residents by allowing Maine to join an interstate Psychology Interjurisdictional Compact. MePA's President, Tom Cooper, and Executive Director Amy Stafford, will be testifying in support of this bill.

Thank you for listening to my testimony. I will be happy to address any questions you may have.

MERCATUS CENTER
George Mason University

TESTIMONY

PROPOSED LEGISLATION INCREASES OPENNESS IN AND ACCESS TO HEALTHCARE IN MAINE

Robert F. Graboyes
Research Fellow, Open Health Program, Mercatus Center at George Mason University

Maine Legislature, Joint Committee on Health Coverage, Insurance, and Financial Services

May 6, 2021

Good morning, Chairs Sanborn and Tepler and members of the committee.[1] I am delighted to testify on Maine's proposed healthcare legislation—LD 1194 and LD 1007.[2] My name is Robert Graboyes, and I am a senior research fellow at the Mercatus Center at George Mason University, where my work focuses on how America can make healthcare as innovative in the next 30 years as information technology was in the past 30 years.[3]

In commenting on these two bills (and others), I offer the following takeaways:

1. LD 1194 and LD 1007 open multiple pathways for saving lives and improving health.
2. Reimbursement methodologies will be a significant challenge for policymakers going forward.
3. Increased options will reduce costs, but that doesn't guarantee lower spending on healthcare.
4. How patients and providers will respond to innovations is unknowable in advance.

LD 1194 AND LD 1007 OPEN MULTIPLE PATHWAYS FOR SAVING LIVES AND IMPROVING HEALTH

A technological revolution is sweeping across healthcare, offering opportunities to bring better health to more people at lower cost. The COVID-19 pandemic forced the healthcare system to test some new ideas, and the results have been heartening,[4] but this is only the beginning. The bills I will address today

1. Portions of this testimony are adapted from recent testimonies delivered to the Arizona and Colorado legislatures. Robert F. Graboyes, "Proposed Telehealth Legislation Is a Positive Step" (Testimony before the Arizona House of Representatives, Committee on Health and Human Services, Mercatus Center at George Mason University, Arlington, VA, February 1, 2021); Robert F. Graboyes, "Telehealth Is Evolving Rapidly; Legal Definition and Reimbursement Methods Need to Evolve with It" (Testimony before the Colorado General Assembly, Senate Health and Human Services Committee, Mercatus Center at George Mason University, Arlington, VA, April 12, 2021).
2. Legis. Doc. 1194, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 1007, 130th Leg. 1st Reg. Sess. (Me. 2021).
3. Some of my ideas on the issue are explained in Robert F. Graboyes, "Fortress and Frontier in American Health Care" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014).
4. Adam Thierer, "Reconsidering Technology during the COVID-19 Crisis," *Discourse*, March 24, 2020.

For more information or to meet with the scholar, contact
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are impressive in their breadth and put Maine in a good position to take advantage of new technologies as they appear.

LD 1194 (a) permanently welcomes out-of-state and recently retired physicians, physician assistants, and nurses (including osteopathic physicians and physician assistants) to care for Maine residents; (b) includes audio-only televisits within the definition of telehealth; (c) allows advanced practice registered nurses to practice without supervision or collaboration; and (d) allows nurses to provide care via telehealth. LD 1007 (a) expands who may practice telehealth and how they may do so, (b) assures that the services provided by those practitioners will be reimbursable, and (c) explicitly includes asynchronous care within the definition of telehealth. All of these actions will expand Mainers' access to timely care.

Other bills are in play in the Maine legislature: LD 323, LD 333, LD 849, and LD 1361 also validate the use of audio-only telehealth.[5] LD 333 puts telehealth prescribing and in-person prescribing on relatively equal terms. LD 863 facilitates telepsychology across state lines.[6] LD 649 and LD 1361 enable out-of-state providers to offer their services to Mainers.[7]

Since 2016, two coauthors and I have produced the Mercatus Center's Healthcare Openness and Access Project (HOAP), which provides comparative data on each state's openness to telehealth and other aspects of healthcare.[8] Using early-2020 data, the project ranks Maine as having a relatively open and accessible healthcare system—18th out of the 50 states and the District of Columbia.[9] At the time that the ranking was performed, the state earned some of the top scores in the country in the areas touched by these bills—telehealth, professional licensure, and scope of practice. Maine has offered broad reimbursement for telehealth providers and relative freedom from telepresenter requirements. The state joined the Interstate Medical Licensure Compact in 2017. It has offered nurse practitioners, opticians, behavioral health providers, and pharmacists broad scope of practice. Executive actions undertaken during the emergency enhanced this openness. And these bills seek to make this enhanced openness permanent. (My coauthors and I have not updated our data or rankings since the pandemic began because of the constant COVID-19-related policy changes.)

Ease of licensure and greater autonomy for advanced practice registered nurses will enable localities to expand access to care. But my remarks here will focus on telehealth, which is especially valuable for those who have traditionally had difficulty receiving timely care. These include patients in rural communities, patients in inner-city communities, foreign-language speakers, people with limited mobility, those with busy schedules, those with childcare responsibilities, and anyone who has a health issue after hours or on weekends.[10] Even when in-person encounters are feasible, telehealth offers advantages, including reduced exposure to pathogens in waiting rooms and examining rooms, reduced no-shows for appointments, and greater patient compliance for treatment regimens (particularly with respect to psychological health).[11] For patients, telehealth dispenses with the time and stress of transit.

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5. Legis. Doc. 323, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 333, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 849, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 1361, 130th Leg., 1st Reg. Sess. (Me. 2021).
6. Legis. Doc. 863, 130th Leg., 1st Reg. Sess. (Me. 2021).
7. Legis. Doc. 649, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 1361, 130th Leg., 1st Reg. Sess. (Me. 2021).
8. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "Healthcare Openness and Access Project 2020: Full Release," Mercatus Center at George Mason University, December 22, 2020, http://www.mercatus.org/HOAP.
9. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "18 | Maine," Mercatus Center at George Mason University, December 22, 2020, https://www.mercatus.org/publications/healthcare/18-maine.
10. Robert F. Graboyes, "Telemedicine as Lifesaver — Ian Tong and Doctor on Demand," *InsideSources*, October 5, 2016.
11. Robert F. Graboyes, "Telepsychiatry — Serving the Underserved," *InsideSources*, October 9, 2018.

The following personal anecdote illustrates well the value of telehealth: In early 2021, I incorrectly thought I might be suffering a heart attack and took my first-ever ambulance ride. It proved to be a false alarm, but I spent a month experiencing intermittent symptoms and repeated blood-pressure spikes. I had just changed primary care physicians, the pandemic was still raging, and I didn't wish to expose myself to a doctor's waiting room. My new doctor was able to diagnose me remotely and change my medications—which immediately fixed the problem. This was all accomplished through telehealth consults and exchanges of texts. Though we have now established a warm relationship, my doctor and I have still never met in person.[12]

REIMBURSEMENT METHODOLOGIES WILL BE A SIGNIFICANT CHALLENGE FOR POLICYMAKERS GOING FORWARD

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

I saw a reimbursement issue firsthand during my earlier-mentioned health crisis in January 2021. When helping me navigate my transitory health problem, my new primary care physician was reimbursed for two virtual visits lasting perhaps 15 minutes apiece. But she spent far more time over a four-week period on my case, communicating with me frequently via text message and doing administrative work. Whereas an attorney or accountant could bill for such uses of time, my doctor received no compensation for anything outside of the two virtual visits. When I asked her about it, she told me, "Under our current system, the only thing that generates income are in-person visits, virtual visits (some insurances aren't covering them) and some telephone visits. . . . I have to learn two mutually exclusive ways to understand my patient's conditions—one to help them and one to get paid."[13]

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

LD 1007 establishes reimbursement for telehealth at parity with in-office encounters—similar to what the Centers for Medicare and Medicaid Services adopted on an emergency basis in August 2020.[14] I recommend that some consideration be given to a more flexible reimbursement policy for telehealth encounters. In a recent release of the Healthcare Openness and Access Project,[15] my coauthors and I write the following: "We take it as beneficial that in some states Medicaid will pay for telehealth. But [payment] parity itself is problematic. One argument for telehealth is that it is less costly than traditional office visits. Therefore, if Medicaid pays the same amount for both, it may be depriving telehealth practices of the ability to compete on the price dimension to push costs downward."[16]

12. In fact, we may never meet, given that the US Army just transferred her husband to a base in Hawaii and that she will soon follow.
13. Web portal message from physician to author, February 18, 2021.
14. Susan Morse, "CMS Proposes Telehealth Changes under Trump Executive Order," *Healthcare Finance*, August 4, 2020.
15. Web portal message from physician to author, February 18, 2021.
16. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "Healthcare Openness and Access Project 2020: Full Release" (project overview, Mercatus Center at George Mason University, Arlington, VA, December 2020), 9.

It would be worthwhile to consider, in lieu of rigid parity (i.e., telephysicians being paid the same as in-person physicians), whether a more flexible version of parity might be in order. For example, telephysicians could be allowed to charge *up to the level of* parity but could, if costs of provision were lower, charge less in order to expand market share. Reference-based pricing and reward-based programs have the potential for introducing cost savings and price competition.[17] With reference-based pricing, payers agree to pay up to a certain price but possibly less. With reward-based programs, patients receive direct financial benefits for using lower-cost providers.

INCREASED OPTIONS WILL REDUCE COSTS, BUT THAT DOESN'T GUARANTEE LOWER SPENDING ON HEALTHCARE

I am confident in predicting that more telehealth, broader scope of practice, and more welcoming licensure laws will reduce costs. A physician examining a patient from a laptop at home is not paying for the same level of office space as a physician examining a patient in an office. A 24-hour clock for telehealth services means that assets aren't idle for two-thirds of each day. Communities across America can share the cost of physicians who stand ready to absorb a sudden increase in demand that hits a particular community during, say, a flu epidemic or natural catastrophe. And the opportunity for earlier intervention will help stave off expensive situations.

But this doesn't mean America will spend less on healthcare. To understand why, one can think of information technology. In the 1950s, the computing power of an iPhone would in theory have cost trillions of dollars. In 1983, I purchased a Kaypro II portable computer whose internal memory was 64KB—not nearly enough memory to hold the PDF document containing this testimony. The Kaypro cost me around $5,000 in today's dollars. The Windows Surface laptop on which I am composing this testimony cost me perhaps $2,000, and its memory is roughly 250,000 times greater than the Kaypro's. And my Surface is vastly faster than the Kaypro was. The price of computing power has probably dropped further and faster than any other good in human history. And yet, Americans are not spending less in 2021 on electronic devices than they did in 1983. They just get unimaginably more bang for each buck they spend.

I'm confident that telehealth in 2046 will be as different from today's telehealth as an iPhone X is from a mid-90s flip phone. I just don't know how—and neither does anyone else. Perhaps Americans will be able to spend less on healthcare and more on other things. Alternatively, with quality improvements in healthcare, Americans may decide to spend even more on their health than they do today. No one knows—and no one can.

If Maine is like Montana,[18] then Maine's local physicians may fear that out-of-state doctors will snatch away some patients and revenue. (An article in the *New England Journal of Medicine* notes that this incentive is common among state licensing boards in general.[19]) I think this worry is exactly backwards. Maine's physicians may be the ones snatching away others' revenue because Maine is a more cost-effective place to live. A doctor living in Maine can do telehealth visits in New York or San Francisco just as easily as a New York or San Francisco doctor can. In fact, the lower cost of living, calm environment, and scenic beauty of Maine could make it a magnet for doctors specializing in telehealth. The bills we are discussing would position Maine very well in this context.

17. Caroline Hroncich, "A How-To Guide for Reference-Based Pricing," *Employee Benefit News*, October 22, 2019.
18. Matt Volz, "The Boom in Out-of-State Telehealth Threatens In-State Providers," *Kaiser Health News*, March 15, 2021.
19. Ateev Mehrotra, Alok Nimgaonkar, and Barak Richman, "Telemedicine and Medical Licensure — Potential Paths for Reform," *New England Journal of Medicine* 384, no. 8 (2021): 687–90.

HOW PATIENTS AND PROVIDERS WILL RESPOND TO INNOVATIONS IS UNKNOWABLE IN ADVANCE

I'm often asked to predict the future of healthcare innovation. How will doctors use telehealth in 5 to 10 years? How many people will use telehealth? How much care will be delivered virtually as opposed to in person? How much will Americans spend on virtual health?

Here's the problem with asking such questions: Imagine going back to, say, 2005, and asking people, "Would you like an app that will summon a total stranger to your house to give you a ride? Or how about another app that will enable you to sleep in another complete stranger's house somewhere in the world?" For most people, those ideas might have been horrifying, and yet, within five years, Uber and Airbnb radically changed how people travel and where they sleep. In 2016, after experiencing a one-time episode of cardiac arrhythmia, I purchased an AliveCor Kardia device that enabled my cellphone to administer an electrocardiogram in 30 seconds and diagnose the condition of my heartbeat.[20] Dave Albert, the Oklahoma doctor who invented the device, came up with the idea in the 1990s, and engineers told him it was impossible. In 2007, he saw Steve Jobs introduce the iPhone and immediately thought that this new phone might make his idea feasible. Engineers told him the answer was still no, but he insisted that they try—and they succeeded. (My $99 device has kept me out of the emergency room several times, thereby saving me and my insurer thousands of dollars.)

In December 2019, plenty of doctors and patients still swore that they would never do medical examinations through an iPad. The novel coronavirus changed all that so that, by midsummer 2020, doctors were seeing patients via telehealth 50 to 175 times as often as they were a mere six months before.[21] The McKinsey Report offering that datum suggests that in the future, "Approximately $250 billion—or ~20%—of all Medicare, Medicaid, and Commercial OP, office, and home health spend, could potentially be virtualized." My hunch is that McKinsey's estimate grossly underestimates the potential of telehealth, particularly when one considers the addition of remote monitoring, artificial intelligence, and machine learning. In Rwanda, drones transport much of the country's blood supply—an approach that would work well with Maine's topography.[22]

Will people want more telehealth in the future? Apple CEO Tim Cook has said, "Our whole role in life is to give you something you didn't know you wanted. And then once you get it, you can't imagine your life without it."[23] The same will be true of telehealth if it is allowed to flourish—as Maine seems to be doing.

20. AliveCor (website), accessed May 3, 2021, http://www.alivecor.com.
21. Oleg Bestsennyy et al., "Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?," McKinsey & Company, May 29, 2020, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.
22. Robert F. Graboyes, Darcy Nikol Bryan, and John Coglianese, "Overcoming Technological and Policy Challenges to Medical Uses of Unmanned Aerial Vehicles" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, January 2020); Robert F. Graboyes and Brent Skorup, "Medical Drones in the United States and a Survey of Technical and Policy Challenges" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, February 2020).
23. Tim Cook, interview with Brian Williams, *Rock Center*, NBC, December 7, 2012, https://www.youtube.com/watch?v=zz1GCpqd-0A.

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May 6, 2021

LD 323 – An Act Regarding Insurance Coverage for Telehealth Services

LD 649 – An Act to Expand and Promote Telehealth Services

Greetings, Senator Sanborn and Representative Tepler, and members of the Joint Committee on Health Coverage, Insurance and Financial Services.

My name is Bridget Quinn and I am the Associate State Director of Advocacy and Outreach for AARP Maine. AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. On behalf of our more than 200,000 members statewide, thank you for the opportunity to share testimony today to highlight the importance of supporting family caregivers.

Today I am submitting testimony in support of LD 323 and LD 649.

Since the start of the COVID-19 pandemic, more and more Americans are turning to telehealth appointments to reduce risk of exposure to COVID-19 when connecting with medical professionals. Government data showed that in just one week in April, nearly 1.7 million Medicare beneficiaries received telehealth services, compared with 13,000 in a typical week before the pandemic.[1] Between mid-March to mid-June 2020, more than 9 million Medicare enrollees received telehealth services.[2]

Telehealth can be a useful tool for medical providers during and beyond a public health emergency. Utilizing telehealth can help family caregivers who may be juggling a number of important responsibilities, saving them time. Telemedicine has also proved helpful in helping a patient manage a chronic condition.[3]

However, there are barriers to older Mainers trying to access telehealth services. According to a 2020 report, more than 26 percent of Medicare beneficiaries lack digital access at home.[4] Lack of access to high-speed internet is a familiar issue to many Mainers. LD 323 and LD 649 will begin

[1] Marsa, Linda. The Future of Telehealth and What It Means for Older Adults. AARP.org August 2020.
[2] Marsa, Linda. The Future of Telehealth and What It Means for Older Adults. AARP.org August 2020.
[3] Marsa, Linda. The Future of Telehealth and What It Means for Older Adults. AARP.org August 2020.
[4] Roberts, Eric T., and Ateev Mehrotra. "Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine." JAMA Internal Medicine, vol. 180, no. 10, 2020, p. 1386., doi:10.1001/jamainternmed.2020.2666.

to address this issue by requiring health insurance carriers to cover telehealth services that are provided through telephone communication only. While we believe that all Mainers should have access to affordable high-speed internet, in part so they can access the newest telehealth technologies, these bills will serve to advance access to important telehealth options.

Further, LD 649 seeks to allow health professionals licensed or certified in other states to practice their professions across state lines through telehealth. Since the start of the pandemic, more and more patients are facing high wait times and delays when trying to make needed in-person appointments to see their physician. Allowing more out-of-state licensed practitioners to offer telehealth services in Maine expands provider availability for in-person services.

Now is an excellent time to take action to increase access to telehealth services for Mainers. An AARP study from June 2020 shows that awareness of telehealth services is rising for healthcare consumers.[5] Those polled are also ready to use telehealth. Among participants in the poll, roughly two-thirds of respondents who are interested in telehealth services, said they would use telehealth;

- To renew prescriptions (85%)
- For help in caregiving (79%)
- To discuss a new medical issue (76%)
- For a routine visit to the doctor (74%)[6]

Services provided by telehealth have great potential to help consumers more easily connect with various health care clinicians, maintain their quality of life, and remain in their communities longer by providing an opportunity to better manage their care.

I respectfully ask you to support LD 323 and LD 649. Thank you for the opportunity to provide testimony today. If you have any questions or need further information, please don't hesitate to contact me: bquinn@aarp.org or 207-272-8563.

Thank you,
Bridget Quinn
AARP Maine

[5] Keenan, Teresa A. *Views on Telehealth.* Washington, DC: AARP Research, June 2020. https://doi.org/10.26419/res.00388.001

[6] Keenan, Teresa A. *Views on Telehealth.* Washington, DC: AARP Research, June 2020. https://doi.org/10.26419/res.00388.001

Alliance for Addiction and Mental Health Services, Maine
The unified voice for Maine's community behavioral health providers
Malory Otteson Shaughnessy, Executive Director

Testimony in support of several bills today:
LD 323: An Act Regarding Insurance Coverage for Telehealth Services
LD 333: An Act Regarding Telehealth
LD 849: An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures

May 6, 2021

Good afternoon Senator Sanborn, Representative Tepler, and members of the Joint Standing Committee On Health Coverage, Insurance and Financial Services. I am Malory Shaughnessy, a resident of Westbrook, and the Executive Director of the Alliance for Addiction and Mental Health Services. Please accept this testimony on behalf of the Alliance **in support of LD 323, 333, 849, and and maintaining expanded telehealth services.**

LD 323, 333, and 849, as well as a couple of the other bills before you today, make permanent several aspects of the Governor's Executive Order #35 dated April 6, 2020, which allowed certain licensed or registered professionals under Title of the Maine Revised Statutes to provide necessary health care or other services to the extent practicable through the use of all modes of telehealth, including visual and audio, audio-only or other electronic media. These bills clarify that these services must be covered by insurance as they would be if provided in person. They also allow patients receiving MaineCare health services to provide verbal, electronic or written consent to telehealth and telemonitoring services.

The Alliance supports rolling these bills up into one omnibus bill that permanently leaves the enhanced access to care that was one of the few silver linings of the Pandemic.

Through the expanded telehealth options, many Mainers were able to access services in geographic areas of Maine that aren't usually covered due to their rural nature. Many Mainers were able to receive services on a regular basis who often miss appointments due to unstable transportation. Many Mainers who struggle to leave their homes were able to meet face to face with therapists.

This expansion added a very useful tool to the healthcare toolbox for our practitioners. We do not want to see them go away. Thank you!

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*With 35 members, the **Alliance** is the state association for Maine's community based mental health and substance use treatment providers. The **Alliance** advocates for the implementation of sound policies and evidence-based practices that serve to enhance the quality and effectiveness of our behavioral health care system. All Mainers should have full access to the continuum of recovery-oriented systems of care for mental illness and substance use disorder – from prevention through treatment and into peer recovery support.*

MAINE ASSOCIATION OF HEALTH PLANS

Testimony of Katherine Pelletreau
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Neither For Nor Against

LD 323 An Act Regarding Insurance Coverage for Telehealth Services
LD 333 An Act Regarding Telehealth
LD 649 An Act to Expand and Promote Telehealth Services
LD 791 An Act Regarding Telehealth Regulations
LD 849 An Act to Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures
LD 1007 An Act to Increase Availability of Health Care through Telehealth
LD 1194 An Act to Reduce Health Care Worker Shortages (Telehealth)
LD 1361 An Act to Amend Telehealth Laws Regarding Out-of-state Telehealth Provisions

May 6th, 2021

Good Morning Senator Sanborn, Representative Tepler, Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

My name is Katherine Pelletreau and I am the Executive Director of the Maine Association of Health Plans (MeAHP). MeAHP has five members including Aetna, Anthem Blue Cross and Blue Shield, Cigna, Community Health Options and Harvard Pilgrim Health Care. Collectively, MeAHP's members provide or administer health insurance coverage to over 600,000 Maine people. The organization's mission is to improve the health of Maine people by promoting affordable, safe and coordinated healthcare.

MEAHP is offering consolidated testimony on the suite of telehealth bills before the Committee.

Health insurers are proponents of telehealth, seeing it as a tool to improve care and reduce costs for both providers and patients. Shared cost saving benefits include better management of chronic diseases, reduced travel times, and fewer or shorter hospital stays and ER visits.

Telehealth should be part of a hybrid care delivery model that includes both in-person and virtual care delivery elements. While its use is situational and does not lend itself to one size fits all policy, the COVID-19 crisis demonstrated that telehealth can be just as clinically effective as in-person care for many conditions. Policy makers should recognize this value by allowing telehealth visits to be counted towards network adequacy requirements, risk adjustment calculations, and quality measures.

Maine's current telehealth mandate

Maine is and has been well ahead of many other states on use and coverage of telehealth. We already have a robust telehealth law that is quite broad and requires that services delivered via telehealth be covered if they would be covered in person. It requires coverage of telephonic services when scheduled telehealth services are technologically unavailable at the time of the scheduled telehealth service.

Parity

The promise and vision of telehealth is to advance access to quality care and reduce costs for both providers and patients. Technology should *lower* unit costs, especially for low barrier access such as audio-only telephonic care.

Requiring parity in this context is not appropriate and carriers believe these matters are best left to negotiation as a contractual matter.

Audio-only telephonic care

During COVID, telehealth expanded exponentially, and audio-only services became more widespread, especially for behavioral health services. Carriers report significant increase in use of telehealth year-over-year. During this time, new codes were developed for audio-only services in recognition of widespread use and to simplify payment. There are now at least three new codes for different time increments for evaluation and management audio only telephone services.

Health insurers are mindful of the limitations of telephonic or audio-only visits. These types of visits can be an important tool for providers and patients to touch base or address questions pertaining to the patients' care but are not equivalent to in-person visits in terms of intensity or provider "touch" and should not be paid at the same rate.

Standard of care also rightfully limits the types of medical services that can appropriately be conducted via an audio-only visit (e.g., dermatology or a routine annual physical).

Audio-only telephonic services make sense in some situations such as during a stay-at-home order as we've experienced during COVID, to facilitate services being provided to people in domestic violence situations, and to provide behavioral health services, particularly for those without good internet access.

However, audio only telephone is not appropriate for many health care services as it cannot replace the visual aspects of audio-visual telehealth. We are wary of the potential for abuse by providers who see audio only telephone visits as a way to maximize their

income, even when they are not necessary, or another form of telehealth would be better suited. For these reasons, we suggest that language be added that would limit when audio only telephone may be used to those instances outlined above.

Telehealth Offerings and Separate Telehealth Deductibles

Several of the bills reference separate deductibles for telehealth. MeAHP members know of no instance where a separate deductible exists. Telehealth services, like in-person, would accrue to the same deductible under a medical policy unless they were being offered as an ancillary service. Many plans offer telehealth services to members through entities such as Teledoc or MDLive that charge a fee. This is separate from the medical policy and not a co-pay or payment under a deductible but rather a flat fee for service.

There is tremendous growth among services like these who are expanding their reach and offerings. Experts have likened the explosion to the dot.com boom some years ago, noting that 100s of telehealth companies have received start-up financing.[1]

Current laws can restrict the ability of clinicians to deliver virtual care to patients outside the state where they are licensed. Carriers are generally supportive of lowering barriers to care including the establishment of multi-state compacts and low barrier multi-state provider licensing.

The Governor's Executive Order #35 issued April 6th, 2020 directs use and coverage of all modes of telehealth across a broad array of practitioners. These telehealth measures were proclaimed on a temporary basis because of the COVID-19 pandemic and need careful consideration before continuation beyond the emergency. In particular, the order includes some categories of practitioner which should not be eligible for provision of telehealth such as acupuncturists, hearing aid fitters, and chiropractors. All these specialists provide hands on treatment modalities and services.

Thank you for your consideration of these comments.

[1] https://khn.org/news/article/the-boom-in-out-of-state-telehealth-threatens-in-state-providers/

TO: **Senator Heather Sanborn, Chair**

Representative Denise Tepler, Chair

Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services

FROM: Dan Colacino, Vice President

DATE:

RE: LD # 323, 333, 649, 791,849, 1007, 1361

On behalf of the Maine Association of Health Underwriters (MaineAHU), I am pleased to have the opportunity to submit comments on the proposed bill.

MaineAHU is a state chapter of the National Association of Health Underwriters and represents licensed agents, brokers, and employee benefit consultants who sell and service individual and group health, disability, Medicare, and long-term care insurance.

We are writing to support LD xxx.

We very strongly endorse the continued and expanded use of Telehealth as a means of delivering health care in the State. The emergency measures enacted during the pandemic should be extended and made permanent.

We would urge the Committee to be certain each proposal is carefully reviewed in terms of existing Federal law, appropriate medical practice and to avoid unnecessary cost or utilization. We agree that audio only should be an option, but only if it is the only option available, to minimize overutilization. LD 333 requires "…reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person." It should be noted that Medicare has published Telehealth codes and rates so it's important to ensure that there is no conflict with the large number of Medicare Advantage and Medicare Supplemental plans filed in the State.

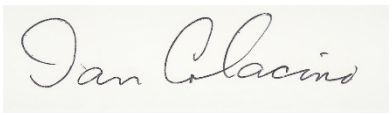
There is language that would prohibit a carrier from placing restrictions on prescribing medication through telehealth that are more restrictive than requirements of applicable state and federal law for prescribing medication in person. Does that mean that controlled substances can be prescribed virtually by a properly licensed provider? That may make sense during the pandemic but beyond that may not be proper.

Additionally, we would urge consideration of the following:

- Can a plan have a network of participating vs. non-participating telehealth providers?
- What is the criteria regarding Electronic Health Records; who are they provided to? Continuity of care?
- Is there criteria that all providers providing virtual consultations are required to have access to a national drug database in order to prescribe?
- What is considered an "episode" of care in terms of a claim as there may be call backs, test results, etc.

We would like to thank the Committee for considering our comments and the opportunity to express our views. If you have questions, please feel free to contact me.

Respectfully,



Dan Colacino

Vice President

Maine Association of Health Underwriters

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May 5th, 2021

Senator Heather Sanborn
Representative Denise Tepler
Joint Standing Committee on Health Coverage, Insurance and Financial Services
% Legislative Information Office
100 State House Station
Augusta, ME 04333

RE: Testimony in support of the following bills:

LD 323, "An Act Regarding Insurance Coverage for Telehealth Services" LD 333, "An Act Regarding Telehealth"
LD 849, "An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures"
LD 1681, "An Act Regarding Telehealth Services for Certain Licensees of the Office of Professional and Occupational Regulation and Certain Licensees Affiliated with the Department of Professional and Financial Regulation"

Senator Sanborn, Representative Tepler and distinguished members of the Health Coverage, Insurance, and Financial Services Committee:

Maine Family Planning (MFP) has been providing telehealth services since 2014. However, there have been significant hurdles over the years that have made this challenging or even impossible for some people in our state to access, particularly those who live in areas with poor internet service and without adequate technology. When Covid-19 arrived, MFP immediately pivoted to assure that Mainers could continue receiving quality reproductive health care, including contraception, STI testing and treatment, and primary care. We never closed our doors and in fact, because of the changes in telehealth policies due to the Public Health Emergency, we were able to provide services to Mainers who otherwise may not have had a way to obtain the care they needed.

As telehealth providers reaching people throughout the state, Maine Family Planning unequivocally supports LD 323, LD 333, and LD 849 and LD 1681. Allowing the option for services by audio only opens care options for many people who do

not have reliable internet access. Similarly, allowing patients to provide their consent verbally has allowed us to provide care to all Mainers regardless of their equipment or familiarity with technology.

To continue this model post-pandemic, it is essential that health insurance carriers and MaineCare reimburse telehealth services at an equal rate to that of in-person services. We believe that all Mainers deserve equal access to obtain their healthcare. Finally, the varied methods of telehealth services, including asynchronous encounters and store and forward transfers, would allow us to further expand options to Mainers who may have challenges in accessing our services during regular business hours. Those working multiple jobs or on long shifts, caring for family members, and with limited options for services outside regular business hours could continue to have their reproductive health needs met by our clinicians.

Patient surveys conducted by MFP during the pandemic revealed many reasons why our patients like the option for telehealth services. Quoting directly from the survey:

- "saved time and gas"
- "not having to take as much sick time from work"
- "quick and convenient"
- "no need for a mask as I was alone in the room, so my points could be made better with full facial expressions"
- "sometimes it is easier to discuss matters when you are not face to face."

Less than one third of patients when asked, *If there was no pandemic and you could have chosen to have this visit through telehealth or in person, which would you have preferred?* indicated that they would prefer in-person care. We anticipate, and are preparing for, telehealth services to continue to be an integral component of the reproductive health services we offer.

During the pandemic, Mainers have not been forced to choose between risking their health to travel and enter a clinic merely because they did not have adequate internet, health insurance coverage, or the ability to take off time from work. We believe that all Mainers deserve to continue to make the decision to access reproductive health care independent of these factors.

Sincerely,

George A. Hill
President/CEO

Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

In Support Of

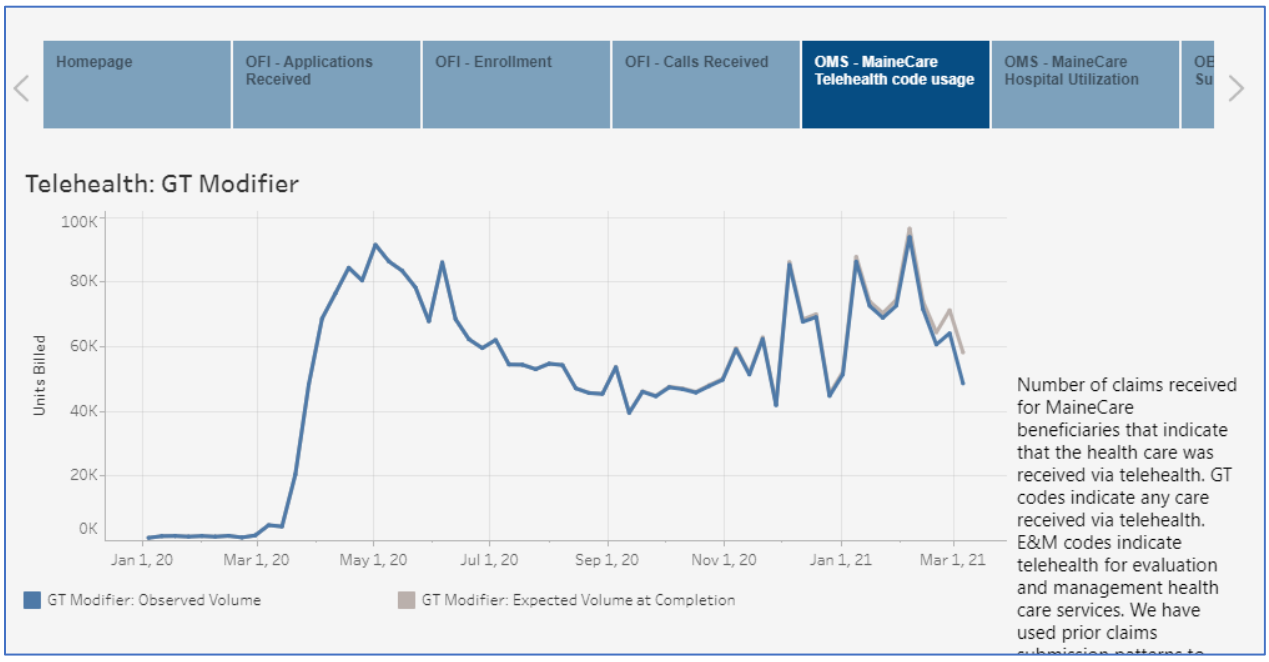
Telehealth Bills

May 6, 2021

Senator Sanborn, Representative Tepler and members of the Health Coverage and Insurance and Financial Services Committee, my name is Jeffrey Austin and I am with the Maine Hospital Association. I am offering this testimony in support of one change to the telehealth statues. I apologize I am not able to participate with you today.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals including 33 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital.

Our members have supported greater utilization of telehealth as well as reasonable state statutes that facilitate use of telehealth. The pandemic was like a lightning bolt into telehealth services. Below is the chart of MaineCare utilization of telehealth during the pandemic.



You can see that the use (which I believe is weekly, but I'm not sure) jumped considerably. I think that is a testament to both patients and providers willingness to embrace a technology that many may have been skeptical of previously.

During the pandemic, telehealth coverage has included telephone-only (as opposed two two-way audio and video) communications. It is this provision we are testifying to support today. I believe Medicaid is going to continue to allow audio-only communication after the state of emergency expires.

The audio-only provision appears in the legislation before you as follows:

- LD 323 – Section 2.
- LD 333 – Section 2.
- LD 849 – Section 1.
- LD 1007 – Section 2 (I think, the wording is a bit unclear).
- LD 1361 – Section 1.
- LD 1681 – Throughout the bill.

I believe it also appeared in legislation that was before this committee earlier this session.

We appreciate that most of the telehealth bills include this provision and whichever vehicle moves forward, we hope you include it.

Thank you.

Maine
Nurse Practitioner
Association

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26 Years of Full Practice Authority as Healthcare Providers for the People of Maine

Testimony in support of LDs 323, 333, 849, and 1007

May 6, 2021

Senator Sanborn, Representative Tepler
Members of the HCIFS Committee

My name is Pamela Cahill, I live in Woolwich, Maine and serve as the Executive Director of the Maine Nurse Practitioner Association. Thank you for hearing these important bills relating to telehealth services in Maine. I offer testimony on behalf of MNPA in support of LDs 323, 333, 849, and 1007. We also look forward to learning more about the Governor's new bill, LD1681, that was printed earlier this week. We have not yet had an opportunity to review or discuss this bill with MNPA's legislative committee.

Currently there are more than 2000 nurse practitioners licensed and working in Maine. These healthcare providers work in nearly every practice environment including private practice, independent practices, medical practices, clinics, FQHCs, physician practices, hospitals and the VA.

The Maine Nurse Practitioner Association is in full support of removing permanently restrictions for telehealth services in Maine by extending provisions of the Governor's Executive Order # 16 for healthcare practitioners, working within their scopes of practice.

Originally, MaineCare required initial prior authorization for telemedicine services followed by annual authorization renewal. In 2016, this requirement was removed after provider feedback asserted that the requirement created significant delays in providing telemedicine services and limited telehealth utilization. This important policy change, along with removal of geographic restrictions, created significant re-engagement from early telemedicine adopters and leadership in our state. The policy further confirmed that a service that could be safely delivered via telemedicine (as determined by the healthcare provider) and was covered by MaineCare in the in-person setting was eligible for telehealth service coverage and reimbursed at the same rate as the in-person service payment. 1

MNPA also supports requiring parity by private insurance carriers to reimburse for all telehealth services at the same basis and at the same rate as if the services were delivered in person.

Telehealth has come a long way in recent years and has become a most important asset to patients and providers alike during this pandemic. Because of telehelath we now can provide remote healthcare to the most rural areas of Maine and from infants to the elderly alike. It is only reasonable that we now include the use of telehealth in everyday healthcare delivery.

All healthcare providers who have stepped up to provide the very best care for Maine people are heroes of the last year. We support an omnibus bill that permanently allows all healthcare providers, working in Maine and beyond and working within their scopes of practice to utilize telehealth as a tool in their healthcare delivery toolbox.

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1 The paediatric weight management office visit via telemedicine pre- to post-COVID-19 pandemic.htm

Thank you for your consideration.

References

The Journal for Nurse Practitioners. 17(2021) 218-221 Telehealth Benefits and Barriers, Shilpa N. Gajarawala, Jessica N. Pelkowski.

Testimony in Support of LD 649, "An Act To Expand and Promote Telehealth Services," **LD 849**, "An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures," **LD 1007**, "An Act To Increase Availability of Health Care through Telehealth," **LD 1194**, "An Act To Reduce Health Care Worker Shortages," **LD 1361**, "An Act To Amend Telehealth Laws Regarding Out-of-state Telehealth Provisions," and **LD 1681**, "An Act Regarding Telehealth Services for Certain Licensees of the Office of Professional and Occupational Regulation and Certain Licensees Affiliated with the Department of Professional and Financial Regulation"

Good morning Senator Sanborn Representative Tepler and the distinguished members of the Committee on Health Coverage, Insurance, and Financial Services, my name is Nick Murray, I live in Cornish, and I serve as policy analyst for Maine Policy Institute, a nonpartisan, non-profit organization that advocates for individual liberty and economic freedom in Maine. Thank you for the opportunity to testify on LDs 649, 849, 1007, 1194, 1361, and 1681.

Telehealth can provide an array of care, including monitoring patients for strokes, eye exams, and even the prescription of certain drugs.[1] By forgoing in-person visits, telehealth can save patients time and transportation expenses. It can also save hospital staff time by eliminating paperwork required for in-person evaluations. The six bills in front of this committee would contribute a great deal to a more flexible and convenient healthcare system for Maine's elderly, rural, and most vulnerable residents.

Governor Mills made the right move early in the pandemic to relax licensing rules for physicians, nurses, pharmacists, and other medical practitioners. This was for the benefit of patients in Maine. Now that a year has passed, and no discernable cost to patient health and safety has been discovered, it is time to make these changes permanent in law and continue their benefits to society. LD 1194 specifically gets this done, and the other bills before you today will help provide more critical healthcare to Maine people.

LD 1361 and LD 649 would allow for practitioners located out-of-state to serve patients in Maine. These provisions are much needed in order to ensure an adequate supply of effective care at competitive prices for rural patients.

While we support it as well, if the committee moves to advance LD 849, we suggest amending Sections 4 and 8 which mandates insurers reimburse providers for

[1] Why rural hospitals should start operating more like a medical clinic to survive | Healthcare Finance News

telehealth services at the same rate as in-person care. Instead, the bill should use the current language of 24-A MRSA §4316, sub-section 2 which spells out that a carrier's telehealth service reimbursement rate may "not exceed" the cost of "a comparable service provided through in-person consultation."[2] A simpler way to accomplish this change would be to fully adopt LD 1007 as well.

This change would ensure that patients may receive the cost savings that telehealth may provide, and to not tie the hands of insurers to take advantage of those savings as well and pass them along to their customers.

We support LD 1681, the governor's bill, because it adds clear definitions related to telehealth service for the following practitioners and licensing boards: nursing home administrators, chiropractors, nurses, sign language interpreters, occupational therapists, optometrists, osteopathic physicians, physical therapists, the board of medical licensure, podiatrists, psychologists, veterinarians, alcohol and drug counselors, social workers, respiratory care practitioners, medical radiation therapists, dietitians, naturopathic doctors, acupuncturists, midwives, pharmacists, counselors, athletic trainers, and speech-language pathologists.

We are glad to see that the recent pandemic and related struggles to guarantee access to care in the pursuit of full-scale public health have shown policymakers the virtue of opening telehealth services to all medical care providers.

Once these common-sense reforms are implemented, the work to reboot Maine's healthcare system must shift to attracting skilled physicians and other medical professionals to Maine by expanding our scope of practice laws. As many Maine-based physicians are approaching retirement,[3] our licensing rules deserve the full scrutiny of the legislature as well.

For these reasons, please deem LDs 649, 849, 1007, 1194, 1361, and 1681 "Ought To Pass" and advance these critical reforms to Maine's telehealth regulations. Thank you for your time and consideration.

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[2] Title 24-A, §4316: Coverage for telehealth services

[3] Maine Physician Workforce Profile | American Association of Medical Colleges 2019 State Physician Workforce Data Report

MaineHealth

MaineHealth
Local Health Systems
Franklin Community Health Network
LincolnHealth
MaineHealth Care At Home
Maine Behavioral Healthcare
Memorial Hospital
Maine Medical Center
Mid Coast-Parkview Health
NorDx
Pen Bay Medical Center
Southern Maine Health Care
Synernet
Waldo County General Hospital
Western Maine Health

Part of the
MaineHealth Family
MaineHealth Accountable Care Organization

MaineHealth Affiliates
MaineGeneral Health
New England Rehabilitation Hospital of Portland
St. Mary's Health System

Jasmine Bishop, MaineHealth
Statement of Support for Telehealth Expansion
Thursday, May 6, 2021

Senator Sanborn, Representative Tepler and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, my name is Jasmine Bishop, Director of Telehealth at MaineHealth, and I am here today to testify in strong support of expanding coverage and maintaining payment parity for telehealth, including video visits and audio-only visits, and telemonitoring services because it will help increase access to healthcare for rural Mainers.

My testimony today generally addresses each of the bills you will hear today, but I would first like to say that we are grateful that the Administration has been proactive in supporting telehealth through MaineCare and requirements on commercial health plans during the pandemic. Because of the flexibilities provided, we have learned an incredible amount about telehealth and what works best for our patients and their clinical needs, and our position on these bills reflects those learnings.

Since the start of the Public Health Emergency, MaineHealth has conducted more than 200,000 video visits to patients' homes. MaineHealth has also conducted over 100,000 phone visits. While we always seek to offer video visits when possible, we acknowledge there are many cases in which a patient may need a phone visit including: patients without access to adequate broadband to support the significant data required for video, patients without significant resources to afford an adequate data plan, and patients without the necessary video-enabled devices. In a telehealth patient survey completed yesterday, May 5th, a patient wrote "The WIFI where I was wasn't great, so we finished the appointment on the phone." This patient was seeing a provider in Portland – access issues occur throughout our state. Back in January, a patient stated simply in their survey response "the phone call visit gave me the information I needed." When we segment services based on patient resources we decrease the access to care for patients without adequate resources and increase the digital divide. Moreover, telehealth is sometimes the only way to reach patients who would not have otherwise come into the clinic setting; this can be particularly true for behavioral health patients.

As a health care system with all eligible hospitals receiving Leapfrog A Safety Ratings or Best Rural Hospital designations, we are committed to ensuring quality of care in all interactions with our patients. Telehealth is simply another means of providing care, but the standards should not change based on the medium through/by which the care is delivered. Licensure protects patients whether the provider is in person or in another state. A patient who receives telehealth from a provider in Maine should expect that the same quality and

oversight standards apply as if the visit was in person. Licensure governs that oversight.

In order to maintain equitable access to all patients and consistent quality across the MaineHealth service offerings, the telehealth offerings must be reimbursed at the same rate as the equivalent in-person visit. Payment parity acknowledges this equivalent level of care is being achieved and the need for the health system to keep open every physical location when an escalation of care is required.

Our providers and patients have reported great success from the expanded use of telehealth during the pandemic and we expect that telehealth will be used long after the Public Health Emergency ends. With that said, we urge the Legislature to support expanding coverage and maintaining payment parity for telehealth.

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

State of Maine
130th Legislature
Joint Standing Committee on Health Coverage, Insurance, and Financial Services

Testimony of Charles F. Dingman

On behalf of the Maine Primary Care Association

Supporting

- LD 1681, An Act Regarding Telehealth Services for Certain Licensees of the Office of Professional and Occupational Regulation and Certain Licensees Affiliated with the Department of Professional and Financial Regulation (GOV BILL, Presented by Senator SANBORN, H. of Cumberland)
- LD 1007, An Act To Increase Availability of Health Care through Telehealth (Presented by Representative LIBBY, L. of Auburn)
- LD 1194, An Act To Reduce Health Care Worker Shortages (Presented by Representative LIBBY, L. of Auburn)
- LD 323, An Act Regarding Insurance Coverage for Telehealth Services" (Representative PERRY, A. of Calais)
- LD 333, An Act Regarding Telehealth (Presented by Representative HYMANSON, P. of York)
- LD 849, An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures (Presented by Representative MATHIESON, K. of Kittery)

May 6, 2021

Senator Sanborn, Representative Tepler, and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Charlie Dingman, a lawyer with the firm of Kozak & Gayer, and I am here today on behalf of the Maine Primary Care Association (MPCA). MPCA is a membership association that includes all of Maine's 20 Community Health Centers (CHCs). Maine's CHCs provide comprehensive primary and preventive care for approximately 1 in 6 Maine people. Community Health Centers make up the largest primary care network in the state, and they provide high quality, wide-ranging health care services. They are at the forefront of delivering care to underserved communities in our State, without regard to patients' ability to pay, and they have reconfigured their services to address the devastating impact of the COVID-19 pandemic on their patients and all of Maine's people.

The Maine Primary Care Association supports the various efforts of the sponsors of the bills before you today to address lessons learned about the value and effectiveness of telehealth,

borne of the unprecedented combination of a need to deliver care remotely during a public health emergency and the capacity in our time to do so. MPCA and its member health centers, which pivoted rapidly to deliver an unprecedented proportion of their services via remote technologies and, in the process, discovered unexpected benefits of doing so, support those portions of LDs 1681, 1007, 1194, 323,333, and 849 that recognize the value of telehealth and support its continued deployment wherever and whenever it serves the objective of providing access to high quality care for all Maine people. MPCA recognizes that the other bills before you this morning may also contain proposals that warrant your consideration as you develop your recommendations.

We thank the sponsors and cosponsors of these bills for bringing them forward. As you consider these bills and select the best parts of each to report out for enactment by the full Legislature, we ask that the final product of your deliberations include the following provisions.

1. **Payment and Coverage Parity.** Those providing health care coverage should pay for comparable telehealth services at the same rates established for in-person delivering of those services provided that the telehealth service is medically appropriate. Reduced reimbursement will hinder the ability of community health centers to continue providing services through telehealth beyond this emergency, wherever that method of delivery will improve access for those located far from the physical locations of their providers or facing other obstacles, such as transportation, to in-person visits. The largest component of the cost of health care is the labor cost for practitioners and support staff, and these costs do not diminish when telehealth is substituted for in-person care – nor can physical facility costs be reduced proportionately, because in-person care will still be needed. Telehealth also imposes additional technology costs. When these factors are considered, reduced rates for telehealth cannot be justified. Reduced rates for telehealth can have the unintended consequences of (1) encouraging providers to encourage in-person service delivery even when that choice will not enhance care and may discourage timely attention to health issues, and (2) providing incentives for development of high-throughput, lower quality health services rather than delivering the equivalent of in-person care without the risks, costs, and potential delays of unnecessary in-person visits.

2. **Continued licensing approval and equitable reimbursement of audio-only telehealth** for those that do not have access to the internet or to affordable internet services, or those who may be uncomfortable with video conferencing but whose health needs can be properly addressed through audio only interaction with a health care professional.

3. **Providing for electronic means of signifying consent** for a telehealth option when it is medically appropriate.

4. **Recognizing the Value of Telehealth for Behavioral Health Services.** The experience of Maine's CHCs has shown that telehealth will be a crucial tool as health care providers respond to the emerging mental health crisis arising from the COVID-19 emergency. CHCs need all the tools at their disposal to meet this unprecedented

demand for counseling, brief interventions, and intensive support for those needing behavioral health care. CHCs learned from the pandemic that people will use telehealth to get these services. In many instances, the CHCs found that telehealth access reduced no-shows and actually improved the quality of therapy dramatically.

5. **Broad scope for Telehealth.** The enacted laws resulting from your deliberations on these bills should continue to allow most health care services to be provided through telehealth when medically appropriate. Licensing and coverage should in fact be expanded to include specialty services to covered during this emergency, such that any service that can be delivered effectively and at high quality via telehealth should be within the scope of a licensee and reimbursed in the same manner as an in-person service of comparable complexity.

As noted in our testimony on the telehealth provisions of LD 1, which the Committee ultimately removed from that bill in recognition of the various other telehealth bills they would need to consider, consideration should be given to standardizing the language defining telehealth services for reimbursement purposes and including audio-only telehealth reimbursement across payor types. MPCA urges the Committee to consider adopting the MaineCare statutory standard, 22 MRS § 3173-H, and also to consider the simplification of that standard proposed by Representative Mathieson in L.D. 849.[1]

Thank you for your attention to MPCA' s concerns. We would welcome the opportunity to participate in the work session as you fashion a final product consistent with the expanded use of telehealth, which has provided unexpected benefits in addition to furnishing a way to limit exposure to COVID-19. I would be pleased to respond to any questions now, at the work session, or via the contact information provided below.

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[1] 22 M.R.S. § 3173-H(1)(D) provides that telehealth "includes telephonic services when interactive telehealth services are unavailable *or when a telephonic service is medically appropriate for the underlying covered service*." (Emphasis added.) This is a workable standard, but L.D. 849 would further improve this to remove case-by-case uncertainty about what audio-only services are reimbursable.

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NASW. MAINE CHAPTER
National Association of Social Workers

Committee on Health Coverage, Insurance and Financial Services
c/o Christian Ricci
Cross Building, Room 220
100 State House Station
Augusta, ME 04333

Re: LD 323: *An Act Regarding Insurance Coverage for Telehealth Services*;
LD 333: *An Act Regarding Telehealth*; and
LD 849: *An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures*

Dear Senator Sanborn, Representative Tepler, and other members of the Committee on Health Coverage, Insurance and Financial Services,

I represent NASW Maine in support of LD 323, LD 333, and LD 849. In response to the public health emergency (PHE) of the COVID-19 pandemic, Maine relaxed restrictions on telehealth provision and authorized reimbursement for audio-only services. Reimbursing audio-only services has not only enabled residents to safely access critical mental and behavioral health services during the pandemic, but has alleviated significant barriers for some Mainers that will still exist in the future (NASW).

Maine's rural, aging, and other low-income populations are most likely to benefit from continued telephone access to telehealth services (NASW). Affordable, accessible broadband is a barrier to receiving care for populations who, due to circumstances or health/mental health conditions, can not use video conferencing. The following are important points to consider:

- 83,000 or more households in Maine do not have adequate broadband access (State of Maine), which makes video conferencing a significant barrier to receiving telemental health services; and
- Only 4.5% of Maine households have access to wired internet of at least 25mbps download speed and 3mbps upload speed that costs $60 or less per month (BroadbandNOW Research).

With stable internet access inaccessible or unaffordable for many households, Maine needs to ensure continued access to care as our economy reopens by maintaining expansions in telehealth policies enacted in response to the PHE, including reimbursement for audio-only services. The ramifications of the COVID-19 pandemic will be felt for years to come, and Maine needs to keep telehealth accessible.

I urge you all to vote "Yes" on LD 323, LD 333, AND LD 849.

Respectfully submitted,

Danielle Blair
Policy Committee Co-Chair
NASW Maine
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Exact References:

BroadbandNow Research: https://broadbandnow.com/research/best-states-with-internet-coverage-and-speed

NASW, Medicare Reimbursing for Audio-Only Psychotherapy: https://www.socialworkers.org/News/News-Releases/ID/2145/Medicare-Now-Reimbursing-for-Audio-Only-Psychotherapy

NASW & Others, Sign-on Letter for the DHHS and the CMS: https://www.socialworkers.org/LinkClick.aspx?fileticket=JjwfXndy9PU%3D&portalid=0

NASW & Others, Sign-on Letter for Sustaining Telehealth Services: https://www.socialworkers.org/LinkClick.aspx?fileticket=d_HXct-60bA%3D&portalid=0

State of Maine, Broadband Action Plan January 2020: https://www.maine.gov/connectme/sites/maine.gov.connectme/files/inline-files/Plan_Action_2020.pdf

National
Multiple Sclerosis
Society

Maine Legislature – Committee on Health Coverage, Insurance and Financial Services
Public Hearing – May 6, 2021
LD 333, LD 323, LD 649, LD 849

Testimony of Laura Hoch,
Senior Manager of Advocacy, National MS Society

Chair Sanborn, Chair Tepler, and members of the Committee on Health Coverage, Insurance, and Financial Services, thank you for the opportunity to submit testimony on telehealth services and how individuals living with multiple sclerosis (MS) are benefiting from them.

MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. Nearly 1 million people in the United States and 2.3 million worldwide are currently living with MS.

Telehealth services help provide access to medically necessary care for individuals that may have limited mobility or live in an area where there is a shortage of primary or specialty health care providers. These services allow patients to access healthcare through various platforms including telephone, digital communications, and video chats with their health care providers. Network adequacy is of particular concern for those living with MS, as an individual may require care from a variety of provider types, including neurology, physical therapy, occupational therapy, urology, ophthalmology and more. Telehealth should supplement, not supplant, provider networks.

Telehealth services are instrumental in ensuring that people with MS get the care they need, as they broaden the number of providers that people living with MS have access to while making it easier and less costly to reach those providers for routine consultations. The need for continued access to telemedicine beyond the current public health crisis is crucial. For many people living with MS, getting out of the house is not easy and they may face physical barriers to care. People with MS use mobility devices and may rely on public transportation or disability services to reach appointments. These options are often unreliable and lead to patients missing their time slots. Allowing virtual appointments means that those living with MS and other

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chronic, disabling conditions can access the care they need when they need it. The Society believes that expanded use of these services allows states to implement innovative health policy reforms that improve health care access, achieve significant cost savings, and improve health outcomes for people living with MS, particularly in rural and underserved communities.

In a survey conducted by the National MS Society (Society) over a three-week period in May, 44% of respondents reported that they had utilized telehealth services for their MS care. In more recent surveys of people living with MS and healthcare providers, there is overwhelming support for the continuation of telehealth. 89% of people living with MS and 93% of providers were satisfied with the telehealth appointments they had while 81% of people living with MS and 94% of providers hoped to continue using telehealth services after the COVID-19 pandemic. While respondents generally liked the convenience and ability to keep their appointments with their providers, people with MS noted that some appointments had to be in-person to appropriately assess their concerns. The Society believes an individual should have the opportunity and flexibility to choose, along with their provider, whether they will access care in-person or via telehealth technologies.

The Society is committed to working with people living with MS and their healthcare providers to identify what telehealth should look like moving forward in order to best address their needs. We are aware that there are many bills being heard today that have the potential to increase access to telehealth services, particularly LD 333, LD 323, LD 649, and LD 849. Generally, what we see as important aspects of telehealth in supporting access for Mainers living with MS are:

- Access to Healthcare Providers and Services: The Society recommends that people living with MS should have access to a comprehensive network of providers and healthcare services focused on producing the best outcomes at affordable costs. Continued access to expanded telehealth services will ensure that data regarding utilization and patient outcomes is consistent and can be assessed in a timely manner by organization and researchers.
- Types of Telehealth Providers: we support allowing all providers to participate in the remote-based delivery of care and medications within each provider's accepted scope of practice.
- Licensure: we support increasing access to telehealth by allowing all providers who are licensed and in good-standing to provide remote-based care, regardless of where they are currently located.
- Reimbursement of Telehealth Encounters and Originating Site (location of patient): we support proposals and policies that requires providers to be reimbursed equally for the

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delivery of remote care as they would be for services provided in-person (pay parity). Further, the Society opposes any policy that places unreasonable restrictions on the delivery of telehealth, including originating site restrictions, geographic restrictions, and restrictions on the types of providers or services that are eligible for reimbursement.

- Access to Broadband Internet Connection: we support efforts to ensure that access to telehealth is as broad as possible. Access to internet connections able to handle video calls for telehealth appointments is limited in minority, rural, and poor communities. Telehealth services should be equitably available through easily useable technologies that are accessible to people with disabilities, with limited English proficiency, and limited technology. When taking steps to expand telehealth support to the country, it is important to ensure that all parts and all people in the nation are able to access it.
- Audio-only services: we support the inclusion of telehealth services via audio-only connections. With the inaccessibility of broadband in many communities, including the rural areas of Maine, many people cannot connect to telehealth services that require video communication. According to the census bureau, nearly 36% of Black and 30% of Hispanic households had no broadband or computer access in their homes. Additionally, an inability to use video communications based on disability can lead to more individuals missing virtual appointments.

Many of the bills being heard today, including LD 333, LD 323, LD 649, and LD 849, are great next steps in providing telehealth access to our Mainers. The Society urges this committee – and the larger legislative body – to update current law to improve telehealth in Maine. Allowing individuals, especially those with chronic diseases such as MS, to use telehealth to conveniently access a wide range of providers, will improve the lives and health of many. We look forward to working with your committee and the legislature on this issue.

Please contact me if I can be of further assistance: laura.hoch@nmss.org (860) 913-2550 X52521.

Dear Senator Sanborn, Representative Tepler, and Members of the Health Coverage, Insurance and Financial Services Committee

The American Heart Association (AHA) is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, whose mission is to be a relentless force for a world of longer, healthier lives. We are writing in support of LD849, *An Act to Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures and LD333, An Act Regarding Telehealth*.

The outbreak of COVID-19 has put a strain on the healthcare industry and laid bare significant gaps in access to quality care in the United States. Issues such as large populations of uninsured and underinsured, primary and specialty care shortages, hospital closures, and the disproportionate impact of chronic disease on minority ethnic and racial populations have been magnified exponentially by the outbreak. Additionally, many states and local communities have implemented stay-at-home edicts, thereby further restricting patients' access to traditional healthcare. The crisis has forced healthcare systems and regulatory bodies to turn to turn to telehealth to provide healthcare. Telehealth has enabled patients, healthcare providers and health systems to communicate through virtual channels in in-patient, ambulatory, and non-healthcare environments. The American Heart Association (AHA) recognizes the potential impact of telehealth on access to quality care and supports policies that ensure patients and healthcare providers are adequately reimbursed for it and have access to its benefits when it is clinically appropriate. The COVID-19 pandemic shifted the paradigm, however, when it comes to ensuring all patients have access to adequate and affordable care. Telehealth filled the void and quickly shifted from a previously slow adoption path to a record pace of uptake. Although telehealth has been showcased as a primary means for accessing care, and for its ability to address long-standing barriers to accessing care for vulnerable populations, it has also shown to be a vehicle for exposing new barriers. Evidence suggests that telehealth can make health care more effective, accessible, and efficient, particularly for those who otherwise lack access to quality healthcare. Telehealth potentially allows quality health care to be delivered to patients in communities where in-person subspecialty services are not available, providing support and training for complex medical conditions to local providers, increasing accessibility for families to specialists, and minimizing time away from work and home.

While access to affordable and adequate care is extremely important during a pandemic, the barriers to care that existed prior to the COVID-19 pandemic remain and new ones have arisen. The actions taken by the Federal and various state governments to expand access to telehealth services have been a step in the right direction, but they have been limited in scope and their impact has been mitigated by disparities in access to adequate broadband and technology. Permanent laws and regulations are needed that establish both public and private reimbursement that is equitable with traditional, in-person care and that does not discriminate based on the patient's or provider's geographical location. Additionally, public health and technological infrastructures must be fully and equitably modernized to ensure that all patients have optimal

access to the benefits of telehealth and that all providers have optimal opportunities to procure, implement, and use telehealth to treat patients. The AHA believes that telehealth has the potential to expand access to quality care for all.

Utilizing a broad definition of chronic disease management ensures that the state's implementation of telehealth includes relevant and critical space to remain aligned with evolving medical evidence, precludes the need to establish a process by which we could revisit a pre-established list of conditions, and removes the potential for bottlenecks in the provision of accessible care that do not exist within in-office settings. Additionally, we would encourage any legislation that defines telemedicine to allow those providers who are providing care and treatment for in-person chronic disease management services to also provide telehealth care and services.

Most importantly, we would note that healthcare providers have been providing care and treatment to patients via telehealth throughout the pandemic – which has been reimbursed on-par with in-person visits. Should such reimbursement parity for the services and patients be reduced, there is the potential for access to telehealth to be reduced, thereby compelling patients to seek in-person services, many of whom have transportation issues, childcare issues, and/or are immunocompromised or at higher risk of contracting, becoming severely ill or being hospitalized with COVID-19. To compel in-person services for such patients could reify existing systemic disparities in accessing healthcare, thereby undoing the significant equity benefits of telemedicine.

We are asking as you work to clarifying in the legislation that you ensure that patients have access to clinically appropriate telehealth services, by including patient homes as an originating site or wherever the patient is located to allow for more flexibility for the patients and to ensure that we do not create barriers for accessing telehealth services and work to ensure it is equitable. We also want to ensure that all coverage for telehealth is consistent for what is covered in person, for our patients' things like cardiac and stroke rehab need to be included. In response to the Covid-19 pandemic, CMS specifically added reimbursement for cardiac rehabilitation delivered through telehealth within the Medicare program. The added services primarily cover cardiac rehabilitation and point to an increased interest among healthcare providers to use remote patient monitoring platforms to improve care management for cardiac care patients at home because recent studies suggest that patients with cardiac issues aren't accessing routine checkups and other services during the pandemic, putting them at higher risk of a serious health issue.

Thank you very much for your time and your consideration of these matters. We appreciate the opportunity to offer these comments as you craft and formulate policies to advance and expand access to telehealth services in Maine. Should you have any questions or concerns, please do not hesitate to reach out me at the American Heart Association, Allyson Perron Drag, Government Relations Director at allyson.perron@heart.org or 857-540-9686.

Northern Light Health

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Mercy Hospital
Northern Light Health Foundation
Sebasticook Valley Hospital

Testimony in Support
May 6, 2021

LD 323 An Act Regarding Insurance Coverage for Telehealth Services
LD 333 An Act Regarding Telehealth
LD 849 An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures
LD 863 An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients
LD 1681 An Act Regarding Telehealth Services for Certain Licensees of the Office of Professional and Occupational Regulation and Certain Licensees Affiliated with the Department of Professional and Financial Regulation

Senator Sanborn, Representative Tepler and members of the Health Coverage, Insurance and Financial Services Committee, my name is Lisa Harvey-McPherson RN, I am here today providing testimony on behalf of Northern Light Health and our member organizations to speak in support of telehealth bills before the committee today. Northern Light Health member organizations include 10 hospitals located in southern, central, eastern and northern Maine, 8 nursing facilities, air and ground ambulance, behavioral health, addiction treatment, pharmacy, primary and specialty care practices and a state-wide home care and hospice program. Ninety three percent of Maine's population lives in the Northern Light Health service area. Northern Light Health is also proud to be one of Maine's largest employers with over 12,000 employees statewide.

Northern Light Health is proud of our clinical and technology expertise as a leader in the provision of telehealth services to the people of Maine. With our experience we worked in partnership with legislators to create a dedicated MaineCare telehealth benefit and modernizing commercial carrier coverage of telehealth services. We never envisioned how important this work was until COVID-19 transformed telehealth allowing us to care for thousands of individuals at home during the pandemic. In February of 2020 Northern Light Health provided 1500 telehealth encounters this grew to over 33,000 monthly encounters in May of 2020 and today we continue to provide a significant volume of telehealth encounters averaging over 20,000 per month.

Our telehealth services lines have expanded to include pre-post-surgical care, rheumatology, cardiology, neurology, gastroenterology, orthopedics, oncology, women's health, pediatrics and primary care and behavioral health. Our patients have also responded positively to telehealth care with 60% responding positively to telehealth care. Twenty one percent respond negatively, and this is focused on lack of adequate internet connectivity.

Expanding telehealth during the pandemic period also identified coverage policy changes that needed to be implemented via waivers and declarations to effectively meet the needs of patients receiving telehealth services. The bills before you today transition these changes to permanent coverage policy.

Telephonic Coverage – Nearly all of the bills transition audio only service into the definition of telehealth as a covered service. We are all well aware of the broadband challenges in many parts of Maine. Individuals in these areas do not have the bandwidth to support a quality video telehealth encounter. In these instances' audio only communication is essential to support providers contacting their patients to address various health care needs. We also learned that audio communication is a preferred method for some of our patients. We are in full support of including audio only communication as a permanent telehealth covered service. Should the committee decide that the provider must document why audio only is the means of telehealth communication, we ask that this be recorded once in the record and not a requirement for each and every encounter. We further support changes in LD 323 that strikes from the current law facsimile machine, email or texting as excluded from the definition of telehealth. These are means of communicating clinical information and the current language creates confusion particularly when clinical information is transmitted between providers via secure email communication.

Consent – LD 323 includes language that is specific to the MaineCare program allowing patients to provide verbal, electronic or written consent for telehealth services. MaineCare provided temporary flexibility for verbal consent and it is important that verbal consent continues as permanent policy. It is highly disruptive to interject paper mandates into an technology-based environment of care.

Payment Parity Including Reimbursement & Deductibles – The bills before you today retain payment parity that was mandated during the pandemic period and we are full support of making parity permanent policy. It is an incorrect assumption to think that provider costs of telehealth are lower than an in-person encounter. We actually have new costs related to telehealth including zoom customer service teams for patient education and troubleshooting and expanded roles for clinical support staff pre- telehealth visit, during the encounter and post telehealth visit.

Prescription Medications – LD 333 states that the carrier may not place any restriction on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that is more restrictive than any requirement in state and federal law for prescribing medication through in-person consultation. We are in full support of this language. During the pandemic patients receiving telehealth encounters received prescriptions for medications to address their particular medical conditions and it is important that this continue post pandemic.

Telehealth Covered Services – LD 1681 allows a variety of licensed and registered professionals to provide necessary health services via telehealth. The bill includes a number of professionals employed by Northern Light Health including psychologists, counselors, clinical social workers, therapists and more. We support transitioning the services provided to permanently covered telehealth services post pandemic.

Thank you for the opportunity to speak in support of the important telehealth bills before you today.

LD 649 & LD 1361

Committee on Health Coverage, Insurance and Financial Services
Maine State Legislature

May 6, 2021

Haley Holik
Visiting Fellow
Opportunity Solutions Project

Committee Members,

In the past year, many of us began to appreciate the tremendous value and potential of telehealth. It helps protects patients with chronic conditions, as well as caregivers, by allowing them to avoid crowded offices. It increases access to remote and rural areas. It provides patients with more immediate access to care. And it does all this while saving families money.[i]

Opportunity Solutions Project (OSP) advocates for state policies that are proven to help people achieve the American Dream. OSP supports LD 649 and LD 1361 because both bills would make health care more accessible and affordable, which means healthier families with more breathing room in their budgets.

These bills present two different paths to achieve the same policy goal—expanding access to care by removing barriers to cross-state telehealth. But between the bills, LD 649 embodies the stronger policy. LD 649 improves Maine's current framework for cross-state telehealth, while LD 1361 replaces it with a new framework.

Current law requires out-of-state physicians to register with the medical board to provide telehealth services to patients located in Maine. LD 649 removes some of the barriers within the existing policy that prevent physicians from delivering cross-state telehealth services to patients. Instead of granting the board discretionary authority, LD 649 requires the board to register out-of-state physicians.

But LD 649 maintains important safeguards to protect patients. In order to be registered in Maine, physicians must hold an unrestricted license to practice medicine from another state, have not had a license revoked or restricted in any jurisdiction, clear professional background checks, and re-register every two years.

The bill removes another critical restraint on cross-state telehealth. Under current law, a health professional licensed in Maine must request the cross-state telehealth service while maintaining authority over the diagnosis. LD 649 allows registered physicians to deliver full, cross-state telehealth services, as opposed to limited consultative services.

Just as the cost of maintaining multiple licenses discourages physicians from utilizing the Interstate Medical Licensure Compact, registration fees can act as a barrier to cross-state telehealth. Importantly, LD 649 reduces the current registration fee by $200. This is also why OSP supports LD 1361.

LD 1361 would repeal the current registration requirement, allowing out-of-state physicians to deliver cross-state telehealth without paying a fee. However, similar to Maine's current law, LD 1361 would require out-of-state physicians to hold an unrestricted license while limiting out-of-state physicians to consultative telehealth services.

The policy changes in LD 649 will create more health care options for Mainers, provide more immediate access to care, and help families control health care costs. And Maine can make telehealth a more valuable tool in the health care toolbox with LD 1361. The last year has shown that telehealth helps patients stay healthy, and Maine should expand access to care with the policies in LD 649 and LD 1361.

Haley Holik, Visiting Fellow

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[i] Garrison Nord et al., "On-demand synchronous audio video telemedicine visits are cost effective," American Journal of Emergency Medicine (2019), https://www.sciencedirect.com/science/article/abs/pii/S0735675718306533?via%3Dihub.

Haley Holik
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Testimony of Rep. Sam Zager introducing

LD 333 An Act Regarding Telehealth
LD 1007 An Act to Increase Availability of Health Care Through Telehealth

Before the Joint Standing Committee on
Health Coverage, Insurance, and Financial Services

May 6, 2021

Senator Sanborn, Representative Tepler, and other honorable members of the Health Coverage, Insurance, and Financial Services Committee, thank you for your service and holding this hearing. I'm Sam Zager, and I am honored to represent House District 41 in Portland, and pleased to testify as a cosponsor of LD 1007.

I cosponsored this bill because, I join others in believing we have an opportunity to thoughtfully define the contours of telemedicine as a mode of the delivery of healthcare in Maine. The current executive order has permitted patients in Maine to continue to have access to credentialed healthcare providers via telemedicine to an extent like never before. *The approach suitable for a pandemic likely needs to be refined as we look toward an eventual time when the current pandemic recedes.*

- Here's an example of an ideal use of telemedicine from a couple weeks ago: I have a young adult male patient who had not come for an appointment, despite our outreach, for a few years. I then received a message that he was at a recovery residence, after having relapsed with heroin. Fortunately, his girlfriend, friends, and employer all recognized opioid use disorder as the treatable condition that it is, and convinced him to get ugent inpatient help. He told me that this wrap-around of "tough love" was very powerful and therapeutic. Before he could be lost to follow up again, we arranged a telehealth visit. It was an opportunity for him to seamlessly re-establish priamry care; see that his doctor was very invested in his wellness and very much welcomed him back; and afforded us an opportunity to coordinate care with the inpatient treatment facility.

- Here's an example of a visit that would have been catastrophic if we assume telemedicine is equivalent to in-person care. An older woman came for an annual wellness visit, and during the routine exam, I heard with my stethoscope some turbulence in her carotid artery. This was an ominous finding, signaling risk of an impending stroke. We obtained an ultrasound, which confirmed a high-risk lesion, which a skilled vascular surgeon cleared.

As Representative Hymanson mentioned in her remarks introducing LD 333, telemedicine has proven utility, but also definite limitations. We in this 130th Legislature see every day how operating in a virtual environment is *functional* but *not ideal* for legislative work. So too with telemedicine, and I would submit, as both a practicine primary care physician and a legislator, that much more legislation than healthcare can be done in the virtual environment.

Thank you for your attention. I would be happy to take questions.

May 6, 2021

Testimony for Committee on Health Coverage, Insurance and Financial Services

Good Morning. My name is Susan Woods. I am a physician and researcher, with over 15 years of digital health expertise gained in private practice and at the Veterans Health Administration. I also served as the telehealth representative on the *ConnectME Authority* for 4 years.

My career in remote care, or care at a distance, began in 1999 when I founded the Maine Tobacco HelpLine, a telephonic treatment program freely available to anyone in the state.

I am here to support LD 323, LD 333, LD 649, and LD 849.

My comments are focus on existing evidence and research, the need to enhance access to care for all Maine residents, and a vision to position Maine for the future of digital health.

I will first start with **evidence on telephone care**, for which the above bills are advocating.

- Telephone interventions have been supported by research for decades.
- The Maine Tobacco HelpLine has delivered phone-based behavioral counseling for 21 years. As Director, we published peer-reviewed papers showing effectiveness and reach. Quit rates rivaled those seen in rigorous trials. Importantly, people from all over the state received services. Telephone care offers superb reach to everyone.
- Much can be accomplished by phone, including discussions about treatment, monitoring health conditions, providing psychological support, and addressing end-of-life care. This can be provided whether it's a scheduled call, or happens *ad hoc*.
- Ask any clinician or adult in Maine today and they will confirm: talking by phone is beneficial, can augment in-person care, or substitute for an in-person visit.
- Digital divides are narrowing but persist. Most residents have a cellphone but 39% of older adults don't have a smartphone. Many rural homes don't have high-speed internet. Audio-only telehealth will help mitigate inequity.

Second, **virtual care *is* health care.** People want *care at a distance,* at home, work, and school. Providing services remotely must be *what healthcare does*. Digital health services, such as access to patient portals, telehealth, remote monitoring, and mobile apps, will improve the health of Mainers at a lower cost, and reduce health professional burden. Telehealth - by video or audio – profoundly improves access to care and should not be placed in a separate technology bucket. Removing requirements such as "medical necessity", and allowing verbal consent and use of a resident's own technology, will help ensure digital health equity. Rural and low-income residents must be afforded the same level of access to and convenience of virtual care services.

Yes, telehealth visits can be qualitatively different than in-person visits. I may have limitations on conducting a full physical exam, but with video I gain more information about a person's life, or can bring in a family member living elsewhere to the encounter. Telehealth visits are clinical encounters and should be treated as such. Medical visit coding and encounter requirements already include all the necessary guidelines and guard rails to help determine the level of effort. Please, do not create standards and bureaucracy that are greater for virtual care than in-person care.

Third, we need skate to the where the puck is going, with policies that **support digital health now and in the future**. We must be also be careful not to micro-manage a clinical encounter by the channel through which it is provided. Today, it is in person, video and phone. Tomorrow we will have visits using virtual or augmented reality. Perhaps eventually via your television. We must make sure to not introduce more complexity in a system and in peoples' lives that is already must too complicated.

Thank you.

Susan S. Woods, MD, MPH
Harspwell, ME 04079

Testimony of Dr. Lew Levy
Health Coverage, Insurance and Financial Services Committee
May 6, 2021

Good morning Senator Sanborn and Representative Tepler and members of the Committee. Thank you for the opportunity to speak to the Committee on policy issues regarding telehealth. I am the Chief Medical Officer of Public Policy & Strategic Partnerships at Teladoc Health. In this position, I am responsible for advocating for policies that support clinical quality and the patient experience thru telehealth. I have over 30 years of clinical experience and am a nationally recognized thought leader on healthcare innovation. I have had extensive experience as an internist and have taught at Harvard Medical School and other leading Hospitals.

I'd like to give you a little background on Teladoc Health. We are a global company delivering care in 175 countries, partnering with employers, hospitals, health systems, and more than 50 health plans in the U.S. to transform care delivery.

We are very proud of our contribution to healthcare in Maine and have a robust presence there; over 2100 employers offer Teladoc Health to their employees and we cover over 110,000 lives in the state. In 2020 we performed over 4500 consults and saved the healthcare system and the patients there over 2 million dollars. Your physicians are our physicians. All physicians who treat Maine patients are licensed by the Maine Board of Medical Licensure. Safety and access are our top priorities and we take that responsibility very seriously.

Good telehealth policy includes three very important pillars; the standard of care must be the same for telehealth as it is for in-person care; secondly, the modality is not important as a standalone policy issue but must support the standard of care. Therefore, we always encourage policy makers to take a "technology neutral approach." Lastly, I tell policy makers that telehealth not only increases the access to quality healthcare, but it also brings savings to the patient and the payor. Teladoc Health believes that if a physician provides a service, they should be fairly compensated for that service. Telehealth providers like Teladoc Health and others don't have the overhead that a bricks and mortar practice do and are able to provide our services at a significant savings. However, your local providers have invested capital into their practices in order to provide telehealth services and it is not unreasonable to expect to reimburse them at a higher amount than you would a virtual only provider.

The bills before you today, with the exception of those that would require reimbursement parity are quite good and speak to not only a technology neutral approach but contemplate issues such as licensure, the importance of asynchronous technologies and the Psychologists Interjurisdictional Compact. All of these will improve access to quality medical and mental health services.

Lastly, the only other recommendation that I would make to the Committee is to consider including email and text in a limited capacity for Mental Health treatment and for use in remote patient monitoring. Experience has shown patients who would not normally seek mental treatment will do so if the entry into treatment is text based with the goal of building up to a video visit. Patient adherence to therapy is greatly increased thru the use of remote patient monitoring for diabetes and cardiovascular disease if the patient can receive prompts and coaching relative to diet and medication adherence.

Thank you and I will be glad to answer any questions.

MAINE PSYCHOLOGICAL ASSOCIATION

May 4, 2021

Representative Perry
Representative Hymanson
Representative Tepler
Health Coverage, Insurance and Financial
State House
Augusta ME 04332

Re: LD323 An Act Regarding Insurance Coverage for Telehealth Services

Dear Representative Perry, Representative Hymanson, and Representative Tepler:

The Maine Psychological Association (MePA) is a membership organization representing psychologists in Maine who work in private practice, at Maine's colleges and universities, and in the public sector. Our mission is to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

MePA supports An Act Regarding Insurance Coverage for Telehealth Services. This bill amends the law that requires health insurance carriers to cover telehealth services to provide that health care services provided through telephone communication are considered telehealth services, thus requiring a carrier to cover health care services provided through telephone communication regardless of whether or not other telehealth services are available. It also allows patients receiving MaineCare health services to provide verbal, electronic or written consent to telehealth and telemonitoring services.

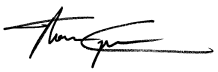
Psychologists and their patients have concerns that as state and national public health emergency declarations end, the current public health emergency mandates will expire resulting in many insurers reverting back or terminating pandemic-related telehealth expansions.

Many patients in need of mental and behavioral health services have conditions and disorders that prevent them from safely (or without great anxiety) leaving their homes and sharing close personal space with other people. This will be especially burdensome on moderate- and low-income subscribers who have no choice but to take public transportation or rely on others to get to their in-person health care appointments.

Allowing coverage and reimbursement of audio-only telephone services addresses the inequity problem that lower SES and older patients tend to have less access to the resources and skills required for telehealth via traditional video-conferencing platforms (access to laptops and smartphones, broadband services, and the skills to use videoconferencing systems) and older patients often have transportation issues that are barriers to accessing in-person services.

Telehealth boosts patient access, which will help Maine meet the increased mental health needs resulting from the pandemic.

Sincerely,



Thomas Cooper, PsyD
President

Maine Academy of Nutrition and Dietetics
an affiliate of the Academy of Nutrition and Dietetics
PO Box 10214, Portland, Maine, 04104; www.eatrightmaine.org

Testimony in Support of LD 323 - An Act Regarding Insurance Coverage for Telehealth Services
Submitted by Patsy Catsos, MS, RDN, LD

Good morning, Senator Sanborn, Representative Tepler and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services,

My name is Patsy Catsos and I am a resident of Portland. I am speaking on behalf of the Maine Academy of Nutrition and Dietetics where I serve as a member of the Public Policy Panel. The Maine Academy is an affiliate of the Academy of Nutrition and Dietetics, an association that represents over 100,000 credentialed dietetics and nutrition practitioners. We are the food and nutrition professionals who can translate the science of nutrition into practical solutions for healthy living. As health care practitioners, we strive to improve the health of Maine's citizens through quality food and nutrition information and nutrition care services. Our members work across the state in hospitals, schools, public health clinics, nursing homes, food service management, universities, research, and private practice.

In my work as a Registered, Licensed Dietitian I am a consultant at Nutrition Works in Portland, providing one-on-one medical nutrition therapy to patients with gastrointestinal diseases and disorders. Other dietitians in our practice deliver specialty nutrition care for patients with a variety of other conditions. While some patients do prefer face-to-face visits, the *option* of telehealth can benefit Maine residents who are referred for medical nutrition therapy, because it is both effective and accessible.

Effective: As we and our patients learned during the COVID-19 pandemic, medical nutrition therapy can be provided very effectively via telehealth, as all of the tasks in our workflow can be performed remotely. Meeting with patients while they are at home allows them to check their pantries and medicine cabinets as needed to share important details about the food and nutrition products they are consuming. Timely follow-ups increase effectiveness, too, and are easier for patients to squeeze into their busy schedules when they can meet with us via secure video-chat. Many of our patients prefer telehealth because of this.

Accessible: With telehealth, travel distance is no longer a barrier to accessing a licensed provider of specialty dietetic care. It seems obvious that Maine residents who live in distant parts of the state benefit from access to the same care as those living in Maine's biggest cities. Telehealth means all Maine citizens can access specialty services without travel expenses and without taking one or more days off from work. Perhaps less obviously, travel can be physically taxing and difficult to manage for those who are ill; telehealth solves this problem. I recently helped an 82-year-old gentleman in Downeast Maine recover from post-infectious irritable bowel syndrome and unintentional weight loss. He needed ready access to a bathroom due to his illness, and he would have been unable to make even a single trip to visit my office in Portland, much less a series of visits. He and his wife adapted readily to the telehealth platform. His weight and his strength have now been restored and he is feeling well again thanks in part to the option of using telehealth for his care.

Registered, licensed dietitians are recognized as reimbursable health care providers in Medicare. Under the current emergency rules, we are permitted to provide medical nutrition therapy via telehealth; before the pandemic, we were not. Many private insurances also provide benefits for nutrition services when provided by a registered, licensed

dietitian. Under the current emergency rules insurance companies are reimbursing us for services provided via telehealth; before the pandemic, it was hit or miss. Patients were reluctant to take a chance on accessing their benefits via telehealth because the coverage information for telehealth was very difficult to determine ahead of time, even by contacting the insurance company, and often resulted in a significant out-of-pocket bill for patients.

I am here today to testify in support of LD 323, An Act Regarding Insurance Coverage for Telehealth Services, as it amends the definition of telehealth to include telephonic services and allows for patients receiving MaineCare to provide verbal, electronic or written consent to services, with recommendations as follows:

- Ensure that the term 'telehealth provider' does include the registered, licensed dietitian of the patient's choice and participating in the patient's payer network. Before the pandemic, some payers were refusing patient access to telehealth benefits for services from licensed specialists in the patient's locale or state. They were apparently able to meet the letter of Maine's telehealth law by offering services only from their own employed health coaches or other staff.
- Ensure that the term 'health care services' does include nutrition services and/or medical nutrition therapy.
- Ensure that all health insurance carriers that cover nutrition services and/or medical nutrition therapy for residents of the State of Maine, are required to follow the legislation, including plans which are self-funded or written out of the state of Maine. Without this, providers are unable to inform patients in advance whether their insurance will cover the services they need. In our experience, without this assurance, most patients will decline the services rather than take a chance.
- Ensure that Maine residents with policies that cover nutrition services and/or medical nutrition therapy get reimbursement of these services at the same rates and co-pays as face-to-face visits. Even during the present healthcare emergency, several payers are reimbursing providers at lower rates for the same nutrition services provided via telehealth compared to in-person visits.

We urge you, the members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, to support LD 323 that will allow Maine people access to nutrition services and medical nutrition therapy from registered, licensed dietitians using telehealth that includes telephonic services. Thank you and we remain available as a resource to this committee and to answer any questions you may have.

Anne C. Perry
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anne.perry@legislature.maine.gov

HOUSE OF REPRESENTATIVES
2 STATE HOUSE STATION
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Testimony of Representative Anne Perry Introducing LD 323, "An Act Regarding Insurance Coverage for Telehealth Services"
May 6, 2021

Good morning Senator Sanborn, Representative Tepler and members of the Committee on Health Coverage, Insurance and Financial Services. I am Representative Anne Perry and I represent nine communities in Washington County. I am here today to introduce LD 323, "An Act Regarding Insurance Coverage for Telehealth Services

This bill seeks to continue as permanent the telehealth services that were expanded as a result of the Covid-19 pandemic.

This bill amends the law that requires health insurance carriers to cover telehealth services to define health care services provided through telephone communication as telehealth services. This will require a carrier to cover health care services provided through telephone communication, regardless of whether or not other telehealth services are available. It also allows patients receiving MaineCare health services to provide verbal, electronic or written consent to telehealth and telemonitoring services.

Telehealth, which has had limited use in rural areas of Maine, can make health care more accessible to those who do not have the means or ability to travel to services. The pandemic emergency rules have given telehealth have allowed for a broader use of telehealth services. This had been a good test of the effectiveness if telehealth, and from what I have seen, the results justify its continued use.

Thank you very much for your consideration.

Proposed Language addition to Maine 333

Additions in Red

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document No. 333

H.P. 237 House of Representatives, February 8, 2021

An Act Regarding Telehealth

Received by the Clerk of the House on February 4, 2021. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT

Clerk

Presented by Representative HYMANSON of York.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2904, sub-§1, ¶A, as amended by PL 2019, c. 289, §1, is further amended to read:

A. A licensed health care practitioner who voluntarily, without the expectation or receipt of monetary or other compensation either directly or indirectly, provides professional services, including services provided through telehealth as defined in Title 24-A, section 4316, subsection 1, paragraph E C, within the scope of that health care practitioner's licensure:

(1) To a nonprofit organization;

(2) To an agency of the State or any political subdivision of the State;

(3) To members or recipients of services of a nonprofit organization or state or local agency;

(4) To support the State's response to a public health threat as defined in Title 22, section 801, subsection 10;

(5) To support the State's response to an extreme public health emergency as defined in Title 22, section 801, subsection 4-A; or

(6) To support the State's response to a disaster as defined in Title 37-B, section 703, subsection 2;

B. A licensed health care practitioner engaging in telehealth shall make a good faith effort to directly contact and coordinate with emergency services in accordance with the standard of care and the written emergency care plan that is appropriate to the situation and to the services rendered through the telehealth encounter. The emergency care plan shall pertain to areas where patients are located during a telehealth encounter and shall use a method with response and equivalent priority to a 9-1-1 dialed call or better. A licensed health care practitioner engaging in telehealth shall make a good faith effort to: provide the name and location of the patient to emergency services in oral and written form; determine the location of a patient if a patient is unaware of his or her location; and provide his or her contact information to emergency services. Consent may be implied, oral, written, or digital in nature, provided that the chosen method of consent is deemed appropriate under the

standard of care. A licensed health care practitioner engaging in telehealth shall report suicide attempts of patient during a telehealth encounter to the Department of Health in a manner that is consistent with federal and State privacy laws emergency and document emergencies which occur during a telehealth encounter.

Sec. 2. 24-A MRSA §4316, sub-§1, ¶C, as enacted by PL 2019, c. 289, §2, is amended to read:

C. "Telehealth," as it pertains to the delivery of health care services, means the use of interactive real-time visual and audio or other electronic media for the purpose of consultation and education concerning and diagnosis, treatment, care management and self-management of an enrollee's physical and mental health and includes real-time interaction between the enrollee and the telehealth provider, synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring. "Telehealth" includes the use of audio-only telephone when no means of interactive real-time visual and audio or other electronic media are available to the enrollee due to lack of such electronic media or of adequate broadband access or when the use of other means of interactive real-time visual and audio or other electronic media is infeasible, impractical or otherwise not medically advisable, as determined by the provider providing telehealth services to the enrollee or as determined by another provider with an existing relationship with the enrollee. "Telehealth" does not include the use of audio-only telephone, facsimile machine, e-mail or texting.

Sec. 3. 24-A MRSA §4316, sub-§1, ¶E, as enacted by PL 2019, c. 289, §2, is repealed.

Sec. 4. 24-A MRSA §4316, sub-§2, as corrected by RR 2019, c. 2, Pt. A, §28, is amended to read:

2. Parity for telehealth services. A carrier offering a health plan in this State may not deny coverage on the basis that the health care service is provided through telehealth if the health care service would be covered if it were provided through in-person consultation between an enrollee and a provider. Coverage for health care services provided through

telehealth must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier shall reimburse a provider for the diagnosis, consultation with or treatment of an enrollee delivered through telehealth services on the same basis and at least at the rate of reimbursement at which the carrier reimburses a provider for the provision of the same, or substantially similar, service through in-person consultation. If an enrollee is eligible for coverage and the delivery of the health care service through telehealth is medically appropriate, a carrier may not deny coverage for telehealth services. A carrier may not offer a health plan under which any deductible applied to health care services delivered through telehealth accumulates separately from the deductible that applies in the aggregate to all services covered under the health plan. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to a comparable service provided through in-person consultation. A carrier may not exclude a health care service from coverage solely because such health care service is provided only through a telehealth encounter, as long as telehealth is appropriate for the provision of such health care service.

A carrier will not be required to reimburse a treating or consulting healthcare provider for a telehealth encounter which does not have an

active emergency plan in place or without coordination of patient emergencies appropriate to the situation.

Sec. 5. 24-A MRSA §4316, sub-§3, ¶G is enacted to read:

G. The carrier may not place any restriction on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that is more restrictive than any requirement in state and federal law for prescribing medication through in-person consultation.

Sec. 6. 24-A MRSA §4316, sub-§5, as enacted by PL 2019, c. 289, §2, is repealed.

Sec. 7. 24-A MRSA §4316, sub-§6, as enacted by PL 2019, c. 289, §2, is amended to read:

6. Utilization review. This section does not prohibit or limit a carrier from conducting a utilization review for telehealth services as long as the utilization review is conducted in the same manner, is applied no more stringently and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

Sec. 8. Application. The requirements of this Act apply to health plans, as defined in the Maine Revised Statutes, Title 24-A, section 4301-A, subsection 7, executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2022. For purposes of this Act, all health plan contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill makes changes to the provisions governing health insurance coverage of telehealth services.

1. It authorizes the delivery of health care services through telehealth by audio-only telephone.

2. It clarifies that reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person.

And here is the reason for the language:

Patient Case:

Our primary care telehealth practice has been seeing a patient for the past year. Late January she told her psychiatrist over telehealth she was going to kill herself. The psychiatrist said this was an emergency and told the patient to “hang up and call 911” to receive in-patient care. They hung up and the patient did not call 911. A few days later she called her psychologist, said she was going to kill herself by taking pills, and again was told to “hang up and call 911.” The patient didn't call.

On Tuesday afternoon the next week, she took a whole bottle of hydroxyzine pills. A few minutes later she called our telehealth practice in Little Falls, NJ and told us she had done something stupid. She is normally in Bergen county but this week she was in Toms River. We have emergency telehealth protocols and were able to activate 911 in Toms River. She became altered to the point she could not open the front door, so our providers coordinated with police and EMS to enter and identify the pills. She made it to the emergency department and survived. The psychologist and psychiatrist had no idea what happened until we called them a few days later.

Although our practice activated 911 and handed off care, this was not a success because she overdosed and there was patient harm. If our practice had not remotely activated 911 she might have died in this attempt or the next. In-person coordination and hand-off of care does reliably happen in hospitals, clinics, and other facilities, however many telehealth programs ask patients who are in emergencies to “hang up and go to the ER or call 911.” Hand-off and transition of care has been shown to reduce

medical error by 30% and reduce adverse events by 21%. The Joint Commission says the best handoff uses both verbal and written communication. Telehealth Emergencies are no different than in-person emergencies, strong hand-off is needed and saves lives. Suicide is the 10th leading cause of death in the US and the leading reason to activate 911 for telehealth, followed by Shortness of Breath and Altered Mental Status.

After this happened a nurse practitioner and a doctor from our practice reached out to this behavioral health practice to help them with their telemedicine emergency protocols and methods. The providers replied “we will consider it.” They still don’t have protocol for activating 911 except to ask patients to call 911 themselves. The patient who attempted suicide is still in the hospital and will be transferred to Florida for inpatient treatment. She is luckier than the other two who killed themselves in Bergen County this past year after telehealth visits. One jumped off a building and the other jumped off a bridge.

Many New Jersey hospitals and practices have great telehealth emergency protocols or technology to reliably handoff and transition care to emergency services when telehealth emergencies happen. And, many do not.

American Occupational Therapy Association

May 5, 2021

Re: Support – LD 333: An Act Regarding Telehealth

Dear Members of the Committee on Health Coverage, Insurance and Financial Services,

On behalf of the American Occupational Therapy Association (AOTA), I am writing in support of LD 333, An Act Regarding Telehealth.

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, students of occupational therapy, and occupational therapy assistants. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners help to improve the quality of life and participation in meaningful life occupations for millions of Americans.

The coronavirus pandemic has required health care policymakers, payers, and providers alike to reconsider how care is delivered. We greatly appreciate the expansions and flexibilities that Maine has adopted for occupational therapy services in this newly imagined healthcare landscape to this point. The ability to supplement or replace in-clinic occupational therapy sessions with those provided through telehealth has been especially beneficial for patients who have mobility issues and find it difficult to leave their homes without assistance, who lack transportation, and/or need to travel long distances.

Therapy interventions delivered through electronic or digital media have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Telehealth as an optional adjunct to in-person care can be a critical healthcare solution that helps beneficiaries overcome access barriers caused by distance, lack of availability of providers, and impaired mobility; and can prevent unnecessary exposure during a pandemic, epidemic, or even the annual flu season, especially for vulnerable, immunocompromised patients.

The very nature of OT services makes them well-suited to telehealth, especially when used as an adjunct, or enhancement, to service delivery rather than a replacement. Education and home exercise programs, including those focused on falls prevention, function particularly well with telehealth because the practitioner is able to evaluate and treat the patient within the real-life context of their home environment, something that is not easy to replicate in the clinic. Patient and caregiver self-efficacy are inherent goals of care provided by occupational therapy practitioners. A patient's ability to interact in their home environment with a therapist where they can immediately identify a challenge with activities of daily living, for example, rather than waiting for the next face-to-face appointment, can be invaluable in supporting the adoption of effective rehabilitative strategies to improve function, enhance safety, and promote engagement.

Benefits of telehealth include increased access to OT services for children and adults who live in remote areas, the prevention of unnecessary delays in receiving services, and coordinated care among team members in different locations. Telehealth transcends geographic limitations and provides an opportunity to match patients' needs with practitioners' areas of expertise. Telehealth provides increased educational opportunities for caregivers, decreased need for travel; decreased health risks for patients with compromised immune systems; and for some, increased attention and decreased behavioral challenges when using a technology platform for intervention.

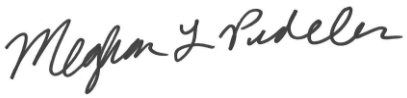
The expansion of telehealth payment and practice policies on the state and federal level during the public health emergency has demonstrated not only that many needs can be met effectively through the use of technology but that patients also have improved access to skilled care by leveraging

telehealth resources. Health professionals, including OT practitioners, who had to rapidly deploy telehealth services were still able to support patients and positively impact outcomes.

The provisions in LD 333, which would change provisions governing health insurance coverage of telehealth, will allow for more access to telehealth services. I urge you to please support the passage of LD 333 which will allow for more access to occupational therapy services for individuals in Maine.

Please contact me at 301-652-6611 x1921 or via email at mpudeler@aota.org if you have any questions or need additional information.

Sincerely,



Meghan Pudeler
Manager, State Affairs
American Occupational Therapy Association

Ashley LaJoie
Van Buren

Dear Members of the Committee On Health Coverage, Insurance and Financial Services,

My name is Ashley LaJoie, I am a resident of Van Buren, Maine. I am an occupational therapist living and working in Maine. I am also a member of the Maine Occupational Therapy Association. I am writing this letter to advocate for LD333 and ask for your support in passage of the bill.

LD 333: An Act Regarding Telehealth changes the provisions governing health insurance coverage of telehealth services by authorizing the delivery of health care services through telehealth by audio-only telephone when needs arise; clarifies that reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person; clarifies that a carrier may not establish separate deductible limits for telehealth services that are not applied in the aggregate with other services covered under a health plan; and prohibits a carrier from placing restrictions on prescribing medication through telehealth that are more restrictive than requirements of applicable state and federal law for prescribing medication in person.

For many Mainers most in need, such as children and youth, older adults, and those with mental health issues, telehealth has been a means to continue delivering necessary Occupational Therapy services.
Occupational therapists provide services in a variety of settings including hospitals, clinics, schools, nursing homes and home health settings. We provide necessary therapy services to clients of all ages including treatment for injured, ill, or disabled clients to develop, recover, and improve skills needed to function in at home, school, work, or in the community.

Practitioners and clients have provided us with feedback in regard to using telehealth; barring the learning curve of using technology and maintaining the technology, utilizing telehealth has enabled clients to continue receiving necessary services, maintain and gain function and skills during the pandemic.

Please support the passage of LD 333 to support the practice of Occupational Therapy in Maine.

Sincerely,
Ashley LaJoie, MOT, OTR/L

Kathryn Brooks
BIDDEFORD

LD 333: An Act Regarding Telehealth

Dear Members of the Committee On Health Coverage, Insurance and Financial Services,

My name is Kathryn Brooks and I am a resident of Biddeford. I currently work at Maine Medical Center. I am a member of the Maine Occupational Therapy Association and occupational therapy practitioner in the state of Maine. I am writing this letter to advocate for LD333 and ask for your support in passage of the bill.

LD 333: An Act Regarding Telehealth changes the provisions governing health insurance coverage of telehealth services by authorizing the delivery of health care services through telehealth by audio-only telephone when needs arise; clarifies that reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person; clarifies that a carrier may not establish separate deductible limits for telehealth services that are not applied in the aggregate with other services covered under a health plan; and prohibits a carrier from placing restrictions on prescribing medication through telehealth that are more restrictive than requirements of applicable state and federal law for prescribing medication in person.

For many Mainers most in need, such as children and youth, older adults, and those with mental health issues, telehealth has been a means to continue delivering necessary Occupational Therapy services. Occupational therapists provide services in a variety of settings including hospitals, clinics, schools, nursing homes and home health settings. We provide necessary therapy services to clients of all ages including treatment for injured, ill, or disabled clients to develop, recover, and improve skills needed to function in at home, school, work, or in the community.

Practitioners and clients have provided us with feedback in regard to using telehealth; barring the learning curve of using technology and maintaining the technology, utilizing telehealth has enabled clients to continue receiving necessary services, maintain and gain function and skills during the pandemic. Additionally, this has enabled < >.

Please support the passage of LD 333 to support the practice of Occupational Therapy in Maine.

Warm regards,

Kathryn Brooks, OTR/L

MAINE
PSYCHOLOGICAL
ASSOCIATION

May 4, 2021

Representative Hymanson
Health Coverage, Insurance and Financial
State House
Augusta ME 04332

Re: LD333 An Act Regarding Telehealth

Dear Representative Hymanson and Committee Members:

The Maine Psychological Association (MePA) is a membership organization representing psychologists in Maine who work in private practice, at Maine's colleges and universities, and in the public sector. Our mission is to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

MePA supports LD 333. This bill changes health insurance coverage to allow for the provision of services through telephone (audio-only) means when there are no other connection options. This will expand telehealth options and will improve access to mental health and other services for consumers in areas with limited broadband.

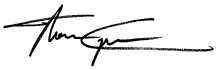
Psychologists and their patients have concerns that as state and national public health emergency declarations end, the current public health emergency mandates will expire resulting in many insurers reverting back or terminating pandemic-related telehealth expansions.

Many patients in need of mental and behavioral health services have conditions and disorders that prevent them from safely (or without great anxiety) leaving their homes and sharing close personal space with other people. This will be especially burdensome on moderate- and low-income subscribers who have no choice but to take public transportation or rely on others to get to their in-person health care appointments.

Allowing coverage and reimbursement of audio-only telephone services addresses the inequity problem that lower SES and older patients tend to have less access to the resources and skills required for telehealth via traditional video-conferencing platforms (access to laptops and smartphones, broadband services, and the skills to use videoconferencing systems) and older patients often have transportation issues that are barriers to accessing in-person services.

Telehealth boosts patient access, which will help Maine meet the increased mental health needs resulting from the pandemic.

Sincerely,



Thomas Cooper, PsyD
President

Maine Medical Association

TO: The Honorable Heather Sanborn, Chair
The Honorable Denise Tepler, Chair
Members, Joint Standing Committee Health Coverage, Insurance and Financial Services

FM: Dan Morin, Director of Communications and Government Affairs

DATE: May 6, 2021

RE: **Support**

LD 333— An Act Regarding Telehealth

The Maine Medical Association is the state's largest professional physician organization representing more than 4300 physicians, residents, and medical students across all clinical specialties, organizations, and practice settings is submitting testimony in support of LD 333, An Act Regarding Telehealth.

First, we would like to formally thank Representative Patty Hymanson, M.D., for her interest in the issue and for sponsoring the bill. She has been an excellent advocate for accessible health care her constituents, all residents of Maine, and her physician colleagues.

LD 333 does four basic things:

- It authorizes audio-only health care.
- Clarifies that reimbursement must be made on the same basis and the same rate as in person care.
- It identifies that no insurance carrier can implement separate deductible limits that are not applied in aggregate with other covered services.
- It prohibits insurance carriers from implementing more restrictive prescribing requirements for telehealth prescriptions than prescriptions given in person.

While telehealth has been around for many years, it took a global pandemic for it to truly go mainstream for many clinicians and their patients. Widespread use of telehealth has arrived. LD 333 helps us maintain gains that may have taken years to achieve, but instead took months, sometimes weeks, and days in some cases.

Will federal and state rules snap back and again present obstacles? We hope the discussions before you this Session on LD 333, and other bills before you today will help answer those questions.

The Maine Medical Association's goal with this legislation is to assist our physician members with telehealth options and guidelines to improve the care they provide their patients and sustain the business models they work under, whether that is in private practice, within a hospital, or part of a larger health system. That means exploring as many workable options as possible to promote ongoing accessible safe and affordable care in the environment best suited for providing it by clinicians best prepared, qualified, and trained to provide it.

When appropriate and necessary emergency pandemic measures were implemented in Maine last spring, the number of office visits for Maine patients either dramatically dropped or ceased all together. As a result, we heard countless concerns, especially from rural members about delayed and necessary care for their patients.

Rural Maine prays death will wait as pandemic upends tradition and civic life (Bangor Daily News, April 2020)
Unprecedented mental health crisis looms as Mainers battle COVID-19, economic downturn, experts warn (WCSH, May 2020)
More Mainers are delaying medical care because of the coronavirus (Bangor Daily News, May 2020)

At the federal level, the Centers for Medicare & Medicaid Services changed Medicare payment policies to reimburse telehealth visits for a wider range of care, and some Health Insurance Portability and Accountability Act (HIPAA) restrictions were temporarily loosened to make it easier for doctors to communicate with their patients through whatever devices they chose. Prior to the pandemic, telehealth would only be reimbursed by Medicare for limited circumstances, such as

patients living in rural areas with little access to care. The communication changes removed requirements for patients to only use often clunky HIPAA-compliant platforms, opening the ability to use smartphones and increasing consumer convenience. Most private payers also followed Medicare's lead and changed their reimbursement policies.

As an aside, yet important, telehealth also proved to be a lifeline for many medical practices across the country, including Maine, that suffered severe business impacts along with many other small Maine businesses. Keeping these access points available and viable could not have been done without telehealth advances.

Maine's Independent Physicians Saw Steep Revenue Declines When Offices Shut Down (Maine Public Radio, May 2020)

It is important that Mainers not lose the many advantages of continuing coverage of telehealth services beyond COVID-19. It has been a huge advantage for patients with mobility problems, those who lack transportation access or live far from their physician's office and all barriers to timely care. It is a major advantage in situations in which travel is dangerous or infeasible, epidemics, severe weather, natural disasters, etc. Telehealth is also preferable to many in situations in which in-person visits carry health risks, e.g., communicable diseases, immunocompromised patients.

Telehealth also enables more coordinated care by including two or more physicians or other clinicians (e.g., a PCP and a specialist) that are located in different places in the patient visit. It can also enable a family member or caregiver to participate in a visit along with the patient without having to be physically present.

Pandemic telehealth advances have led to high patient satisfaction: "The overall customer satisfaction score for telehealth services is 860 (on a 1,000-point scale), which is among the highest of all healthcare, insurance and financial services industry studies conducted by J.D. Power" J.D. Power 2020 U.S. Telehealth Satisfaction Study

It will be incredibly important to maintain appropriate reimbursement across the health care coverage spectrum. Fair payments, and ongoing state budget investment discussions, should also support advancement and investments in telehealth.

According to the COVID-19 Healthcare Coalition, Survey of physicians and other qualified health care professionals conducted between July 13 and August 15, 2020, 73.3% of physician respondents indicated no or low reimbursement for telehealth will be a major challenge post COVID.

LD 333 includes cost-sharing provisions for private carriers. They should not be used to incent care away from, or toward certain providers. Reducing cost-sharing for select telehealth providers who do not also provide in-person services inappropriately steers patients away from their current physician, fragmenting the health care system and disrupting the continuity of care.

We also hope any comprehensive telehealth legislation decided along with your legislative colleagues in the House and Senate be taken in concert with equitable access to telehealth through expanded broadband, expanded acceptable modalities, and policies to promote digital literacy. The same above-referenced COVID-19 Health Coalition Survey revealed that 64 percent of clinicians stated technology challenges for patients were a barrier to sustainable use of telehealth, including lack of access to technology, and/or internet/broadband and low digital literacy. These issues have been echoed in our discussions and correspondence with MMA members.

In closing, many members wanted to stress that in many cases a patient-physician relationship may need to be established before the provision of services via telehealth. However, for new patients, a relationship can be established via telehealth if it meets the standard of care, including via real-time audio/video under appropriate circumstances.

Thank you for your time and consideration of our comments and suggestions in support of LD 333, An Act Regarding Telehealth. We look forward to working with members of the Committee, the Governor's office, and stakeholders across Maine to pass meaningful legislation to maintain and improve the health of your constituents.

Ongoing Value of Telehealth

- Address longstanding health inequities
- Improve access to specialists in rural or underserved areas.
- Provide patients flexibility in how they receive care.
- Integrating high quality telehealth into physician practice (hybrid care) can improve overall quality of care.

Medicare Started Covering Audio-Only Visits

- CMS changed CPT codes for telephone evaluation and management services from non-covered to active, for new or established patients.
- Helps patients who cannot engage in 2-way, real-time audio-video communication due to lack of connectivity, or not having, knowing how to use, or being comfortable with audio-video devices.
- Payments for the three CPT codes for audio-only visits of 5-10, 11-20, or 21-30 minutes are equivalent to in-person established patient office visit codes.

Telehealth and Other Flexibilities During COVID-19 from the Drug Enforcement Agency (DEA) & Substance Abuse and Mental Health Services Administration (SAMSHA)

- Controlled substance prescriptions may be based on telehealth visit, including audio-only telephone visit.
- Physicians with X-waiver to prescribe buprenorphine for opioid use disorder can initiate or continue treatment with telehealth or phone visits.
- Opioid treatment programs (OTPs) can initiate new patients and treat existing patients on buprenorphine using telehealth or phone visits; existing patients on methadone can be treated via telehealth or phone.
- OTPs can provide stable patients with take-home medication.
- Alternate satellite locations (such as temporary surge hospitals) do not need to apply for their own DEA number.

Maine Academy of Nutrition and Dietetics
an affiliate of the Academy of Nutrition and Dietetics
PO Box 10214, Portland, Maine, 04104; www.eatrightmaine.org

Testimony in Support of LD 333 - An Act Regarding Telehealth
Submitted by Patsy Catsos, MS, RDN, LD

Good morning, Senator Sanborn, Representative Tepler and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services,

My name is Patsy Catsos and I am a resident of Portland. I am speaking on behalf of the Maine Academy of Nutrition and Dietetics where I serve as a member of the Public Policy Panel. The Maine Academy is an affiliate of the Academy of Nutrition and Dietetics, an association that represents over 100,000 credentialed dietetics and nutrition practitioners. We are the food and nutrition professionals who can translate the science of nutrition into practical solutions for healthy living. As health care practitioners, we strive to improve the health of Maine's citizens through quality food and nutrition information and nutrition care services. Our members work across the state in hospitals, schools, public health clinics, nursing homes, food service management, universities, research, and private practice.

In my work as a Registered, Licensed Dietitian I am a consultant at Nutrition Works in Portland, providing one-on-one medical nutrition therapy to patients with gastrointestinal diseases and disorders. Other dietitians in our practice deliver specialty nutrition care for patients with a variety of other conditions. While some patients do prefer face-to-face visits, the *option* of telehealth can benefit Maine residents who are referred for medical nutrition therapy because it is both effective and accessible.

Effective: As we and our patients learned during the COVID-19 pandemic, medical nutrition therapy can be provided very effectively via telehealth, as all of the tasks in our workflow can be performed remotely. Meeting with patients while they are at home allows them to check their pantries and medicine cabinets as needed to share important details about the food and nutrition products they are consuming. Timely follow-ups increase effectiveness, too, and are easier for patients to squeeze into their busy schedules when they can meet with us via secure video-chat. Many of our patients prefer telehealth because of this.

Accessible: With telehealth, travel distance is no longer a barrier to accessing a licensed provider of specialty dietetic care. It seems obvious that Maine residents who live in distant parts of the state benefit from access to the same care as those living in Maine's biggest cities. Telehealth means all Maine citizens can access specialty services without travel expenses and without taking one or more days off from work. Perhaps less obviously, travel can be physically taxing and difficult to manage for those who are ill; telehealth solves this problem. I recently helped an 82-year-old gentleman in Downeast Maine recover from post-infectious irritable bowel syndrome and unintentional weight loss. He needed ready access to a bathroom due to his illness, and he would have been unable to make even a single trip to visit my office in Portland, much less a series of visits. He and his wife adapted readily to the telehealth platform. His weight and his strength have now been restored and he is feeling well again thanks in part to the option of using telehealth for his care.

Registered, licensed dietitians are recognized as reimbursable health care providers in Medicare. Under the current emergency rules, we are permitted to provide medical nutrition therapy via telehealth; before the pandemic, we were not. Many private insurances also provide benefits for nutrition services when provided by a registered, licensed

dietitian. Under the current emergency rules insurance companies are reimbursing us for services provided via telehealth; before the pandemic, it was hit or miss. Patients were reluctant to take a chance on accessing their benefits via telehealth because the coverage information for telehealth was very difficult to determine ahead of time, even by contacting the insurance company, and often resulted in a significant out-of-pocket bill for patients.

I am here today to testify in support of LD 333, An Act Regarding Telehealth, as it is a comprehensive approach to the use of and payment for telehealth services by licensed health care practitioners, with recommendations as follows:

- Delete the multiple considerations when audio-only telephone can be used so it simply states that telehealth includes audio-only telephone or telephonic services, similar to language in LD 323. When I am seeing a patient who does not have high-speed internet, or who does not have good technical problem solving skills, it is sometimes necessary to fall back on use of the telephone to get the job done without causing undue stress on the patient.
- Ensure that the terms 'licensed health care practitioner' and 'telehealth provider' do include the registered, licensed dietitian of the patient's choice and participating in the patient's payer network. Before the pandemic, some payers were refusing patient access to telehealth benefits for services from licensed specialists in the patient's locale or state. They were apparently able to meet the letter of Maine's telehealth law by offering services only from their own employed health coaches or other staff.
- Ensure that the term 'health care services' does include nutrition services and/or medical nutrition therapy.
- Ensure that all health insurance carriers that cover nutrition services and/or medical nutrition therapy for residents of the State of Maine, are required to follow the legislation, including plans which are self-funded or written out of the state of Maine. Without this, providers are unable to inform patients in advance whether their insurance will cover the services they need. In our experience, without this assurance, most patients will decline the services rather than take a chance.

We urge you, the members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, to support LD 333 that will allow Maine people access to nutrition services and medical nutrition therapy from registered, licensed dietitians using telehealth. Thank you and we remain available as a resource to this committee and to answer any questions you may have.

College of Natural Sciences,
Forestry, and Agriculture
School of Nursing

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Dear Senator Sanborn, Representative Tepler and distinguished members of the Health Coverage, Insurance, and Financial Services Committee I am a practicing pediatric nurse practitioner at Penobscot Pediatrics and an Assistant Professor at the University of Maine in the School of Nursing. I serve as a member of the board of the Maine Chapter of the American Academy of Pediatrics. I am here today representing both the University of Maine and the Maine Chapter of the American Academy of Pediatrics.

I am testifying today in support of LD 333 An Act Regarding Telehealth presented by Representative Patricia Hymanson.

You have and will hear testimony on evidence supporting the benefits of telehealth in regards to improving access to healthcare and reducing healthcare costs, which is particularly salient in a rural state such as Maine.

However, I would like to take this opportunity to share my experience as a pediatric nurse practitioner and an Assistant Professor to highlight how telehealth not only improves access to care but most importantly can improve quality of care and quality-of-life using as one example children, adolescents and their families who have chronic illnesses. Furthermore, telehealth can also serve as a conduit to forge collaborative partnerships between healthcare providers and universities to achieve theses outcomes.

Let me illustrate this point with a focus on pediatric asthma. According to statistics from the Maine CDC, 11.2% of Maine adults currently have asthma compared to 7.7% nationally. The rate of childhood asthma in Maine is 8.0% similar to the 8.4% nationally. Of course, children do grow up to be adults.

We know that there is an economic burden associated with asthma which includes costs of emergency room care and hospitalizations but asthma also poses significant direct personal and indirect societal costs. An indirect societal cost can be related to days missed from school which often equates to lost work time and productivity for parents of children with asthma. The impact on quality of life for children and adolescents includes the scary experiences associated with exacerbations (e.g., not being able to breathe, being admitted to the hospital), activity limitations, and days missed from school.

Telehealth has been demonstrated to improve quality of life for children with asthma. It allows providers to work with children, adolescents and their families on asthma education, monitoring symptoms, and tailoring asthma treatment. Through the technology of telehealth, we can actually determine level of control by monitoring pulmonary functions in the home with telehealth equipment. Traditionally (without telehealth) multiple visits are required to achieve this level of care. However, with the availability of telehealth services there is improved access and reduced associated costs of travel to achieve these health outcomes.

Telehealth also provides the opportunity for collaborative partnerships between healthcare providers and universities which can improve access to care and improved quality of care and quality of life. For example, the University of Maine Systems just recently received a $1 million grant from the USDA of

which a portion is allocated for telehealth equipment to be used with our clinical partners. As the author of that portion of the grant, I requested funding for telehealth equipment which included the pulmonary function equipment I spoke of earlier. Additionally, a university is in the unique position of educating our future health care providers in providing evidenced base telehealth services. Students also contribute to the healthcare work force and these collaborations can improve care and health. For example, the nursing students from the University of Maine administered over 10,000 Covid vaccines during this pandemic! Imagine what we could do as partners in care through the use of telehealth.

Thank you kindly for your attention!

Mary Tedesco-Schneck PhD, RN, CPNP
Assistant Professor
University of Maine
School of Nursing

Board Member
Maine Chapter of the American Academy of Pediatrics

References

Maine CDC. (2021). *Asthma in Maine.* https://www.maine.gov/dhhs/mecdc/population-health/mat/asthma-information/asthma-in-maine.shtml

Snoswell, C.L. & Lalor, A. (2021). A systematic review and meta-analysis of change in health-related quality of life for interactive telehealth interventions for patients with asthma. *Value in Health, 24*(2), 291-302.

Maine Chapter

INCORPORATED IN MAINE

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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Thank you kindly for your attention!

Mary Tedesco-Schneck PhD, RN, CPNP
Assistant Professor
University of Maine
School of Nursing

Board Member
Maine Chapter of the American Academy of Pediatrics

References

Maine CDC. (2021). *Asthma in Maine.* https://www.maine.gov/dhhs/mecdc/population-health/mat/asthma-information/asthma-in-maine.shtml

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Mary Tedesco-Schneck
Bangor

The testimony is the same on both documents but I am speaking on behalf of 2 organizations so I did not know if it had to be on the letterhead of both organizations.

LD 333: An Act Regarding Telehealth

Dear Members of the Committee On Health Coverage, Insurance and Financial Services,

My name is Jessica Bolduc, I am the current president of the Maine Occupational Therapy Association and occupational therapy practitioner in the state of Maine. I am writing this letter to advocate for LD333 and ask for your support in passage of the bill.

LD 333: An Act Regarding Telehealth changes the provisions governing health insurance coverage of telehealth services by authorizing the delivery of health care services through telehealth by audio-only telephone when needs arise; clarifies that reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person; clarifies that a carrier may not establish separate deductible limits for telehealth services that are not applied in the aggregate with other services covered under a health plan; and prohibits a carrier from placing restrictions on prescribing medication through telehealth that are more restrictive than requirements of applicable state and federal law for prescribing medication in person.

For many Mainers most in need, such as children and youth, older adults, and those with mental health issues, telehealth has been a means to continue delivering necessary Occupational Therapy services. Occupational therapists provide services in a variety of settings including hospitals, clinics, schools, nursing homes and home health settings. We provide necessary therapy services to clients of all ages including treatment for injured, ill, or disabled clients to develop, recover, and improve skills needed to function in at home, school, work, or in the community. A few things we do are to help children with disabilities to participate fully in school and develop social skills; assist older adults to support themselves through physical/cognitive changes, address physical, psychological, and cognitive aspects of a client's well-being; evaluate a client's abilities and environments, create customized goals and interventions, recommend equipment, and deliver training for adaptation, and provide guidance and education for family members and caregivers.

Practitioners and clients have provided us with feedback in regard to using telehealth; barring the learning curve of using technology and maintaining the technology, utilizing telehealth has enabled clients to continue receiving necessary services, maintain and gain function and skills during the pandemic. Additionally, this has enabled private practices to continue to function during in-person restrictions with the pandemic and allowed them to expand the number of the clients they are able to serve. Therefore, client access to occupational therapy services has improved with the use of telehealth by OTs and OTAs. These gains cannot be lost. This is not a substitution for in-person, hands on intervention, but rather another tool that occupational therapy practitioners can utilize to meet the needs of the clients they serve.

Please support the passage of LD 333 to support the practice of Occupational Therapy in Maine.

Warm regards,

Jessica
Jessica J Bolduc DrOT, MSOTR/L, FAOTA
President
meotapresident@gmail.com

Kim
Kimberly Davis OTD, MS OTR/L
President-Elect

Patricia Hymanson
Maine House District 4

Good day Senator Sanborn, Representative Tepler and members of the Joint Committee on Health Coverage, Insurance and Financial Services.
I am Representative Patty Hymanson, serving House District 4, parts of York, Wells, Sanford and all of Ogunquit.

I present to you LD 333, An Act Regarding Telehealth.

You will hear a lot of enthusiasm today for maintaining the expansion of telemedicine the pandemic has afforded us both in the provider and in the patient sectors. I share that enthusiasm and also caution. This bill reflects both.

I want to thank the Maine Medical Association for working with me on this bill, the clinicians around the state who shared their experiences with me and my own patients who left me with the idea that we needed telemedicine to help improve quality, improve access and lower the cost of care for patients. Of these 3 metrics, it is easy to see telemedicine improves access especially in a rural state. I had a patient with severe migraine who had to drive from Biddeford to my office in Portsmouth even when she had a migraine or when she could report to me that everything was going well. Because I knew her so well, both of these visits could have been handled via telemedicine if it were possible at the time.

The other 2 metrics which to are improve quality and to lower the cost of care for patients, need to be looked at more carefully over time and with attention otherwise we could have poorer care, inequities and even larger medical bills.

This bill, LD 333, adds "audio-only telephone" to the definition of "telehealth" but only after the provider determines that real-time visual with audio is not available, infeasible or impractical. If the exam is not in-person, audio-visual can be adequate but audio-only is not adequate unless there are barriers to better care.

There is still real value to an in-person exam using all the examiner's senses. A diagnosis is more complete, as is the building of a trusting relationship for the future. The in-person examination is the standard of care and some states have laws that mandate the primary provider must physically examine the person at an interval, for example at least 18 months before a telemedicine visit can be used. That is not in this bill but I ask you to consider it.

This bill provides for reimbursement through telehealth services on the same basis at which the carrier reimburses for a substantially similar service through in-person consultations. This bill establishes that telehealth is included in the deductible limits with other services with no separate deductible limit. Also, prescribing medication by telemedicine would be the same as if prescribed in-person.

In line 7 of page 2, I would ask that you consider amending the line by inserting "as determined by the provider" after "medically appropriate." If I leave you with only one message it is that telemedicine needs to be a tool for the provider, not a tool the payer controls. This is very important. A dermatologist in York told me she stopped using telemedicine to diagnose skin lesions because the lighting and contrast, inability to touch the skin were impediments to her being able to make a diagnosis. The provider has to have discretion to stop the telemedicine visit and convert it to an in-person exam, require an in-person exam or judge that a telemedicine visit is the best option. Who pays for the telemedicine visit exam that the provider rightly converted? We talk about value-based care but we still use fee-for-service payments.

This bill, like most others, was submitted by cloture in December 2020. Federal, state, payer and private companies have had vigorous conversations about how to manage telemedicine after the public health emergency. Waiting for the dust to settle a little more before changing Maine law by carrying over the Acts and bridging with a Resolve might help create better and more longer-lasting statutes.

Thank you for your attention and consideration of this important and transformational tool to bring better quality, access and lower costs to health care so that Mainers can be their best

and healthiest selves. I am happy to answer questions as I am able and I plan to be at the work session.

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

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May 6, 2021

Senator Heather B. Sanborn, Chair
Representative Denise A. Tepler, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Re: LD 649 – *"An Act To Expand and Promote Telehealth Services"*

Dear Senator Sanborn, Representative Tepler and Distinguished Committee Members:

The Maine Board of Licensure in Medicine ("BOLIM") licenses and regulates allopathic physicians and physician assistants in Maine. The BOLIM is composed of 11 members: 6 physicians who actively practice medicine; 2 physician assistants who actively render medical services; and 3 public members. The BOLIM's mission is to protect the public by ensuring its licensees are ethical, professional and competent. It fulfills this mission by licensing, regulating, and educating physician and physician assistants.

The BOLIM respectfully offers the following comments in opposition to LD 649:

The BOLIM appreciates the importance of telemedicine and its benefits, especially during the COVID-19 pandemic and for those patients living in rural areas of the State. Like the Legislature, the BOLIM is in the process of amending its telemedicine rule to include "audio only" to allow healthcare providers and patients greater flexibility when appropriate. Telehealth is an important model for delivering health care – just as is in-person health care is one model for delivering health care.

The BOLIM appreciates the good intent behind the bill; however, as written it fails to accomplish its goal of expanding and promoting telehealth services in Maine. Notably, LD 649 unnecessarily limits telemedicine to allopathic physicians by referring to 32 M.R.S. § 3300-D. By doing so, the bill excludes many other types of health care providers who provide telehealth such as osteopathic physicians, physician assistants, advanced nurse practitioners, and others. Telehealth is not a medical specialty limited to allopathic physicians. The limitation in LD 649 can be eliminated by removing Sec. 24-A MRSA § 4316, sub-§10 or by amending it to read that "any health care provider located outside of the State who holds an active and unrestricted license in Maine may provide telehealth to a patient located in Maine."

Nearly one half of the BOLIM's licenses (allopathic physicians and physician assistants) are located outside of the State of Maine. That means a large number of BOLIM's licensees are already practicing telehealth – and do so in a variety of medical specialties including radiology, neurology, internal medicine, and psychiatry. BOLIM and the Board of Osteopathic Licensure

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have an existing joint telemedicine rule that provides standards for those licensees who practice telehealth.

As written, LD 649 will have several significant negative impacts besides the fact that it provides for no transition for those currently possessing a telemedicine consultative registration: (1) It will discriminate against those physicians and physician assistants who live and work in Maine; (2) It will provide a path for licensure without appropriate verification of credentials and/or disciplinary history; (3) It removes a "guardrail" designed for the safety of patients; and (4) It will have a significant impact on the BOLIM's revenue – and potentially its ability to perform its duty to protect the public.

1. LD 649 discriminates against physicians and physician assistants who live and work in Maine, pay taxes in Maine, and provide other types of support to their communities. In essence, the physicians and physician assistants who pay BOLIM's licensing fees and work and live in Maine would bear the financial burden of BOLIM's operations (it is funded only through licensing fees). Telemedicine is not a medical specialty. Telemedicine is simply one model for delivering medical care via the practice of medicine. The bill effectively discriminates against physicians who are living and working in Maine and seeing and treating Maine patients in person and by telemedicine by allowing out of state physicians to practice telemedicine medicine on Maine patients with potentially less qualifications and for less than half of the license fees. Nearly one half of the BOLIM's licensees are located out of State and are able to provide telehealth services with their permanent licenses.

2. LD 649 will provide a path for licensure without appropriate verification of credentials and/or disciplinary history. The BOLIM has two paths to full medical licensure for physicians: (1) traditional application that requires complete credentials and qualification verification; and (2) the Interstate Medical Licensure Compact that issues a license to qualified physicians with no criminal history, no disciplinary history, no pending investigations, possesses current national board certification and possess a full and valid license in another Compact state. Physicians who are issued a full license pursuant to either of these pathways may practice medicine in Maine – either by being physically present and working here or via telemedicine from outside the State. This LD would essentially create a 3rd path to licensure without the requisite background check which is vital to protection of the public. The LD would require the BOLIM to issue a license despite the fact that an applicant may have had discipline in another jurisdiction or a pending investigation in another jurisdiction. Furthermore, the LD would create an "unverified" fast-track to licensure for individuals who may not meet the post-graduate training requirements under the Board's existing statute. Other states or jurisdictions do not require the same amount of post-graduate training that Maine does. This bill would allow lesser trained physicians to provide care to Maine patients.

3. LD 649 removes an existing "guardrail" designed to protect the public for telemedicine consultations. The current law requires an expert consultant to coordinate with a physician, physician assistant or nurse practitioner in Maine who is ultimately responsible for the patient's care and treatment. In light of that fact, it makes sense that the current background check would be more abbreviated given the more limited role of the consultant. This LD would remove that provision – and allow the consultant to become the patient's physician – something that was not

originally intended in the original law. In addition, it removes the prohibition that the consultant not have an office in Maine

4. LD 649 will have a significant financial impact to the BOLIM and potentially its operations. Here are some statistics to demonstrate this point:

- As of 2/1/21 there were 7,825 active MD licenses (excluding educational certificates) and 1, 050 PA licenses for a total of 8,875 active licenses. Of those 3,782 MD licensees have a Maine address and 945 PA licensees have a Maine address. This means 52% of MD licensees are out of state and 10% of PA licensees are out of state. A total of 47% of licensees are out of state.

- The Board processes about 750 permanent MD licensees per year. The current permanent license fee for MDs is $700. If we assume 50% of applications are for physicians who are located outside of Maine in order to practice telemedicine, this LD would cause Board revenue to go from $525,000.00 to $375,000.00. That is a decrease of $150,000.00 per year.

- The Board processes approximately 3,300 renewals per year. The renewal fee is $500. If the registration fee of $300 also translates to each renewal cycle, and we assume 50% are for physicians who are located outside of Maine in order to practice telemedicine, the revenue would go from $1,650,000.00 to $1,320,000.00. That is a decrease of $330,000 per year.

Contrary to expanding and promoting telehealth services, LD 649 unnecessarily limits it to allopathic physicians, discriminates against physicians living and working in Maine, and provides an unnecessary and unverified path to licensure for physicians with less qualifications and disciplinary history.

Thank you for the opportunity to provide these comments regarding LD 649. I would be happy to answer any questions at the work session.

Sincerely,

Timothy Terranova
Assistant Executive Director

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

Janet T. Mills
GOVERNOR

Louisa Barnhart, MD
CHAIR

Dennis E. Smith, JD
EXECUTIVE DIRECTOR

Timothy E. Terranova
ASSISTANT EXECUTIVE DIRECTOR

May 6, 2021

Senator Heather B. Sanborn, Chair
Representative Denise A. Tepler, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Re: LD 649 – *"An Act To Expand and Promote Telehealth Services"*

Dear Senator Sanborn, Representative Tepler and Distinguished Committee Members:

The Maine Board of Licensure in Medicine ("BOLIM") licenses and regulates allopathic physicians and physician assistants in Maine. The BOLIM is composed of 11 members: 6 physicians who actively practice medicine; 2 physician assistants who actively render medical services; and 3 public members. The BOLIM's mission is to protect the public by ensuring its licensees are ethical, professional and competent. It fulfills this mission by licensing, regulating, and educating physician and physician assistants.

The BOLIM respectfully offers the following comments in opposition to LD 649:

The BOLIM appreciates the importance of telemedicine and its benefits, especially during the COVID-19 pandemic and for those patients living in rural areas of the State. Like the Legislature, the BOLIM is in the process of amending its telemedicine rule to include "audio only" to allow healthcare providers and patients greater flexibility when appropriate. Telehealth is an important model for delivering health care – just as is in-person health care is one model for delivering health care.

The BOLIM appreciates the good intent behind the bill; however, as written it fails to accomplish its goal of expanding and promoting telehealth services in Maine. Notably, LD 649 unnecessarily limits telemedicine to allopathic physicians by referring to 32 M.R.S. § 3300-D. By doing so, the bill excludes many other types of health care providers who provide telehealth such as osteopathic physicians, physician assistants, advanced nurse practitioners, and others. Telehealth is not a medical specialty limited to allopathic physicians. The limitation in LD 649 can be eliminated by removing Sec. 24-A MRSA § 4316, sub-§10 or by amending it to read that "any health care provider located outside of the State who holds an active and unrestricted license in Maine may provide telehealth to a patient located in Maine."

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Thank you for the opportunity to provide these comments regarding LD 649. I would be happy to answer any questions at the work session.

Sincerely,

Timothy Terranova
Assistant Executive Director

Harold "Trey" Stewart III
Senator, District 2

130th MAINE SENATE

3 State House Station
Augusta, ME 04333

Testimony of Senator Harold "Trey" Stewart
Presenting L.D. 649, An Act to Promote Telehealth Services
Before the Health Coverage, Insurance and Financial Services Committee
May 6, 2021

Senator Sanborn, Representative Tepler and colleagues on the Legislature's Health Coverage, Insurance and Financial Services Committee: I am Senator Trey Stewart and I have the honor of representing 51 communities located in Aroostook and Penobscot Counties. I am before you today to present testimony on L.D. 649, An Act to Expand and Promote Telehealth Services.

As we have heard many times, the medical and technology sectors have been making improvements at a rapid pace. We saw this to be particularly true over the last year as people adapted to working from home and communicating with loved ones via Zoom, but who were simultaneously unable to see their physician for routine and minor medical issues. Living in a rural part of the state, the benefits that come with telehealth are attractive as it often results in less travel time, cost savings, and greater flexibility in scheduling a patient-physician visit. For example, if patients in Fort Kent no longer have to drive to Portland to see their doctor every month, the costs savings in gas, lodging expense, and time are substantial.

The bill before you would make telehealth more readily available to Mainers while strengthening the licensing laws around physicians, not licensed in the State of Maine, providing telehealth services to Maine patients. With the patients consent, a physician may perform telemedicine using the patient's choice of telecommunications technology. This idea would have a significant benefit to rural Mainers and even those living in urban parts of our state who would now be able to visit a specialist from out-of-state.

To ensure that physician's are meeting Maine's standards of practice, providers from outside of Maine must follow our medical licensing laws and shall be registered by the Maine Board of Licensure to provide telehealth services. In addition to being registered by the Board, they will be required to pay a fee of $300. The securities are in place with this proposal to ensure that Mainers will be receiving quality healthcare, but able to do so without incurring the added, unnecessary expense of travel.

This is not just a nebulous idea, it has real world implications. For example, a constituent of mine reached out last year whose wife needed the treatment of a specialist for a psychological disorder. Prior to the Governor's executive order allowing for as much, she was unable to get approval to even have a phone call with this specialist. While this was one of the silver linings of the COVID pandemic, it should not be this challenging for Mainers to access the only forms

of health care that they need—particularly when it's not available in-state. Forcing them to travel from Aroostook County to New York City because we haven't updated our statutes in this area is simply unacceptable.

Please join me in supporting this policy so that regardless of your zip code, you can access quality health care without incurring unnecessary expenses to get there. Thank you for your time and consideration of this important issue. I'm happy to answer any questions the committee may have at this time.

MAINE
PSYCHOLOGICAL
ASSOCIATION

May 4, 2021

Senators Sanborn
Representative Tepler
Health Coverage, Insurance and Financial
State House
Augusta ME 04332

Re: LD791 An Act Regarding Telehealth Regulations

Dear Senator Sanborn and Representative Tepler, and Committee Members:

The Maine Psychological Association (MePA) is a membership organization representing psychologists in Maine who work in private practice, at Maine's colleges and universities, and in the public sector. Our mission is to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

MePA supports LD 791: An Act Regarding Telehealth Regulations. This bill is a concept draft pursuant to Joint Rule 208 and proposes to amend the laws governing telehealth.

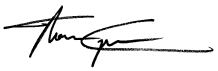
Psychologists and their patients have concerns that as state and national public health emergency declarations end, the current public health emergency mandates will expire resulting in many insurers reverting back or terminating pandemic-related telehealth expansions.

Many patients in need of mental and behavioral health services have conditions and disorders that prevent them from safely (or without great anxiety) leaving their homes and sharing close personal space with other people. This will be especially burdensome on moderate- and low-income subscribers who have no choice but to take public transportation or rely on others to get to their in-person health care appointments.

Allowing coverage and reimbursement of audio-only telephone services addresses the inequity problem that lower SES and older patients tend to have less access to the resources and skills required for telehealth via traditional video-conferencing platforms (access to laptops and smartphones, broadband services, and the skills to use videoconferencing systems) and older patients often have transportation issues that are barriers to accessing in-person services.

Telehealth boosts patient access, which will help Maine meet the increased mental health needs resulting from the pandemic.

Sincerely,



Thomas Cooper, PsyD
President

Testimony of Mark Pundt, MD in Support of LD-849, "An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures" (May 6, 2021)

Good morning Senator Sanborn, Representative Tepler and respective members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Dr. Mark Pundt, I reside in Portsmouth, New Hampshire and I am the President and Chief Medical Officer of ConvenientMD.

ConvenientMD is a leading walk-in and virtual urgent care provider dedicated to delivering the best medical care and experience for patients throughout Maine, New Hampshire and Massachusetts. At ConvenientMD, patients with non-life threatening illnesses and injuries, can be seen virtually, or just walk into one of its 26 urgent care locations.

I understand there are a number of bills being heard today that seek to address a variety of issues regarding telehealth delivery. We sincerely appreciate your attention to these issues. Of particular interest is LD-849, sponsored by Rep. Mathieson addressing the issue of "Payment Parity".

Patients now accept and utilize telehealth as another important access point of patient care more than ever before. Due to the increased access and ease of use patients continue to embrace telehealth as the pandemic fades and all indications are that they will continue to do so in the future. To this point, according to McKinsey and Company, 11% of their survey respondents used telehealth in 2019 and after using telehealth during the pandemic, 76% of the respondents noted they would be highly or moderately likely to use telehealth going forward. The McKinsey report also noted that 64% of providers are more comfortable using telehealth to provide care to their patients.

Telehealth increases access to health care for all patients including those in rural and urban underserved regions, the homebound and those without transportation.

In Maine 40% of our telehealth visits were from outside the area served by our urgent care clinics thereby expanding access to rural communities. In compliment, another benefit Telehealth offers, is that it can be used to manage acute and chronic medical and behavioral health conditions resulting in lower downstream costs due to the increased access to care.

The increased access to care allows acute and chronic medical issues to be addressed at an earlier point, thereby reducing exacerbations of chronic conditions and addressing acute illnesses before they worsen resulting in reduced ED visits and reduced referrals to medical specialists reducing the overall cost of care. Telehealth also reduces the cost of care to the patient by reducing the need for transportation (public and private) and child care. Addressing what has clearly become a key challenge to many families.

For physicians and medical providers to support telehealth in the future it is important that the reimbursement for the services supports the infrastructure costs. To support this point, we believe the reimbursement for care provided by telehealth services should be at parity with in person care because. Our reasoning for this is straightforward; the encounter covers the same level of detail as an in-person encounter; and the time spent in the encounter is similar, and can be, longer than an in-person encounter for the same complaint or medical problem. Also, telehealth encounters require the same and often more of the providers knowledge and expertise than in-person visits as there are less physical cues to inform the provider. Additionally, Provider and clinical support team salaries and benefits are the same as for in-clinic providers and clinical support team members and Medical liability insurance costs mirror those of in-clinic coverage.

Proper reimbursement is also needed to support costs involved in creating and supporting telehealth services, including: investing in technology platforms required to support HIPAA compliant telehealth provider-patient interactions; investing in the increased cybersecurity infrastructure needed to support the remote clinical and provider team; supporting the cost of the additional bandwidth and phone lines to support the virtual care team; developing new provider and clinical team workflows;

training staff on the new technology and workflows; adding new scheduling requirements; and creating and implementing methods to ensure quality of care and quality of the patient experience.

Again, I'd like to thank the committee for its attention and work on the issues regarding Telehealth medical care. I appreciate your consideration of my position and ask that you vote Ought-To-Pass on LD-849.

I'd be happy to answer any questions the committee has.

111 New Hampshire Avenue, Suite #2, Portsmouth, New Hampshire • 603-501-0878

MAINE
PSYCHOLOGICAL
ASSOCIATION

May 4, 2021

Representative Mathieson, Brooks, Gramlich, Sachs
Senator Brenner
Health Coverage, Insurance and Financial
State House
Augusta ME 04332

Re: LD849: An Act to Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures

Dear Representative Mathieson, Representatives Brooks, Gramlich, Sachs, Senator Brenner:

The Maine Psychological Association (MePA) is a membership organization representing psychologists in Maine who work in private practice, at Maine's colleges and universities, and in the public sector. Our mission is to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

MePA supports LD849: An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures. This bill makes permanent the authorization for the delivery of health care services through telehealth by telephone that was provided through executive order during the declared public health emergency related to COVID-19. Under current law, health insurance carriers are required to reimburse for services delivered through telehealth at parity with the reimbursement that would be provided if the services were delivered through an in-person consultation, but the use of audio-only telephone to deliver those services is not permitted. This bill removes that prohibition.

The bill also clarifies that reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person and that a carrier may not establish separate deductible limits for telehealth services that are not applied in the aggregate with other services covered under a health plan.

Under current law, telehealth services reimbursed under the MaineCare program for the delivery of service using the telephone are limited to when interactive telehealth services are unavailable or when a telephonic service is medically appropriate for the underlying covered service. This bill removes that limitation and also clarifies that services provided through telehealth must be reimbursed at the same rate as comparable services provided through an in-person consultation. The requirements in the bill apply to health plans issued or renewed on or after January 1, 2022.

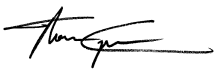
Psychologists and their patients have concerns that as state and national public health emergency declarations end, the current public health emergency mandates will expire resulting in many insurers reverting back or terminating pandemic-related telehealth expansions.

Many patients in need of mental and behavioral health services have conditions and disorders that prevent them from safely (or without great anxiety) leaving their homes and sharing close personal space with other people. This will be especially burdensome on moderate- and low-income subscribers who have no choice but to take public transportation or rely on others to get to their in-person health care appointments.

Allowing coverage and reimbursement of audio-only telephone services addresses the inequity problem that lower SES and older patients tend to have less access to the resources and skills required for telehealth via traditional video-conferencing platforms (access to laptops and smartphones, broadband services, and the skills to use videoconferencing systems) and older patients often have transportation issues that are barriers to accessing in-person services.

Telehealth boosts patient access, which will help Maine meet the increased mental health needs resulting from the pandemic.

Sincerely,



Thomas Cooper, PsyD
President

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

May 6, 2021

Senator Heather Sanborn, Chair
Representative Denise Tepler, Chair
Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333-0100

Re: LD 849 – *An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures*

Senator Sanborn, Representative Tepler, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

We are offering information neither for nor against LD 849 – *An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures*. This bill makes permanent the authorization for the delivery of health care services through telehealth by telephone that was provided through executive order during the declared public health emergency related to COVID-19.

This bill, among other things, would require the Department to permanently remove from the MaineCare Benefits Manual, Chapter I, Section 4 Telehealth Services, the requirement that telephonic services are reimbursable only when interactive video telehealth services are unavailable and telephonic service is medically appropriate for the underlying covered service. This requirement has been in MaineCare policy since the Telehealth Services policy was originally proposed in 2015. The Department generally believes that interactive telehealth is preferable, and that the exception to allow telephonic only when interactive video technology is unavailable is reasonable and necessary to sustaining telehealth as a service delivery model moving forward.

The Department is unclear on the federal allowability of permanently removing the interactive telehealth exception without any additional safeguards from a federal compliance perspective. Currently, the Centers for Medicare and Medicaid Services have announced flexibilities related to audio-only telehealth through the end of the public health emergency. However, there has not been any formal guidance outlining what flexibilities and waivers will apply after the Section 1135 waivers expire.

We wanted you to be aware of the above information as you consider this bill going forward. If you have any further questions, please feel free to contact me.

Sincerely,

Michelle Probert
Director
Office of MaineCare Services

Kristi Mathieson
26 Haley Road
Kittery, ME 03904
Phone: (603) 969-7496
Kristi.Mathieson@legislature.maine.gov

HOUSE OF REPRESENTATIVES
2 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0002
(207) 287-1400
TTY: MAINE RELAY 711

Testimony of Representative Kristi Mathieson Introducing LD 849, "An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures".
May 6, 2021

Good morningChair Sanborn, Chair Tepler, and esteemed fellow members of the Health Coverage, Insurance and Financial Services Committee. I am Representative Kristi Mathieson and I represent District 1 - the beautiful town of Kittery. I am here today to introduce LD 849,"An Act To Make Permanent the Telehealth Reimbursement Options Passed by Emergency Measures."

This was the first bill I considered as a freshman legislator –health care access and affordability are two issues I hear about daily. In our rural state, access to preventative healthcare can be challenging, and this challenge was never more evident than in 2020. Expansion of telehealth (including phone appointments) helps to offer continuity of care and avoids negative consequences from delayed preventive, chronic or routine care. Remote access to healthcare services helps increase participation for those who are medically or socially vulnerable; those who do not have ready access to providers and ultimately preserves the patient-provider relationship when an in-person visit is not practical or feasible. I feel strongly that consistent/preventative care is the key to lowering overall health care costs. Continued telehealth care (including phone audio only) is one part of this and an especially important part in our rural state with limited broadband services and limited access to providers.

The key components of LD 849 include:

- Telehealth to include telephonic audio-only services
- Carrier reimbursements for telehealth and telemonitoring services at the same reimbursement rate as comparable services provided through in-person consultation.
- Carrier may not offer a health plan where any deductible applied to telehealth accumulates separately from the deductible that applies in the aggregate to all services covered under the health plan.
- Carrier may offer a health plan with a copayment or coinsurance requirement for a health care service provided through telehealth as long as this does not exceed

the amounts applicable to a comparable service provided through in-person consultation.

- Carrier may not exclude a health care service from coverage solely because the service is provided through a telehealth encounter.

I hope the committee can offer its full support to LD 849.Thank you very much for your consideration.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Janet T. Mills
Governor

Anne L. Head, Esq.
Commissioner

TESTIMONY OF KRISTINA M. HALVORSEN
Administrator, Office of Professional and Occupational Regulation
Department of Professional and Financial Regulation

Neither for Nor Against L.D. 863
"An Act to Have Maine Join the Interstate Psychology Interjurisdictional Compact to Improve Telehealth Options for Psychologists and Their Patients"

BEFORE THE JOINT STANDING COMMITTEE ON HEALTH COVERAGE,
INSURANCE AND FINANCIAL SERVICES
Presented by Representative Denise Tepler
Public Hearing: May 6, 2021 – 10:00 a.m.

Senator Sanborn, Representative Tepler, and members of the Committee, I am Kristina Halvorsen, Administrator for the Board of Examiners of Psychologists within the Office of Professional and Occupational Regulation. I'm here today to testify neither for nor against LD 863, which proposes that Maine join the Psychology Interjurisdictional Compact, more commonly referred to as "PSYPACT."

PSYPACT was created by the Association of State and Provincial Psychology Boards ("ASPPB") to facilitate the practice of psychology using telecommunications technologies (telepsychology) and/or temporary, in-person, face-to-face psychological practice. PSYPACT operates as an agreement between participating states and must be enacted by a state legislature. Once enacted, the state joins the PSYPACT Commission, the governing body of PSYPACT. The Commission consists of a representative from each participating state and is supported by PSYPACT staff.

To practice telepsychology under the authority of PSYPACT, a psychologist licensed in a compact state applies for what is called an "E.Passport" from ASPPB. Then, the psychologist must obtain an Authority to Practice Interjurisdictional Telepsychology ("APIT") from the PSYPACT Commission. The psychologist may use the E.Passport/APIT to practice telepsychology in any compact state without an additional license. The state where the client/patient is physically located is called the "Receiving State" and the psychologist is subject to the scope of practice of that state. The fee for the E.Passport is $400, with a $100 annual renewal fee.

PSYPACT also provides for temporary in-person, face-to-face practice (for 30 days per calendar year in each PSYPACT state). A psychologist licensed in PSYPACT states must obtain an

Interjurisdictional Practice Certificate (IPC) from ASPPB. The psychologist is also required to obtain a Temporary Authorization (TAP) to Practice from the PSYPACT Commission. The psychologist practicing with the IPC/TAP is subject to the scope of practice of the state where they are physically present when providing the temporary, in-person face-to-face psychological services. The IPC costs $200 and $50 to renew annually.

The Office of Professional and Occupational Regulation (OPOR) and the Board are acutely aware of the shortage of mental health providers in Maine and around the country and we are committed to thoughtful efforts to increase access to high quality care. This session we worked with Rep. Kristin Cloutier to introduce LD 149 which establishes a "licensure by endorsement" application process for U.S. license holders who wish to obtain a Maine license. This endorsement process strikes a balance between allowing Maine's boards to serve their public protection mission while also expanding the workforce to serve Maine citizens.

Similarly, joining PSYPACT would allow psychologists here in Maine to care for their clients in other PSYPACT jurisdictions and visa-versa. For example, a psychologist treating a client living in Maine part of the year, but in another compact state for another part of the year, would have the option to seek privileges under PSYPACT to be able to continue treatment. One group of individuals who would benefit from this would be students from Maine who leave the state to attend college in another PSYPACT state. In addition, this bill would allow psychologists physically located in other "home states" that are part of PSYPACT to treat clients located in Maine via telehealth, increasing the number of providers who can offer behavioral health care services in our state.

While we are supportive of facilitating Maine licensure and expanding the workforce, the Board has some lingering questions about the implementation of this compact. For one, it is important to note that states wishing to join the compact must adopt the model language—this is a contract that the states are mutually bound to, and there is no ability to modify or tailor it to a particular state (and, states are similarly bound to all rules promulgated by the PSYPACT Commission). A concrete example of how that might affect Maine is the requirement to report "significant" investigatory information to the Commission to make it available to other compact states, which is in conflict with Maine statute providing that all complaints and investigatory information remain confidential until the matter is dismissed, a hearing is scheduled, or a consent agreement is signed.

As Maine would be the "Home State" for psychologists practicing under the PSYPACT privileges while physically present in Maine, the Board would be responsible for investigating and taking appropriate action with respect to reported inappropriate conduct conducted by a licensee which occurred in a Receiving State. This may require the issuance of a subpoena that would need to be enforced in another state in order to obtain records or compel witnesses. The cost and logistics of issuing and enforcing out-of-state subpoenas is unknown at this time.

Moreover, it's important to note that PSYPACT, while developed many years ago, only became "active" in April 2019 when Georgia joined as the 7th state to enact PSYPACT. The first Commission meeting took place in the summer of 2019, and ASPPB only began accepting E.Passport and IPC applications last summer. As such, many of the details are still being worked out, as was evident during the PSYPACT Commission's November 2020 meeting. At the November meeting, a member state asked if a psychologist providing telepsychology services into another compact state was subject to the

scope of practice of that state, and which laws and rules apply to that psychologist? Would it be the Home State laws or the Receiving State's laws? Further, what happens if there is a conflict of laws? No clear answer emerged from the governing documents and the PSYPACT Rules Committee took the matter under review.

Lastly, there is a cost associated with participating -- $10 per psychologist holding a PSYPACT privilege in Maine with a maximum cap of $6,000 annually. The Board does not receive any revenue from any privilege granted to PSYPACT practitioners, and may need to consider raising license fees to cover this cost. In addition to a financial cost, there is one other cost to consider with this and any other compact. When a state joins a compact, it must abide by the licensure requirements of that compact. OPOR has been undertaking substantial efforts to facilitate licensure for our foreign educated and trained immigrants. The state's ability to be flexible with documentation requirements or other standards may be limited by the dictates of a compact.

Thank you for your attention and I would be happy to answer your questions now or at the work session.

May 3, 2021

Representative Tepler
Health Coverage, Insurance and Financial Committee
State House
Augusta ME 04332

Re: LD863 An Act to have Maine Join the Interstate Psychology Interjurisdictional Compact to Improve Telehealth Options for Psychologists and their Patients

Dear Chairpersons Sanborn and Tepler, and Distinguished Committee Members,

I am Amy Safford, the Executive Director of the Maine Psychological Association. On behalf of MePA, I urge the committee to recommend that the Maine legislature pass LD 863, allowing Maine to join the Interstate Psychology Interjurisdictional Compact. The goal of PSYPACT is to improve access to mental health services, facilitating the practice of telehealth by licensed psychologists across state lines – a crucial step in providing better access to quality mental health treatment.

The American Psychological Association strongly supports the adoption of PSYPACT for three reasons:

1. PSYPACT seeks to improve patient access to psychological care for both Maine residents and for those patients of Maine licensed psychologists who travel outside the state.
2. In response to the COVID-19 pandemic and widespread adoption of telehealth, payers and policymakers recognize the need for psychologists to provide ethical care in a more flexible way beyond the current public health emergency.
3. The compact will allow the Maine Board of Examiners of Psychologists to better regulate out-of-state psychologists providing telehealth services to Maine residents.

These compacts create mutual professional licensing practices between states, while ensuring the quality and safety of services and safeguarding the state sovereignty. If Maine enacts PSYPACT legislation, the Maine licensing board will appoint a representative to the PSYPACT commission to address the needs and views of Maine.

Any psychologist wishing to practice under PSYPACT must obtain either an EPassport to provide telepsychology services or an Interjurisdictional Practice Certificate (IPC) to provide face to face services for a limited 30-day period in other PSYPACT states. Authorization is granted by the PSYPACT commission.

Psychologists must be licensed, have acceptable levels of training, and be in good standing in their home state without any disciplinary action on their record to be eligible for credentialing. Current state licensing requirements vary, and though the requirements to practice under PSYPACT may not exactly

mirror each state's specific requirements, the PSYPACT commission provides each state representation for regulation.

Psychologists will continue practice under the authority of their home state license, but they must abide by the scope of practice in the "receiving" state where the client is located. This requirement includes liability insurance in the state into which the services are being provided. Where there is a conflict between the states regarding laws, regulations and standards, psychologists will adhere to the laws, regulations and standards of their home state.

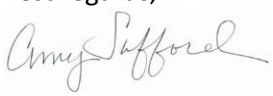
Last year, states had to rapidly institute stay-at-home orders in response to the COVID pandemic, requiring psychologists to rapidly transition to telehealth. Recognizing the need to ensure patient access to care, CMS issued a statement verifying the validity of multi-state licensing compacts, and that Medicare-enrolled psychologists in PSYPACT states can provide services to Medicare beneficiaries in other PSYPACT states.

The reality is that there are many healthcare providers engaging in practice across state lines unwittingly, but there is no coordinated way for Maine or other state licensing boards to track this, and often no means to regulate or enforce state laws if a problem arises with an out-of-state provider. PSYPACT creates a coordinated system for licensing boards to better protect their citizens by identifying those out-of-state providers and ensuring that they are qualified to do so.

If a psychologist authorized to practice under PSYPACT is alleged to have engaged in misconduct in a PSYPACT state, that state can alert the commission and the psychologist can be barred from continuing to practice virtually or in-person temporarily into other PSYPACT states. The psychologist's home state can determine whether disciplinary action is appropriate in consultation with the other state where the alleged misconduct occurred.

PSYPACT has been approved in 20 states, with two more pending final approval. We encourage this committee to recommend the passage of LD 863 to join these other states for the benefit of Maine residents who need mental health treatment they cannot otherwise access, and for licensed psychologists who wish to provide continuity of care to their patients, wherever they may be. Thank you for your time today and I am happy to answer any questions.

Best regards,



Amy Safford
Executive Director

Donna M. Hastings Psy.D.

Licensed Psychologist

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(603) 429-1190 DonnaMHastingsPsyD@gmail.com

Representative Denise Tepler
Health Coverage, Insurance and Finance Committee
State House
Augusta, Maine 04332

May 2, 2021

Re: LD 863 (HP631)

Dear Representative Tepler and Health Coverage, Insurance and Finance Committee Members,

I am writing to ask you to support LD 863 (HP 631) which would require Maine to join the Interstate Psychology Interjurisdictional Compact to Improve Telehealth Options for Psychologists and Their Patients.

Because psychologists are licensed by state, in order to treat a client in another state via telehealth, the psychologist must be licensed in both the state where the client is and the state where the psychologist is. People move, take vacations, and travel for business taking their mental health needs with them. Switching therapists is a difficult task, requiring clients to retell their stories, wait a long time for an appointment, and build trust with a new therapist.

Although I am licensed in MA, NH and ME, I cannot use a telehealth platform to provide services in any other states. I am in the process of applying to PSYPACT to improve my availability. Let me give you a couple of examples, I had a client who due to COVID was not going to school because her Vermont college was only remote. She moved to Maine to live with friends where she had a job. She began to “see” me. She then went home to Massachusetts where I could continue to treat her. However, when she returned to school in Vermont, I had to stop, and she had to find another therapist. If Maine and Vermont were PSYPACT states and I had completed my application, I would have been able to continue to see her and provide better continuity of care. Legislation is in process in both states.

Another example, also a college student, was home in Maine due to COVID and then went back to college in Massachusetts. I am able to continue to see her because I am licensed in both states, providing better continuity of care.

Currently, the need for mental health services has increased. Telehealth is enabling persons to obtain care although they may live a distance from mental health facilities, have no transportation, must stay home to monitor their children, or as a current client of mine, rest her broken leg.

I have not completed my PSYPACT application yet but will do so in the hopes that Maine will join the organization. For further information on PSYPACT go to psypact.com. There you can find a list of the current PSYPACT states as well as those with legislation pending.

Please note that the opinions in this letter are my own and not necessarily those of any organization for which I work or belong.

If I can provide you with more information, please do not hesitate to contact me.

Donna M. Hastings

Donna M. Hastings, Psy.D.
Licensed Psychologist

Good morning. I am Dr. Thomas Cooper, President of the Maine Psychological Association. I would like to thank Chairperson Sanborn and Chairperson Tepler, as well as the committee members for the opportunity to discuss the Psychology Inter-Jurisdictional Compact (PSYPACT) initiative with you. I would also like to thank Chairperson Tepler for studying this issue and working to sponsor the legislation.

As you are all well aware, we are experiencing unprecedented demands on our healthcare system. While we continue to make remarkable strides in combatting COVID-19, the psychological consequences of the pandemic will last long beyond when we have "opened up." The American Psychological Association warns of long-standing behavioral health and substance abuse crises and has been advocating for psychologists to evolve the way evidence-based treatment is provided. PSYPACT, is an example of such evolution. PSYPACT is an interstate compact which provides a mechanism for the ethical and legal practice of telehealth across state lines. As both the President of the Maine Psychological Association and a psychologist in private practice, I strongly support the passage of this legislation.

The practice of psychology is uniquely suited to telehealth services as our interventions are accessible to most without requiring specialized equipment. Changes during the pandemic - such as allowing for audio-only calls and mandated insurance coverage - have further removed obstacles to treatment. Long-standing research as well as current anecdotal evidence from both Maine psychologists and providers across the country have clearly shown that, for most populations, telehealth is just as effective as delivering services in-person.

In fact, I have found certain advantages to telehealth services. Over the course of the pandemic, many of my clients have moved or traveled out of state for various reasons. Some states created easily accessible temporary licensing laws that allowed therapy to continue. Other states did not enact such laws and treatment was terminated. In a number of instances, my clients indicated that they would have kept meeting with me but were unlikely to prioritize finding a new provider as they settled into their new state. This lapse in coverage obviously has significant implications for maintaining the wellbeing, health, and safety of many Americans.

As president of MePA, I can speak for a number of Maine psychologist and say that PSYPACT enhances our profession by eliminating many barriers to practice. As more and more states continue to adopt PSYPACT, it is easier for out-of-state providers to relocate to Maine while maintaining their practice. Allowing specialists the opportunity to move to Maine without surrendering their current practice can help us attract more highly qualified professionals to the state. MePA is regularly contacted by psychologists who have had to postpone or cancel plans to move to Maine because of difficulties with licensure. Increased access to inter-jurisdictional practice will significantly alleviate this bottleneck.

Finally, and most importantly, enacting PSYPACT has dramatic benefits for the people of Maine. The increased demand for services during the pandemic has highlighted the extent to which there are not

enough psychologists in the state to meet the needs of many Mainers. Currently, most of my peers have long waitlists and I continue to field calls from hospitals, schools, and primary care settings that are unable to find behavioral health providers for those in need. Access to out-of-state providers will help reduce the burden on Maine psychologists. Additionally, PSYPACT will allow at-risk Mainers, such as those with Opioid Use Disorder, Autism Spectrum Disorder, as well as children and Veterans, greater access to out-of-state specialists.

I am happy to answer any questions you may have and want to thank you again for considering this important legislation.

Sincerely,

Thomas Cooper, Psy.D.
President
Maine Psychological Association

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Office of Behavioral Health
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel: (207) 287-2595; Fax: (207) 287-9152
TTY: Dial 711 (Maine Relay)

May 6, 2021

Senator Heather Sanborn, Chair
Representative Denise Tepler, Chair
Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333-0100

Re: LD 863 – An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients

Senator Sanborn, Representative Tepler, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

This letter is to provide information regarding LD 863, An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients.

This bill would enact the Psychology Interjurisdictional Compact, an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries.

There have been an increasing number of court orders for community-based defendants who live out of state at the time of the court order. To evaluate those out of state defendants, State Forensics Services (SFS) either needs to find an examiner who is licensed in the state the defendant is located, determine if that state allows temporary practice without a license by a psychologist licensed in another state, or require the defendant to drive back to Maine for the evaluation. This has been especially difficult during the pandemic. Some COVID related exceptions have been helpful but is not a permanent solution.

This bill would allow SFS examiners to have a blanket allowance for temporary practice in another state if that state is part of the Compact. Approximately fifteen states have already enacted this legislation, with approximately fifteen more states pending legislation.

We wanted the Committee to be aware of the above information as it considers this bill moving forward. If you have any further questions, please feel free to contact me.

Sincerely,

Jessica M Pollard, PhD

Jessica Monahan Pollard, PhD, Director
Office of Behavioral Health

John M. O'Brien, Ph.D. **obrien@mentalhealthassociates.me**
Mental Health Associates of Maine, LLC **Phone: (207) 773-2828 x105**
251 Woodford St. Portland, Maine 04103 **Fax: (207) 761-8150**

April 30, 2021

Representative Tepler
Health Coverage, Insurance and Financial Committee
State House
Augusta ME 04332

Re: LD863 An Act to have Maine Join the Interstate Psychology Interjurisdictional Compact to Improve Telehealth Options for Psychologists and their Patients

Dear Representative Tepler and members of the Health Coverage, Insurance and Financial Committee:

I am writing to ask you to support LD 863 (HP 631). This bill is to have Maine join the Interstate Psychology Interjurisdictional Compact to Improve Telehealth Options for Psychologists and Their Patients. It is sponsored by Representative Denise Tepler.

Because psychologists are licensed by state, in order to treat a client in another state via telehealth, the psychologist must be licensed in both the state where the client is and the state where the psychologist is. People move, take vacations, and travel for business taking their mental health needs with them. Switching providers is a difficult task requiring clients to retell their stories and build trust with a new person. I would like to provide a few examples of the negative implications of these current practice limitations on clients and on my business.

I had a client who moved out of state a few years ago. He contacted me last April as he was experiencing an increase in anxiety symptoms related to the pandemic. He wanted to return to treatment and reached out to me to seek care with some sense of urgency. I had to decline working with him and refer him to providers in his state, none of whom I knew. If Maine were a PSYPACT state, I would have been able to continue to see him and provide better continuity of care as he was living in Washington, DC (a PSYPACT state/territory member).

Another example of the impact of these practice limits is in reference to my recent training as an executive coach (which was a significant commitment of time and money). After completing the program, I established a new and separate coaching practice to distinguish it from my practice as a psychologist. However, I recently learned that several states have updated their laws to indicate that if a psychologist is providing coaching, this service is AUTOMATICALLY seen as a psychological intervention and therefore covered by licensing laws. This means that I can only practice coaching in Maine. Other professionals with less training are free to practice in any state in the United States or even with clients overseas. Psychologists are unfairly limited in their practice by licensing laws. If Maine were to enter PsyPact, I would be able to provide better continuity of care for my coaching work (if a client moves) and grow my business.

John M. O'Brien, Ph.D. **obrien@mentalhealthassociates.me**
Mental Health Associates of Maine, LLC **Phone: (207) 773-2828 x105**
251 Woodford St. Portland, Maine 04103 **Fax: (207) 761-8150**

I have not completed my PSYPACT application yet as it is not useful to me unless Maine becomes a part of this network. I sincerely hope that you will consider passing this legislation as it will allow for better client care and for psychologists in Maine to be able to expand their businesses across state lines.

For further information on PSYPACT go to psypact.com. There you can find a list of the current PSYPACT states as well as those with legislation pending. If I can provide you with more information, please do not hesitate to contact me.

Sincerely,

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National Center for Interstate Compacts
THE COUNCIL OF STATE GOVERNMENTS

April 30, 2021

Representative Denise Tepler
Health Coverage, Insurance and Financial Committee
State House
Augusta, ME 04332

Subj: LD 863: An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients

Dear Representative Tepler:

My name is Dan Logsdon. I am the Director of the National Center for Interstate Compacts at The Council of State Governments. The Council of State Governments facilitated the creation of the Counseling Compact.

Founded in 1933, The Council of State Governments (CSG) is our nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national, and international opportunities to network, develop leaders, collaborate and create problem-solving partnerships. All states are members of CSG and pay dues to support our work. We appreciate the participation of Maine with CSG East.

The National Center for Interstate Compacts (NCIC) is a program borne from CSG's more than 87-year history of promoting multi-state problem solving and advocating the role of the states in determining their respective futures. During that time, CSG began tracking the progress of more than 200 active interstate compacts, researching innovative state solutions and bringing the states together to build consensus on national issues.

In the past decade CSG has focused on helping states enhance the ability of licensed professionals to engage in interstate practice through the creation of occupational licensure interstate compacts. CSG has helped develop licensure compacts for nurses, physicians, psychologists, emergency medical services personnel, physical therapists, audiologists and speech-language pathologists.

In my capacity the Director of the National Center for Interstate Compacts (NCIC) at The Council of State Governments (CSG), I have been asked to write to you about the nature and scope of the language for the Psychology Interjurisdictional Compact (PSYPACT).

In recent years I have been involved with developing compacts focused on interstate occupational licensure. To date, Maine has enacted two occupational licensure compacts: Interstate Medical

Licensure Compact (IMLC) and the Nurse Licensure Compact (NLC). Maine is a member of over 30 interstate compacts including five national compacts:

- The Emergency Management Assistance Compact
- The Military Children's Compact Commission
- The Interstate Compact for Juveniles
- The Interstate Compact for Adult Offender Supervision
- The Intestate Compact for the Placement of Children

The Maine State Legislature is currently considering enacting PSYPACT (LD 863). PSYPACT's provisions are similar in form and function to the provisions of the IMLC and the NLC for interstate mobility previously enacted by Maine. PSYPACT provides greater access to care and strong provisions for patient and public safety. Specifically, PSYPACT addresses the growing demand to provide and receive psychological services via electronic means while empowering states to regulate telepsychology practice.

Occupational licensure compacts do not impact state scope of practice statutes or how a state regulates practice within its borders. Occupational licensure compacts are simply a means for professionals to achieve interstate occupational licensure mobility in an expeditious, cost effective manner that lessens the burdens on practitioners.

Further, a key benefit to states for adopting an interstate occupational licensure compact is that it allows states to cooperatively achieve "economies of scale" in regulating the interstate practice of a profession. These licensure compacts create a mechanism whereby states can jointly share information, conduct investigations and mete out discipline in furtherance of protecting the public, the chief goal of professional licensure.

To date, twenty (20) states have enacted the Psychology Interjurisdictional Compact.

I appreciate your time and consideration of PSYPACT. Please feel free to contact me at dlogsdon@csg.org with any additional questions you may have.

Respectfully,

Dan Logsdon

Dan Logsdon
Director, National Center for Interstate Compacts
The Council of State Governments

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May 6, 2021

Testimony of Rep. Denise Tepler presenting

LD 863, An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients

Before the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Senator Sanborn and respected colleagues of the Health Coverage, Insurance and Financial Services Committee, I am Denise Tepler, representing House District 54, all of the sweet Town of Topsham from Merrymeeting Bay to Sky-Hi. I am pleased to present **LD 863, An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients.**

Interstate Licensing Compacts in general can improve efficiency and effectiveness of Maine's professional licensing programs. They can provide benefits in limiting the amount of work licensing boards must do in checking out of state credentials and can allow more opportunities for Maine-based professionals to do work in border states while protecting patients from unscrupulous practitioners.

PSYPACT in particular, is an interstate compact which provides a mechanism for the ethical and legal practice of telepsychology by licensed psychologists whose states join the compact. 20 States including New Hampshire have passed legislation joining the Compact and 11 more, including Vermont, have pending legislation.

Joining PSYPACT will offer our fellow Mainers with more opportunities to obtain the highest level of mental health services from doctoral level licensed psychologists, including those with specialties like opioid use disorders.

Thank you for the opportunity to present this bill. I will be happy to answer any questions you have but members of the Maine Psychology Association are present in support of the bill and may be better able to answer. Please note that the Department of Defense has submitted written testimony supporting the bill.

MANPOWER AND
RESERVE AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
1500 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-1500

May 6, 2021

Senator Heather B. Sanborn
Representative Denise A. Tepler
Co-Chairs, Joint Committee on Health Coverage, Insurance and Financial Services

Remarks of
Christopher R. Arnold
Northeast Region Liaison
United States Department of Defense-State Liaison Office

Support of: LD863 – An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients

Testimony
The Department of Defense expresses its support for the policy changes proposed in Maine LD863, the Psychology Interjurisdictional Compact (PsyPACT), which addresses licensing issues affecting our service members and their families. I would like to thank you for considering this issue in the 2021 session.

My name is Christopher Arnold. I am the northeast region liaison at the United States Department of Defense-State Liaison Office, operating under the direction of Under Secretary of Defense for Personnel and Readiness. We represent the Department and establish relationships with state leaders across the country who are concerned for our troops and their families' welfare by harmonizing state and federal law and regulation on policy problems of national significance. These are identified by the Office of the Secretary of Defense, the Military Departments, and the National Guard Bureau as areas where states can play a crucial role.

Portable employment opportunities support military spouse career development. PsyPACT allows an active duty service member, or their spouse, to designate a home state where the individual has a current license in good standing. This state then serves as the individual's home state for as long as the service member is on active duty, while adhering to the laws, rules and scope of practice in Maine.

Licensure issues for both our transitioning military members and their spouses have been a priority for the Department for several years. The issue is so important, the Secretary of Defense has made taking care of Service members and their families a fourth line of effort in the National Defense Strategy.

To address license portability for military spouses, states have turned to occupational licensure interstate compacts, which streamline relicensing between member States of a compact for all practitioners in an occupation, and provide specific support for military spouses of relocating active-duty personnel through provisions recognizing unique requirements of military life.

The Secretaries of the Military Departments have made the importance of military spouse licensure explicitly clear as they consider the availability of license reciprocity when evaluating future basing or mission alternatives.[1] In 2018, the secretaries of the Army, Navy and Air force issued a policy memorandum to the national governor's association noting they will consider the quality of schools near bases and whether reciprocity of professional licenses is available for military families when evaluating future basing or mission alternatives. [2]

The Air Force's approved criteria assesses states' policies for accepting professional licenses for psychologists as part of its strategic basing process.[3] Future air force basing decisions made with a consistent framework will ensure optimal conditions for service members and their families.[4]

A 2018 study by the Federal Trade Commission, "Options to Enhance Occupational License Portability," recognized there are two approaches to alleviating barriers to license portability. Namely, mutual recognition, which relates to occupational compacts, and expedited licensure, which encompasses exemption-based approaches.[5]

Occupational licensure compacts provide consistent rules for licensed members to work in other states. Common misinformation about compacts is that they either lower or raise the standards for the occupation, when in fact, compact states have the option to issue a "compact license" and also a "State-only license" to maintain their State's standards.

Professional licensure has been an enduring problem for military spouses. Obtaining a license in a new State can be both time consuming and expensive, and military spouses often cannot adequately anticipate how to prepare for licensure in a new State due to the unpredictable nature of military moves. The short duration of military assignments, coupled with lengthy relicensing processes, can discourage military spouses from seeking relicensure, causing them to quit an occupation or causing military families to leave the military.

Complicating matters further, the term "reciprocity" is used differently among the States. The continuum of reciprocity related programs is represented graphically below. The continuum goes from red, representing little to no portability, to dark green, representing the DoD's optimum state of full reciprocity. Understanding that military spouses need assistance now, and that many States have already committed to a variety of approaches, the Department advocates that States

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[1] This consideration was codified by Congress as a requirement in the 2020 National Defense Authorization Act. Notably, §2883(h) requires the Department and each of the military services to produce annual basing decision scorecards at the state and installation level considering military family readiness issues, including interstate portability of licensure credentials.

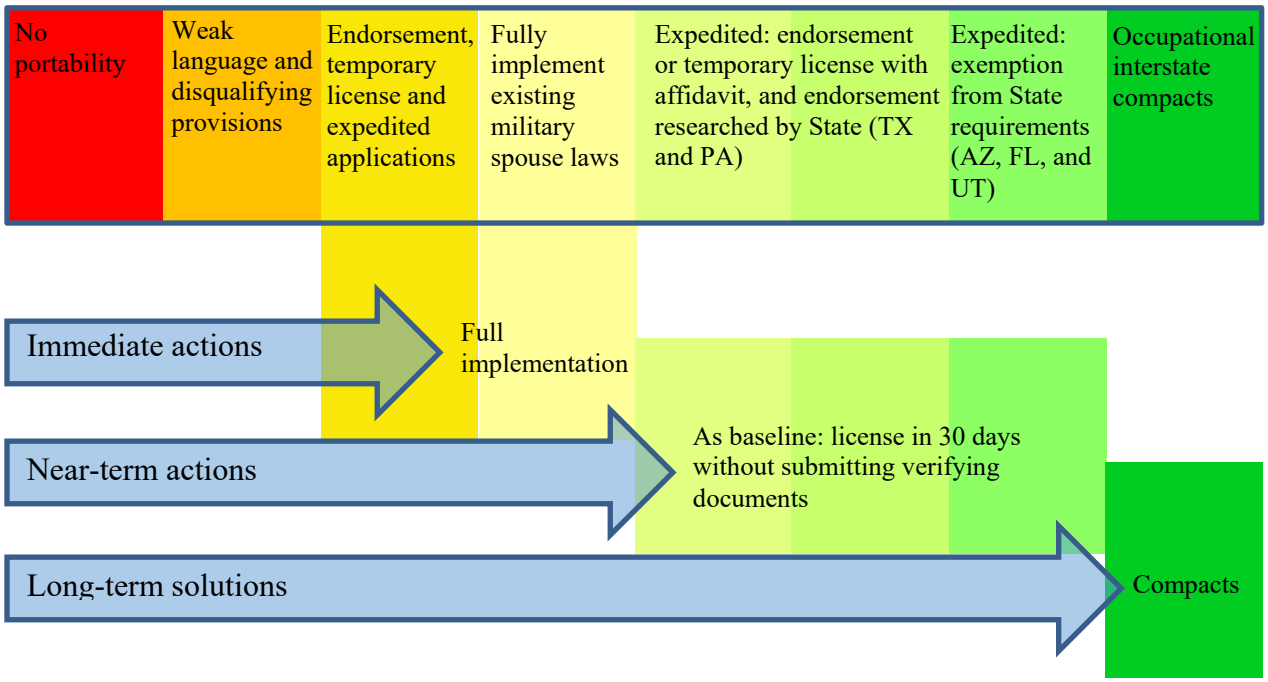
[2] The secretaries must further consider "*whether the State in which an installation subject to a basing decision is or will be located ... has entered into reciprocity agreements to recognize and accept professional and occupational licensure and certification credentials granted by or in other States or allows for the transfer of such licenses and certifications granted by or in other States*." (Id. (b))

[3] Secretary of the Air Force Public Affairs. "Department of the Air Force to consider military family support measures in future basing decisions." February 24, 2020. Retrieved from https://www.af.mil/News/Article-Display/Article/2092427/department-of-the-air-force-to-consider-military-family-support-measures-in-fut/

[4] The licensure portability framework is used to assess state laws, governors' executive orders, state Supreme Court or bar association rules and the ability for an area to accommodate licenses earned from other locations.

[5] Karen A. Goldman. "Options to Enhance Occupational License Portability." Federal Trade Commission. September 2018. Retrieved from http://www.ftc.gov/policy/reports/policy-reports/commission-and-staff-reports

should pursue multiple approaches to reciprocity simultaneously. Available alternatives can be categorized as being more immediately attainable, achievable within the near-term, or obtainable in the long-term:



Military spouses are a cross-section of the American population, although a greater percentage of them are in licensed occupations than their civilian counterparts,[6] and they are significantly more mobile.[7] States have committed to using interstate compacts, which establish common understanding of competency and its measurement within the occupation, to resolve the interstate issue of license portability.

Approved in February 2015 by the Association of State and Provincial Psychology Boards (ASPPB) Board of Directors, PsyPACT has been created to facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries. Under PsyPACT, a psychologist can obtain an E.Passport to practice telepsychology and/or conduct temporary in-person, face-to-face practice. A doctoral degree in psychology is required to obtain the E.Passport.[8]

PsyPACT is of dual benefit, in that it not only expands access to care for military services members, but also allows military spouses who are practicing psychologists to conduct interstate

[6] 34 percent of active duty spouses self-identified as needing a State issued license to work (2017 Survey of Active Duty (Active Component) Spouses, Tabulations of Responses; Office of People Analytics Report No. 2018-006, May 2018), compared to 30 percent of the civilian population (The Hamilton Project, Brookings Institute, https://www.hamiltonproject.org/charts/percent_of_occupations_requiring_a_license_by_state)
[7] "Military spouses are 10 times more likely to move across State lines than their civilian counterparts," "Supporting Our Military Families: Best Practices for Streamlining Occupational Licensing Across State Lines," U.S. Department of Treasury and U.S. Department of Defense, February 2012, page 7.
[8] The Association of State and Provincial Psychology Boards *PSYPACT FAQs*. Retrieved from https://cdn.ymaws.com/www.asppb.net/resource/resmgr/PSYPACT_Docs/PSYPACT_FAQs.pdf

practice via telehealth or in person. To date, 20 states have joined PsyPACT and 11 states currently have legislation pending in addition to Maine. This compact is designed to achieve the following purposes and objectives:

- Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology;
- Enhance the states' ability to protect the public's health and safety, especially client/patient safety;
- Encourage the cooperation of Compact States in the areas of psychology licensure and regulation;
- Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions and disciplinary history;
- Promote compliance with the laws governing psychological practice in each Compact State; and
- Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

The Department encourages States to engage in immediate actions to fully implement military spouse licensure laws, near-term actions to at least attain a baseline of getting military spouses a license in 30 days based on minimal documentation, and long-term solutions for reciprocity through compacts. How fast these actions and solutions can be approved and implemented is up to the States.

In closing, we are grateful for the tremendous efforts that Maine has historically made to support our military members and their families. We appreciate the opportunity to support the passage of the policies reflected in LD863 and the enactment of PsyPACT and are especially grateful to the Representative Tepler for introducing this important piece of legislation.

Thank you for taking the time to consider this issue. Please feel free to contact me with any questions you may have.

Yours etc.,

CHRISTOPHER R. ARNOLD
Northeast Region Liaison
Defense-State Liaison Office

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
1500 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-1500

MANPOWER AND
RESERVE AFFAIRS

April 30, 2021

The Honorable Heather B. Sanborn
3 State House Station
State House, Room 320
Augusta, ME 04333-0003

The Honorable Denise A. Tepler
2 State House Station
State House, Room 333
Augusta, ME 04333-0002

RE: Memorandum of Support – LD863 – An Act To Have Maine Join the Interstate Psychology Interjurisdictional Compact To Improve Telehealth Options for Psychologists and Their Patients

Dear Senator Sanborn, Represtantive Tepler and Honorable Committee Members:

On behalf of military families and the Department of Defense, I am writing to express the support of the Department of Defense for the policy changes proposed in Maine LD863, the Psychology Interjurisdictional Compact (PsyPACT), which addresses licensing issues affecting our service members and their families. I would like to thank you for considering this issue in the 2021 session.

My name is Christopher Arnold. I am the Northeast Regional Liaison for the United States Department of Defense-State Liaison Office, operating under the direction of Under Secretary of Defense for Personnel and Readiness. Our mission is to be a resource to state policymakers as they work to address quality of life issues of military families.

The Secretaries of the Military Departments have made the importance of military spouse licensure explicitly clear as they consider the availability of license reciprocity when evaluating future basing or mission alternatives. This consideration was codified as requirement in the 2020 National Defense Authorization Act.[1]

Approved in February 2015 by the Association of State and Provincial Psychology Boards (ASPPB) Board of Directors, PsyPACT has been created to facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries. PsyPACT is an interstate compact, which is an agreement between states to enact legislation and enter into a contract for a specific, limited purpose or address a particular policy issue.

PsyPACT is of dual benefit, in that it not only expands access to care for military services members, but also allows military spouses who are practicing psychologists to conduct interstate

[1] Notably, §2883(h) requires the Department and each of the military services to produce annual basing decision scorecards at the state and installation level considering military family readiness issues, including interstate portability of licensure credentials.

practice via telehealth or in person. To date, 20 states have joined PsyPACT and 11 states currently have legislation pending in addition to Maine. This compact is designed to achieve the following purposes and objectives:

- Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology;
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- Promote compliance with the laws governing psychological practice in each Compact State; and
- Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

Portable employment opportunities support military spouse career development. PsyPACT allows an active duty servicemember, or their spouse, to designate a home state where the individual has a current license in good standing. This state then serves as the individual's home state for as long as the servicemember is on active duty, while adhering to the laws, rules and scope of practice in Maine.

We appreciate the opportunity to support the policies outlined in LD863 this session and would like to thank Rerpesentative Tepler for sponsoring this important initiative. Joining PsyPACT will improve access to care and allow military personnel and spouses to more easily maintain their certifications when relocating. Please feel free to contact me with any questions you might have.

Sincerely,

CHRISTOPHER R. ARNOLD
Northeast Region Liaison
Defense-State Liaison Office

CC: Members of the Joint Committee on Health Coverage, Insurance and Financial Services

APTA Maine
A Chapter of the American Physical Therapy Association

Testimony on Telehealth Bills

May 6, 2021

Senator Sanborn, Representative Tepler and Honorable Members of the HCIFS Committee:

My name is Gwen Simons. I am the lobbyist for the Maine Chapter of the American Physical Therapy Association. I am a physical therapist myself and a healthcare lawyer in Scarborough. The Maine APTA represents over 2500 physical therapists (PTs) and physical therapist assistants (PTAs) in Maine.

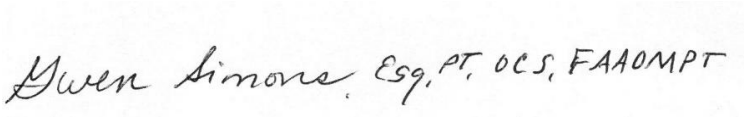
MEAPTA supports all of the proposed telehealth bills, specifically provisions that:

- Allow the use of audio only (telephonic) services to qualify as telehealth services because many patients, especially MaineCare patients, may not have adequate internet access,
- Require parity in payment for telehealth services that can be delivered via telehealth,
- Prohibit on carrier establishing a separate deductible for telehealth services (LD 849), and
- Explicitly identify the providers who may provide telehealth service (LD 1007)

Telehealth has become an important means of accessing health care services. Such services should be available to all patients regardless of their insurance coverage.

Thank you for your consideration. Please feel free to contact me if you have any questions or need more information at gwen@simonsassociateslaw.com or 207-883-7225.

Sincerely,



Gwen Simons, Esq, PT, OCS, FAAOMPT
Lobbyist, Maine Chapter APTA

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Janet T. Mills
Governor

Anne L. Head
Commissioner

TESTIMONY OF ANNE L. HEAD

COMMISSIONER, DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

IN OPPOSITION TO LD 1007

AN ACT TO INCREASE AVAILABILITY OF HEALTH CARE THROUGH TELEHEALTH

SPONSORED BY REPRESENTATIVE LAUREL LIBBY

BEFORE THE JOINT STANDING COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

Public Hearing: May 6, 2021

Senator Sanborn, Representative Tepler, and Members of the Committee, my name is Anne Head. I am the Commissioner of the Department of Professional and Financial Regulation (DPFR) and Director of the Office of Professional and Occupational Regulation. I am here today to speak in opposition to LD 1007, *An Act to Increase Availability of Health Care through Telehealth*.

The Department is committed to enabling Maine-licensed health care providers to continue to provide vital services to Maine citizens via telehealth. Even before this pandemic, OPOR boards were considering how to address the delivery of health care through remote means. As we all know, the current global pandemic accelerated that discussion in warp speed and highlighted the importance of being able to provide services through audio and visual means, rather than only in traditional brick and mortar settings.

While the Department appreciates the intent behind this bill and thanks the sponsor for her commitment to ensuring that health care practitioners have the ongoing authority to provide services through telehealth – we respectfully disagree with the proposal to make the Executive Order permanent.

Executive Order 35 was drafted and issued in an *emergency*, with the intent to temporarily authorize use of telehealth as quickly as possible. The Executive Order does not set forth guardrails for delivery of care through this virtual medium. Development of those guardrails are best left to the expertise of the health care boards in conjunction with the public input required by the APA rulemaking process. The Department anticipated this need and worked with the Assistant Attorneys General for each of the health care boards and the Governor's office to develop a bill, LD 1681, that sets forth in each of our health care licensing statutes, statutory enabling language, consistent definitions of telehealth, and rulemaking requirements.

I assure you that our boards are eager to maintain telehealth as a means of health care delivery. They lived through the same public health emergency as Committee members and your constituents. Our health care providers, for example, are acutely aware of the shortage of health care providers in many specialties in Maine and around the country and we are committed to thoughtful efforts to increase access to high quality care.

These health care provider licensing boards are also committed to their statutorily mandated public protection mission and want to assure that, at the conclusion of the pandemic, services delivered via telehealth are delivered on secure platforms to protect confidential health care information, are clinically appropriate for the service being delivered, and are driven by the patient's needs and not the provider's convenience.

We urge the Committee to reject the wholesale adoption of an emergency practice and instead support the Administration's approach in LD 1681 authorizing each of its health care boards to individually consider and adopt telehealth practice and ethics standards appropriately tailored to specific professions and situations.

Thank you for your time and I would be happy to answer any questions now or at the work session.

Katie Dolinsky
Falmouth

I am a licensed mental health professional and am submitting testimony in support of increasing behavioral health support via telehealth in the state of Maine. I believe that increasing Maine citizens access to behavioral health care even once the emergency order is over would be beneficial to public health. During the last year, when the pandemic began, emergency orders were put in place which allowed providers licensed in other states to get a temporary emergency license to provide services to Maine residents, even if they were not licensed in this state. The state of Maine historically has a lower number of mental health professionals then is needed, which leaves a shortage for residents needing care. In the last year, we have seen an increased rate of mental health symptoms (over 50% increase) in all areas, including anxiety, depression, suicidal ideation, and substance abuse. Domestic family violence has increased by 40%. These increases are not going to end when the emergency order ends. People (adults and children) are going to need months to years of continued support to heal from the trauma of the last year. It will be imperative to Maines public health for there to be an adequate number of behavioral health care providers, whether they are in person or via telehealth. Research has shown that telehealth therapy is as effective if not more effective in some cases in treating many mental health symptoms.
In short, any provider who was granted an emergency license should be eligible to maintain that license in ME long term to help combat the increased mental health crisis that the state is/ will continue to face.

MAINE
PSYCHOLOGICAL
ASSOCIATION

May 4, 2021

Representative Libby
Senator Stewart
Health Coverage, Insurance and Financial
State House
Augusta ME 04332

Re: LD1007: An Act to Increase the Availability of Health Care Through Telehealth

Dear Representative Libby, Senator Stewart, Representatives Craven, Madigan, Morris, Perry, Stover, Warren, and Zager, Senator Brenner and Members of the Committee:

The Maine Psychological Association (MePA) is a membership organization representing psychologists in Maine who work in private practice, at Maine's colleges and universities, and in the public sector. Our mission is to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

MePA supports LD1007: An Act to Increase Availability of Health Care through Telehealth. This bill makes permanent the Governor's Executive Order #35 dated April 6, 2020, which allows certain licensed or registered professionals under Title 32 of the Maine Revised Statutes to provide necessary health care or other services to the extent practicable through the use of all modes of telehealth, including visual and audio, audio-only or other electronic media. The bill also clarifies that these services must be covered by insurance as they would be if provided in person.

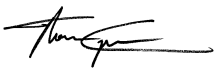
Psychologists and their patients have concerns that as state and national public health emergency declarations end, the current public health emergency mandates will expire resulting in many insurers reverting back or terminating pandemic-related telehealth expansions.

Many patients in need of mental and behavioral health services have conditions and disorders that prevent them from safely (or without great anxiety) leaving their homes and sharing close personal space with other people. This will be especially burdensome on moderate- and low-income subscribers who have no choice but to take public transportation or rely on others to get to their in-person health care appointments.

Allowing coverage and reimbursement of audio-only telephone services addresses the inequity problem that lower SES and older patients tend to have less access to the resources and skills required for telehealth via traditional video-conferencing platforms (access to laptops and smartphones, broadband services, and the skills to use videoconferencing systems) and older patients often have transportation issues that are barriers to accessing in-person services.

Telehealth boosts patient access, which will help Maine meet the increased mental health needs resulting from the pandemic.

Sincerely,



Thomas Cooper, PsyD
President

Maine Academy of Nutrition and Dietetics
an affiliate of the Academy of Nutrition and Dietetics
PO Box 10214, Portland, Maine, 04104; www.eatrightmaine.org

Testimony in Support of LD 1007 - An Act To Increase Availability of Health Care through Telehealth
Submitted by Patsy Catsos, MS, RDN, LD

Good morning, Senator Sanborn, Representative Tepler and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services,

My name is Patsy Catsos and I am a resident of Portland. I am speaking on behalf of the Maine Academy of Nutrition and Dietetics where I serve as a member of the Public Policy Panel. The Maine Academy is an affiliate of the Academy of Nutrition and Dietetics, an association that represents over 100,000 credentialed dietetics and nutrition practitioners. We are the food and nutrition professionals who can translate the science of nutrition into practical solutions for healthy living. As health care practitioners, we strive to improve the health of Maine's citizens through quality food and nutrition information and nutrition care services. Our members work across the state in hospitals, schools, public health clinics, nursing homes, food service management, universities, research, and private practice.

In my work as a Registered, Licensed Dietitian I am a consultant at Nutrition Works in Portland, providing one-on-one medical nutrition therapy to patients with gastrointestinal diseases and disorders. Other dietitians in our practice deliver specialty nutrition care for patients with a variety of other conditions. While some patients do prefer face-to-face visits, the *option* of telehealth can benefit Maine residents who are referred for medical nutrition therapy because it is both effective and accessible.

Effective: As we and our patients learned during the COVID-19 pandemic, medical nutrition therapy can be provided very effectively via telehealth, as all of the tasks in our workflow can be performed remotely. Meeting with patients while they are at home allows them to check their pantries and medicine cabinets as needed to share important details about the food and nutrition products they are consuming. Timely follow-ups increase effectiveness, too, and are easier for patients to squeeze into their busy schedules when they can meet with us via secure video-chat. Many of our patients prefer telehealth because of this.

Accessible: With telehealth, travel distance is no longer a barrier to accessing a licensed provider of specialty dietetic care. It seems obvious that Maine residents who live in distant parts of the state benefit from having access to the same care as those living in Maine's biggest cities. Telehealth means all Maine citizens can access specialty services without travel expenses and without taking one or more days off from work. Perhaps less obviously, travel can be physically taxing and difficult to manage for those who are ill; telehealth solves this problem. I recently helped an 82-year-old gentleman in Downeast Maine recover from post-infectious irritable bowel syndrome and unintentional weight loss. He needed ready access to a bathroom due to his illness, and he would have been unable to make even a single trip to visit my office in Portland, much less a series of visits. He and his wife adapted readily to the telehealth platform. His weight and his strength have now been restored and he is feeling well again thanks in part to the option of using telehealth for his care.

Registered, licensed dietitians are recognized as reimbursable health care providers in Medicare. Under the current emergency rules, we are permitted to provide medical nutrition therapy via telehealth; before the pandemic, we were

not. Many private insurances also provide benefits for nutrition services when provided by a registered, licensed dietitian. Under the current emergency rules insurance companies are reimbursing us for services provided via telehealth; before the pandemic, it was hit or miss. Patients were reluctant to take a chance on accessing their benefits via telehealth because the coverage information for telehealth was very difficult to determine ahead of time, even by contacting the insurance company, and often resulted in a significant out-of-pocket bill for patients.

I am here today to testify in support of LD 1007, An Act To Increase Availability of Health Care through Telehealth, as it includes the profession of Dietitians in Title 32 at chapter 104, removes the limitations for telephonic use of telehealth, requires that reimbursement for telehealth services is at the same rate and copay as for in-person consultation and allows for the use of and payment for telehealth past the public health emergency, with recommendations as follows:

- Ensure that the licensed, registered dietitian is of the patient's choice and participating in the patient's payer network. Before the pandemic, some payers were refusing patient access to telehealth benefits for services from licensed specialists in the patient's locale or state. They were apparently able to meet the letter of Maine's telehealth law by offering services only from their own employed health coaches or other staff.
- Ensure that all health insurance carriers that cover nutrition services and/or medical nutrition therapy for residents of the State of Maine, are required to follow the legislation, including plans which are self-funded or written out of the state of Maine. Without this, providers are unable to inform patients in advance whether their insurance will cover the services they need; in our experience, most patients will then refuse the telehealth services rather than take a chance on incurring a bill.

We urge you, the members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, to support LD 1007 that will allow Maine people access to nutrition services and medical nutrition therapy from registered, licensed dietitians using telehealth past the public health emergency. Thank you and we remain available as a resource to this committee and to answer any questions you may have.

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

Janet T. Mills
GOVERNOR

Louisa Barnhart, MD
CHAIR

Dennis E. Smith, JD
EXECUTIVE DIRECTOR

Timothy E. Terranova
ASSISTANT EXECUTIVE DIRECTOR

May 6, 2021

Senator Heather B. Sanborn, Chair
Representative Denise A. Tepler, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Re: LD 1194 – *"An Act To Reduce Health Care Worker Shortages"*

Dear Senator Sanborn, Representative Tepler and Distinguished Committee Members:

The Maine Board of Licensure in Medicine ("BOLIM") licenses and regulates allopathic physicians and physician assistants in Maine. The BOLIM is composed of 11 members: 6 physicians who actively practice medicine; 2 physician assistants who actively render medical services; and 3 public members. The BOLIM's mission is to protect the public by ensuring its licensees are ethical, professional and competent. It fulfills this mission by licensing, regulating, and educating physician and physician assistants.

The BOLIM respectfully offers the following comments in opposition to LD 1194:

The BOLIM appreciates the importance of telemedicine and its benefits, especially during the COVID-19 pandemic and for those patients living in rural areas of the State. Like the Legislature, the BOLIM is in the process of amending its existing telemedicine rule to include "audio only" to allow healthcare providers and patients greater flexibility when appropriate. Telehealth is not a medical specialty but simply one model, and an important one, for delivering health care – just as in-person health care is one model for delivering health care. During the pandemic, the BOLIM has issued over 900 Emergency COVID-19 licenses to physicians and physician assistants located throughout the country who provide telemedicine services to Maine patients. Many of these individuals are converting their licenses to permanent status in order to continue to provide telemedicine to Maine patients after the end of the declared emergency.

The BOLIM appreciates the good intent behind the bill; however, as written it fails to accomplish its goal of reducing health care worker shortages in Maine. Indeed, as written it would: (1) discourage health care workers from moving to Maine; (2) discriminate against health care workers who live in Maine, work in Maine, and pay license fees and taxes in Maine; (3) deprive the BOLIM of the authority to investigate the unlicensed health care workers located in other states; and (4) seriously and negatively impact the BOLIM's finances and thus its ability to protect the public.

Nearly one half of the BOLIM's licenses (allopathic physicians and physician assistants) are located outside of the State of Maine. That means a large number of BOLIM's licensees are

OFFICE LOCATION: 161 CAPITOL STREET, AUGUSTA, ME
www.maine.gov/md
PHONE: (207) 287-3601
FAX: (207) 287-6590

already practicing telehealth – and do so in a variety of medical specialties including radiology, neurology, internal medicine, and psychiatry. BOLIM and the Board of Osteopathic Licensure have an existing joint telemedicine rule that provides standards for those licensees who practice telehealth. LD 1194 would allow these individuals to practice telemedicine without renewing their Maine medical licenses. It would also allow any physician or physician assistant licensed in another state to treat patients located in Maine via telemedicine without ever applying for or obtaining a license in Maine. For example, if a psychiatrist licensed in Arizona can treat patients located in Maine via telemedicine without a license, why would they ever want to move to Maine and have to pay license fees and taxes? LD 1194 actually discourages health care workers from moving to Maine.

LD 1194 discriminates against physicians and physician assistants who live and work in Maine, pay taxes in Maine, and provide other types of support to their communities. Under this bill only the physicians and physician assistants who live and work in Maine and pay taxes in Maine would need to pay for licenses to practice on patients located in Maine. Physicians and physician assistants licensed in states other than Maine would not have to pay anything to Maine as they would be exempt from licensure. Physicians and physician assistants living and working in Maine would bear the financial burden of BOLIM's operations (it is funded only through licensing fees). As previously stated, telemedicine is not a medical specialty. Telemedicine is simply one model for delivering medical care via the practice of medicine. The bill discriminates against physicians and physician assistants who are living and working in Maine and seeing and treating Maine patients (in person and by telemedicine) by allowing out of state physicians and physician assistants to practice telemedicine medicine on patients in Maine without a license.

LD 1994 deprives the BOLIM of any authority to investigate and discipline incompetent or unprofessional conduct by these unlicensed physicians and physician assistants. The bill effectively eliminates the Board's authority and jurisdiction over these individuals and leaves Maine patients who are harmed by them with no recourse. BOLIM's telemedicine rule – which establishes standards of conduct – would be inapplicable to these individuals but applicable to physicians and physician assistants working and living in Maine – effectively creating a double standard. If a physician or physician assistant in another state can practice telemedicine on Maine patients without a license and without fear of investigation by BOLIM for incompetence or unprofessional conduct or the applicability of the BOLIM telemedicine rule, why would they want to physically move to Maine and practice?

LD 1194 will create significant revenue loss to the BOLIM - and potentially its ability to protect the public – that would result in fee increases or the need for General Fund appropriations to continue its operations. The revenue loss attributable to "permitted activity without a license" alone is estimated at $480,000 annually based upon the number of current licensees who reside outside of Maine. If section 1 of LD 1194 waives all fees if licensed in another state, the BOLIM could potentially lose all revenue as there may be no incentive to pay for a Maine license if a license is held in another state or can be obtained cheaper in another state, and then get a "free" Maine license.

Contrary to reducing health care worker shortages in Maine, LD 1194 discourages health care workers from moving to Maine, deprives the BOLIM of the authority to investigate and

discipline physicians and physician assistants who are not licensed yet provide telehealth services to patients in Maine, and severely impacts BOLIM's revenues and, therefore, its mission to protect the public.

The BOLIM supports the approach to telemedicine proposed by the Administration, which explicitly gives physicians and physician assistants who are licensed with the BOLIM the ability to provide telemedicine services to Maine patients pursuant to standards in rules promulgated by the BOLIM.

Thank you for the opportunity to provide these comments regarding LD 1194. I would be happy to answer any questions at the work session.

Sincerely,

Timothy Terranova
Assistant Executive Director

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

Janet T. Mills
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May 6, 2021

Senator Heather B. Sanborn, Chair
Representative Denise A. Tepler, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

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FAX: (207) 287-6590

already practicing telehealth – and do so in a variety of medical specialties including radiology, neurology, internal medicine, and psychiatry. BOLIM and the Board of Osteopathic Licensure have an existing joint telemedicine rule that provides standards for those licensees who practice telehealth. LD 1194 would allow these individuals to practice telemedicine without renewing their Maine medical licenses. It would also allow any physician or physician assistant licensed in another state to treat patients located in Maine via telemedicine without ever applying for or obtaining a license in Maine. For example, if a psychiatrist licensed in Arizona can treat patients located in Maine via telemedicine without a license, why would they ever want to move to Maine and have to pay license fees and taxes? LD 1194 actually discourages health care workers from moving to Maine.

LD 1194 discriminates against physicians and physician assistants who live and work in Maine, pay taxes in Maine, and provide other types of support to their communities. Under this bill only the physicians and physician assistants who live and work in Maine and pay taxes in Maine would need to pay for licenses to practice on patients located in Maine. Physicians and physician assistants licensed in states other than Maine would not have to pay anything to Maine as they would be exempt from licensure. Physicians and physician assistants living and working in Maine would bear the financial burden of BOLIM's operations (it is funded only through licensing fees). As previously stated, telemedicine is not a medical specialty. Telemedicine is simply one model for delivering medical care via the practice of medicine. The bill discriminates against physicians and physician assistants who are living and working in Maine and seeing and treating Maine patients (in person and by telemedicine) by allowing out of state physicians and physician assistants to practice telemedicine medicine on patients in Maine without a license.

LD 1994 deprives the BOLIM of any authority to investigate and discipline incompetent or unprofessional conduct by these unlicensed physicians and physician assistants. The bill effectively eliminates the Board's authority and jurisdiction over these individuals and leaves Maine patients who are harmed by them with no recourse. BOLIM's telemedicine rule – which establishes standards of conduct – would be inapplicable to these individuals but applicable to physicians and physician assistants working and living in Maine – effectively creating a double standard. If a physician or physician assistant in another state can practice telemedicine on Maine patients without a license and without fear of investigation by BOLIM for incompetence or unprofessional conduct or the applicability of the BOLIM telemedicine rule, why would they want to physically move to Maine and practice?

LD 1194 will create significant revenue loss to the BOLIM - and potentially its ability to protect the public – that would result in fee increases or the need for General Fund appropriations to continue its operations. The revenue loss attributable to "permitted activity without a license" alone is estimated at $480,000 annually based upon the number of current licensees who reside outside of Maine. If section 1 of LD 1194 waives all fees if licensed in another state, the BOLIM could potentially lose all revenue as there may be no incentive to pay for a Maine license if a license is held in another state or can be obtained cheaper in another state, and then get a "free" Maine license.

Contrary to reducing health care worker shortages in Maine, LD 1194 discourages health care workers from moving to Maine, deprives the BOLIM of the authority to investigate and

discipline physicians and physician assistants who are not licensed yet provide telehealth services to patients in Maine, and severely impacts BOLIM's revenues and, therefore, its mission to protect the public.

The BOLIM supports the approach to telemedicine proposed by the Administration, which explicitly gives physicians and physician assistants who are licensed with the BOLIM the ability to provide telemedicine services to Maine patients pursuant to standards in rules promulgated by the BOLIM.

Thank you for the opportunity to provide these comments regarding LD 1194. I would be happy to answer any questions at the work session.

Sincerely,

Timothy Terranova
Assistant Executive Director

STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0158

JANET T. MILLS
GOVERNOR

KIM ESQUIBEL, PHD, M.S.N., R.N.
EXECUTIVE DIRECTOR

May 6, 2021

Senator Heather Sanborn, Chair
Representative Denise Teplar, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Re: ***LD 1194 - "An Act to Reduce Health Care Worker Shortages"***

Dear Senator Sanborn, Representative Teplar, and Distinguished Committee Members:

The State Board of Nursing ("BON") licenses and regulates licensed practical nurses, registered professional nurses and advanced practice registered nurses in Maine. The Board is composed of 9 members – 5 actively practicing registered nurses, 1 actively practicing advanced practice registered nurse, 1 actively practicing licensed practical nurse and 2 public members. The Board's mission is to protect the public by ensuring its licensees are professional, ethical, and competent.

The BON respectfully offers the following comments in opposition to LD 1194:

The BON appreciates the importance of telehealth and its benefits and is committed to enabling its Licensees, both within and outside the state of Maine, to continue to provide vital nursing services via telehealth. Even before the COVID-19 pandemic the Nurse Licensure Compact (NLC) allowed both registered professional nurses and licensed practical nurses to provide nursing care via telehealth. COVID-19 has, however, brought to light the importance of being able to provide nursing care services through audio and visual means.

While the BON appreciates the intent behind this bill, we respectfully disagree with the proposal to make permanent the authorization for licensing out-of-state nurses and recently retired nurses that was provided through Executive Order during the state of civil emergency related to COVID-19.

The Executive Order was drafted and issued during an emergency, with the intent to temporarily authorize telehealth as quickly as possible. The Executive Order does not set forth the safeguards needed for delivery of nursing care through this virtual medium. The BON believes that those safeguards are best left to the expertise of the Board in conjunction with the public input required by the APA rulemaking process.

In addition, LD 1194 fails to accomplish its goal of reducing health care worker shortages in Maine. As written it would: 1) discourage health care workers from moving to Maine; (2) discriminate against health care workers who live in Maine, work in Maine, and pay license fees and taxes in Maine; (3) deprive the BON of the authority to investigate the unlicensed health care workers located in other states; and (4) negatively impact the BON's finances and thus its ability to protect the public.

- The BON already has a robust process in place to issue licenses expeditiously. **32 M.R.S. §2205-A & 2254-A. Licensure of persons licensed by another jurisdiction.** These licensure regulations authorize the Board to grant licensure to an individual who holds an active, unencumbered, valid license in another state or territory of the United States. The Board provides the mechanism by which credentials are evaluated of persons educated and licensed in U.S. jurisdictions and territories, Canada, or foreign countries. This process involves a review of educational preparation, as well as verification of appropriate testing mechanisms leading to original licensure through the NURSYS database. Public protection is accomplished by ensuring that only nurses with appropriate preparation, licensed through nationally recognized testing, are permitted to practice nursing in this state. Individuals can apply for Licensure by Endorsement on-line and upload required documents within minutes. Licenses are issued after review of applicant materials within 2-10 business days.

- **90-day Authorization to Practice/Temporary License:** 32 M.R.S. §§2103(4) and 10 M.R.S. §8003(5)(G) – these licensure regulations authorize the Board to grant a 90-day authorization to practice to any individual who holds an active, valid license in another state or jurisdiction. The 90-day authorization allows applicants to begin work more quickly while their permanent license applications are being processed. A 90-day authorization to practice can be issued within hours of receipt of an online application and on-line verification of licensure in another state or U.S. territory.

  The above licensing processes apply to all nurses (including those that are retired) but does not impose the "retired within two years" language. The LD would create a barrier for nurses that have been retired more than two years.

- Maine is a member of the Nurse Licensure Compact (NLC) (32 M.R.S., Chapter 31, Subchapter 2-A). Today, 34 states have joined the compact and an additional 8 states have introduced compact legislation. The NLC makes it unnecessary for a registered profession nurse (RN) and licensed practical nurse (LPN) to seek licensure in every jurisdiction and it provides for safeguards in place to ensure that nurse licensees are providing safe, competent nursing care to the citizens of Maine. Registered Professional Nurses and Licensed Practical Nurses holding a compact license are already permitted to practice telehealth under the NLC.

- Allowing Advanced Practice Registered Nurses who are licensed and working in another state to treat Maine patients by telehealth would have a significant negative impact on those Advanced Practice Registered Nurses who are working, living, and paying taxes in Maine. In essence, the Advanced Practice Registered Nurses who pay the BON's licensing fees and work and live in Maine would bear a part of the

financial burden of the BON's operations (it is funded only through licensing fees). Telehealth is not a nursing specialty. Telehealth is simply one model for delivering nursing care via the practice of nursing. The bill effectively discriminates against Advanced Practice Registered Nurses who are living and working in Maine and seeing and treating Maine patients in person and by telehealth by allowing out of state Advanced Practice Registered Nurses to practice telehealth on Maine patients with potentially less qualifications and no license fees. For example, an Advanced Practice Registered Nurse who is licensed in another state and practices nursing would be able to treat patients in Maine without being located in Maine, paying taxes in Maine, or ever coming to Maine. If an Advanced Practice Registered Nurse in another state can practice telehealth on Maine patients without a license, why would they want to physically come to Maine and practice?

- Allowing Advanced Practice Registered Nurses who are licensed and working in another state to treat Maine patients by telehealth and without a Maine license deprives the Board of any authority to investigate and discipline incompetent or unprofessional conduct by these unlicensed Advanced Practice Registered Nurses. The LD effectively eliminates the BON's authority and jurisdiction over these individuals and leaves Maine patients who are harmed by them with no recourse. If an Advanced Practice Registered Nurses in another state can practice telehealth on Maine patients without a license and without fear of investigation by the BON for incompetence or unprofessional conduct, why would they want to physically move to Maine and practice?

  The nurse licensure compact makes it unnecessary for a registered profession nurse (RN) and licensed practical nurse (LPN) to seek licensure in every jurisdiction and gives the Board expanded jurisdictional powers to investigate and take action against a Maine license or a compact privilege to practice in Maine when necessary.

- The language of the LD eliminates the current 24-month supervision requirement for out-of-stat nurse practitioners. The LR would eliminate any "mandatory supervision" for otherwise qualified nurse practitioners in good standing in another state and grant a license under this section..." In addition, to the extent that this law is attempting to eliminate another state's requirement for supervision for nurse practitioners, it cannot do so and the laws of the other state where the nurse practitioner is located would govern.

Contrary to reducing health care worker shortages in Maine, LD 1194 discourages health care workers from moving to Maine, deprives the BON of the authority to investigate and discipline nurses who are not licensed yet provide telehealth services to patients in Maine, and negatively impacts the BON's revenues and, therefore, its mission to protect the public.

For the above reasons, the BON urges this committee to reject making permanent the authorization for licensing out-of-state nurses and recently retired nurses that was provided through Executive Order during the state of civil emergency related to COVID-19; and instead, support the Administration's proposed approach, which would authorize the BON to individually consider and impose telehealth practice and ethics standards appropriately tailored to the nursing profession.

Thank you for the opportunity to provide these comments regarding LD 1194. I would be happy to answer any questions at the work session.

Sincerely,

Kim Esquibel, PhD, MSN, RN
Executive Director

HOUSE OF REPRESENTATIVES
2 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0002

Laurel D. Libby
442 Park Avenue
Auburn, ME 04210

May 6, 2021

Senator Sanborn, Representative Tepler, and distinguished members of the Committee on Health Coverage, Insurance and Financial Services,

My name is Laurel Libby, and I reside in Auburn. I represent House District 64, which is Minot and part of Auburn. I come before you today to present LD 1194, "An Act To Reduce Health Care Worker Shortages." This bill makes permanent the authorization for licensing out-of-state and recently retired doctors, physician assistants and nurses that was provided through executive order during the declared state of civil emergency related to COVID-19. The bill also expands the scope of health care services that can be provided though telehealth to include the use of audio-only telephone.

I've been a nurse since 2003, primarily in the ICU, as well as being part of a federal medical disaster relief team for over a decade. In that time I have seen many new developments in healthcare, but one thing generally remains the same - regulations that restrict, and even impede, medical care while increasing costs. For the past two years I have been working to grow my small business instead of working at the bedside, but have continued to see how excessive regulations impede healthcare, whether accessing it for a broken arm or a well-child appointment.

This year, we've faced unprecedented challenges here in Maine due to COVID-19, but I've been pleased to see some ongoing challenges to healthcare access eased via emergency orders. We should use the lessons that we are learning from COVID and put in place policies that will better prepare Maine for future outbreaks while improving our healthcare system now. While COVID-19 has given us some lemons here in Maine, I

look forward to turning them into lemonade and ensuring that we continue to improve healthcare access in our state.

On March 20th, 2020 Governor Mills relaxed regulations relating to licensing and telehealth in Executive Order No. 16. Throughout COVID, this has enabled healthcare providers an expanded ability to provide health care services to Maine citizens.

Here in Maine we face a chronic healthcare provider shortage. Every facility in which I've ever worked has utilized travel nurses to fill those gaps, and I myself worked as a travel nurse in Detroit for a summer. The ease of obtaining a license comes into play at times when staff are considering their next travel assignment. Under Governor Mills' Emergency Order No. 16, healthcare providers in good standing that are licensed in another state can be issued a Maine license to practice very rapidly, reducing the waiting period from 45-90 days to 48 hours.

I do have an amendment I'd like to request, that I discussed with my co-sponsor, Representative Evans, that would strike the sections related to supervision or collaborative practice agreement suspensions, as your committee has already addressed this issue this session. Maine's healthcare provider shortage existed long before COVID. Now that we have learned we have the capabilities to expedite the licensing process we should reduce the shortage by removing obstacles to licensure, including their expensive price tags. These reforms will give Maine a competitive edge in recruitment of the healthcare professionals that we so desperately need.

I'd like to read to you what a constituent shared with me: "My baby has a rare genetic condition that affects only 1:32,000 people. Only two hospitals in the entire United States research it. Before telehealth became available because of Covid, he spent 80% of his life admitted to hospitals or traveling to distant appointments. Travel cancelled because of extreme weather had severe consequences for my son. Now, with telehealth, we can go to the local hospital for labs and imaging and the results are sent to the specialist. The specialist is then able to diagnose and discuss concerns via Zoom. We need this. We need faster answers and a decent quality of life for our son who already has to fight harder."

If these changes can be done safely during a national health crisis, why can't they be done during stable times? We should remove these regulations permanently and safely ease the red tape around licensure and telehealth so that Maine people can access the care they need. I would like to thank Senator Claxton and Representatives Evans, Geiger, Perry, and White for co-sponsoring this bill, and this committee for your time and consideration, and would be happy to answer any questions you may have.

Dear Senator Sanborn, Representative Tepler, and distinguished members of the committee.

My name is Seth Rabinowitz and I am a Certified Registered Nurse Anesthetist practicing at Bridgton Hospital. I am a current board member, and a past President of the Maine Association of Nurse Anesthetists and am testifying neither for nor against LD 1194 on behalf of the greater than three hundred members of our organization. Certified Registered Nurse Anesthetists are the primary providers of anesthesia in the state of Maine and the only providers of anesthesia services in 80% of rural Maine hospitals such as mine. Without us Mainers would not have access to surgical and obstetric care in many rural Maine communities.

We would like to specifically address Section four, provision number four of LD 1194, which speaks to the suspension of supervision and collaborative practice agreements. As it is stated

"Any requirement related to mandatory supervision or collaborative practice agreements for an otherwise qualified advanced practice registered nurse licensed in good standing in another state and granted a license under this section is suspended. "

This wording is similar to Governor Mills Executive order number 16, issued March 20th, 2020, Section 1, letter D, which says

"Mandatory supervision or collaborative practice requirements for otherwise qualified physician assistants and advanced practice registered nurses who are assisting or will assist in the health care response to Covid - 19 are suspended during the public health emergency."

Certified Registered Nurse Anesthetists (CRNAs) are Advanced Practice Registered Nurses (APRNs). We are concerned how the language in provision four of LD 1194 impacts the practice of CRNAs that reside in Maine. It is our position that the language of Governor Mills emergency measures be made permanent to continue to allow for the flexibility of our Maine resident CRNAs to be able to respond to any continued need. The language as it is written in provision number four of LD 1194 creates a double standard between non-resident and resident CRNAs and in fact gives greater practice autonomy to non-residents than residents. We support the intent of the language in provision four of LD 1194 but we feel its scope is limited.

CRNAs have played a vital role in the pandemic response. When surgical volumes dwindled at the beginning of 2020 due to the pandemic many CRNAs re-deployed to ICUs across Maine to handle airway, programming and adjusting of ventilators, and critical care assessment and treatment of the sickest of Maine residents. This was not a reach for us as we all must have a background in critical care nursing prior to commencing our CRNA training and residencies. I sat on a Zoom call with Dr. Shah last April where he asked anesthesia personnel from across the state to sign up for Maine responds in case we needed to be deployed to any mobile Covid hospitals that were being planned for. Thankfully that outcome did not happen but CRNAs were happy to put their hands up and volunteer to go into the most contagious environments to care for the most critically ill Mainers. Why continue to have unnecessary and cumbersome supervision language when we have already proven that we are an asset that is capable of independent practice and are flexible enough to work in a variety of settings?

Sincerely,

Seth Rabinowitz, CRNA

Harold "Trey" Stewart III
Senator, District 2

130th MAINE SENATE

3 State House Station
Augusta, ME 04333

Testimony of Senator Harold Trey Stewart
Presenting L.D. 1361, An Act To Amend Telehealth Laws Regarding Out-of-state Telehealth Provisions
Before the Health Coverage, Insurance and Financial Services Committee
April 20, 2021

Senator Sanborn, Representative Tepler and esteemed members of the Committee on Health Coverage, Insurance and Financial Services: I am State Senator Trey Stewart and I represent 51 communities in Senate District 2, which is comprised of Southern Aroostook County and Northern Penobscot County. I am here today to present testimony on L.D. 1361, An Act To Amend Telehealth Laws Regarding Out-of-state Telehealth Provisions.

The legislation before you is aimed at making access to telehealth easier for patients and providers alike. To do so, it amends the definition of telehealth and broadens it to include audio-only telephone, facsimile machine, e-mail and texting.

Serving on this committee as well as on the Energy, Utilities and Technology committee, I am keenly aware of the barriers Mainer's face at accessing good internet and healthcare. Despite having hearings online via Zoom, I know a few legislators that continue to drive to Augusta every day because their internet cannot handle real time visual means of communication such as Zoom or Microsoft Teams. Additionally, with an aging population the new learning curve to modern day technology is a barrier.

One of the key reasons telehealth is important is because it allows people to connect with a physician from the comfort of their own home, without having to drive or have someone drive them a far distance. I believe by adding those other methods for telehealth providers and patients to connect will make it easier for our elderly and those living in rural Maine to access telehealth. While they may not be able to navigate a meeting over Zoom or Teams, they certainly know how to use a phone.

The bill also provides that practicing physicians with an unrestricted license in other states may practice telehealth in Maine without being registered in the State of Maine. For individuals needing a consultation visit with a specialist out-of-state before a procedure, this provision will make it easier and eliminate the geographical barrier to quality healthcare. This will make it easier for disabled and elderly patients who already struggle to make it to a traditional, in-patient visit.

While telehealth has been around for years, the COVID-19 pandemic has made it even clearer that greater access to healthcare is important. By reducing the current barriers to telehealth – as is suggested in this legislation, we will be able to accomplish that goal for rural, disabled, and elderly Mainers. Thank you for your time and consideration of this important piece of legislation. I'm happy to answer any questions the committee may have at this time.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Janet T. Mills
Governor

Anne L. Head
Commissioner

TESTIMONY OF ANNE L. HEAD

Commissioner, Department of Professional and Financial Regulation

IN SUPPORT OF LD 1681

AN ACT REGARDING TELEHEALTH SERVICES FOR CERTAIN LICENSEES OF THE OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION AND CERTAIN LICENSEES AFFILAITED WITH THE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

SPONSORED BY SENATOR HEATHER SANBORN

BEFORE THE JOINT STANDING COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

Public Hearing: May 6, 2021

Senator Sanborn, Representative Tepler, and Members of the Committee, my name is Anne Head and I am the Commissioner of the Department of Professional and Financial Regulation (DPFR) and Director of the Office of Professional and Occupational Regulation (OPOR). I am here today to speak in support of LD 1681 on behalf of the Administration and the Department. Thank you, Senator Sanborn, for your sponsorship of this important piece of legislation.

The Administration is committed to enabling Maine-licensed health care providers to continue to provide health care services to Maine citizens via telehealth into the future. Even prior to this pandemic, boards within and affiliated with DPFR were considering how to address the delivery of health care through remote means. As we all know, the current global pandemic accelerated that discussion and highlighted the importance of being able to provide services through audio and visual means, rather than only in a traditional brick and mortar setting.

LD 1681 has a different focus than other telehealth bills the Committee will hear about today. Currently, our health care boards and their licensees do not have express statutory authority in their licensing statutes to use telehealth. Health care licensees are only able to use telehealth to serve their clients during the pandemic by virtue of authority provided by Executive Order 35. The purpose of this bill is to make sure that when the pandemic is over, each health care licensing statute includes express authorization for providers to use telehealth to serve their Maine clients. Although the bill is lengthy, it contains a separate section for each health care licensing board and uses the same statutory authority language in each section.

LD 1681 is a foundational bill. It provides the statutory foundation for the use of telehealth by health care licensing boards. The bill also authorizes our licensing boards to use the APA rulemaking process to make sure appropriate guardrails are in place to guide licensees in their use of telehealth for the protection of their clients. By authorizing boards to individually impose certain standards and ethics that must be adhered to, the rules can be tailored to specific professions and situations.

For example, boards may want to adopt rules:

- Establishing standards to ensure patient confidentiality such as the use of HIPAA-compliant platforms. Boards may also wish to develop standards to ensure that practitioners deliver health care service in a confidential setting and not in public settings.

- Reinforcing that licensees must maintain separate professional and personal social media accounts and websites in order to maintain clear boundaries and avoid inappropriate dual relationships.

- Establishing guidelines in which telehealth would not be appropriate for a virtual encounter and in-person evaluation or treatment is necessary. This could include an initial visit or standards for intermittent in-person visits.

- Ensuring that practitioners residing out-of-state but licensed to practice in Maine are held to the same patient protection standards as Maine licensees physically present in the state.

These are just a few illustrations of the kinds of standards that could be considered. The process of considering appropriate rules won't be a one-size-fits-all approach. Standards adopted by the Board of Occupational Therapy deems appropriate may differ from those of the Board of Social Worker Licensure.

Finally, I want to assure you that our boards are as eager as you to maintain telehealth as a means of health care delivery. They lived through the same public health emergency as did you and your constituents. I encourage you to support LD 1681 to enable all DPFR internal and affiliated health care boards to use their collective expertise and discretion to adopt ongoing standards for telehealth appropriate for their practices for the protection of the health and safety of their clients.

Thank you for your attention and I would be happy to answer your questions now or at the work session.

130th Legislature
Senate of Maine
Senate District 28

Senator Heather Sanborn
3 State House Station
Augusta, ME 04333-0003
(207)287-1515

Introducing LD 1681, "An Act Regarding Telehealth Services for Certain Licensees of the Office of Professional and Occupational Regulation and Certain Licensees Affiliated with the Department of Professional and Financial Regulation"

Joint Standing Committee on Health Coverage, Insurance and Financial Services

May 6, 2021

Representative Tepler, and HCIFS Committee Colleagues, I am Senator Heather Sanborn and I am here today to present LD 1681 on behalf of the Administration.

LD 1681 is different from the other bills being heard by the Committee today. It is a foundational bill whose purpose is to ensure that our licensed health care providers may continue to use telehealth by embedding statutory authority to do so in each of the health care board licensing statutes. This explicit statutory authority makes clear that telehealth as a means of health care delivery is within a health care provider's scope of practice. The bill is also designed to allow boards, through APA rulemaking, to set parameters for appropriate telehealth practices for each health care profession.

I have spoken with the Department of Professional and Financial Regulation and I know they and their boards feel a sense of urgency around implementing this bill and the proposed rulemaking. They are committed to moving as quickly as possible to ensure the ongoing and appropriate provision of health care services via telehealth.

Thank you and I would be happy to answer any questions although Commissioner Head may be better poised to answer specific questions about this bill.