PAUL HENDERSON: All right, we're recording.

HOWARD: OK, thanks, Paul. All right, good afternoon and welcome to the Health and Human Services Committee via Zoom. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha and I serve as Chair of this committee. I'd like to invite the members of our committee to introduce themselves, starting alphabetically with Senator Arch.

ARCH: Senator John Arch, District 14: Papillion, La Vista in Sarpy County.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Senator Machaela Cavanaugh, District 6: west-central Omaha, Douglas County.

HOWARD: OK. I think Senator Hansen will be joining us later. Senator Murman.

MURMAN: Senator Dave Murman, District 38, seven counties in south-central Nebraska: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps and southwest Buffalo County.

HOWARD: Thank you. Senator Walz.

WALZ: Hi. Senator Lynne Walz, I represent District 15, which is all of Dodge County.

HOWARD: And Senator Williams and I serve on both the Banking and the HHS Committees, and I'm going to invite him to introduce himself and then the members of his committee who are joining us today.

WILLIAMS: Thank you, Chairperson Howard. I'm Matt Williams from Gothenburg, Legislative District 36, which is Dawson, Custer and the north portion of Buffalo Counties. Other members will introduce themselves. Let's start with Senator Gragert.

GRAGERT: Good afternoon. Senator Gragert, northeast Nebraska, District 40, which is Cedar, Dixon, Knox, Holt, Rock and Boyd Counties.

WILLIAMS: Senator Kolterman.

KOLTERMAN: Yes. Senator Mark Kolterman from Seward, 24th District: Seward, York and Polk Counties.

WILLIAMS: Senator Quick.

QUICK: Dan Quick, I represent District 35: Grand Island.

WILLIAMS: And I believe that's the only remaining members of the Banking Committee that are on the call right now.

HOWARD: Perfect, thank you. Also assisting the committee are our legal counsels, T.J. O'Neill. T.J., will you wave? Perfect, he's over there. OK, and Paul Henderson, who will be moderating the Zoom meeting. A few notes about our policies and procedures, these interim hearings are being recorded. They'll be posted on the Health and Human Services Committee's page through the Legislature's Web site. Please keep yourself muted unless you are testifying. There is an icon at the bottom of your Zoom window that looks like a microphone, which you can click to mute yourself. This afternoon, we'll be hearing one interim study and we'll be taking them on the order listed on the agenda on the legislative calendar. If you're planning on testifying today, please ensure the introducer of the interim study has your updated contact information, including name, email and phone number. This will help us keep an accurate record of the hearing. If you also have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. And everything that we've received so far has been emailed out to the committee. Any handout submitted by testifiers will also be included as part of the record as exhibits. Please provide a copy of your handout to the introducer of the interim study and a copy to our committee clerk, Sherry Shaffer. Her email address will be posted in the chat so that if you need to send your testimony to her, you can do that. Each testi-- testifier will have five minutes to testify. When you begin, the timer will start. We may ask you to wrap up your testimony after four minutes have passed. So we're very lo-fi because we're new to Zoom here in the Legislature. So if you can get a gander at T.J. O'Neill, who's going to wave at you, he's got a yellow card when you have a minute and he's going to have a red card when you are done. OK? And then we'll ask you to wrap up your final thoughts at that point. When you testify, please begin your testimony by stating your name clearly and then please spell both your first and last name. The hearing on each interim study will begin with the introducer's opening statement. After the opening statement, we'll

hear invited testimony in the order in which it's been given to me. And I'll call out your name so that you're recognized. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a very strict no prop policy in the HHS Committee. Before we get started for the hearing today, I want to note a few things. My office really laid out the pros and cons of holding our interims in person versus virtually and decided that being fully virtual would be safer and more convenient for many members and their testifiers without justifying-- jeopardizing the important fact-finding role of committees in the Unicameral. This has put a huge burden on my staff, the Legislature's Technology office and the Clerk's Office, and I want to make sure that they know that we're very grateful for all of their efforts. This committee and, and particularly this joint hearing between Banking and HHS is serving as guinea pigs for the Legislature as we work out the kinks on virtual hearings. So I'll ask for your patience for any technology issues that come up. And as I mentioned before, we're recording the hearing and once we conclude it, it will be posted on the HHS area on the Legislature's Web site for folks to watch later. With that, we'll begin today's interim hearing, LR350, a telehealth interim study with Senator Arch. Welcome, Senator Arch.

ARCH: Thank you. Good afternoon, Chairperson Howard, Chairperson Williams, members of both the Health and Human Services Committee and the Banking, Commerce and Insurance Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. I'm here today to open on the interim study hearing on LR350. LR350 was introduced to examine the role of telehealth during the COVID-19 pandemic and the practices and regulations that were adjusted in order to effectively meet healthcare needs. My primary goal with this study was to identify those specific state regulations on telehealth or statutes that were waived in order to accommodate the demands brought on by COVID. And of those regulations, which ones have proven to be overburdensome, unnecessary and perhaps we could continue waiving. My question is, what did we learn about telehealth as a result of the pandemic? I introduced LR350 in July when we resumed session, but I began the study process when we recessed in March at the height of the pandemic's onset. While more healthcare services are again being delivered in person today, the massive reliance and utilization of telehealth early on was an opening of the floodgates. Moving forward, telehealth and the practice of telemedicine will be major components of our healthcare system

forever, I think that's the general consensus of that. As part of the study, my office conducted two different surveys: one focused on utilization, which involved getting numbers from commercial insurance carriers, two of the state's large self-insured plans, the state of Nebraska and the University of Nebraska and the Medicaid program. We did a comparison of outpatient telehealth visits during a three-month period from this year at the start of the pandemic, March, April, May, 2020, to last year, 2019, during the same period and we provided that data to you. Of course, the utilization of telehealth services was way up. For example, in March, April and May of 2019, the University of Nebraska health plan recorded 139 telehealth visits. In 2020, that number rose to 10,351 visits, which equates to a-- I had to do the math on this one-- 7,447 percent increase in telehealth utilization. Phenomenal. We broke it down even further and looked specifically at behavioral health visits and again found a significant increase among the groups. Except for Medicaid, due to the clientele it serves, mostly children and adolescents, the percent of overall outpatient telehealth visits that were related to behavioral health jumped from less than 20 percent of the total to nearly 50 percent of the total. You should have received a copy of the chart showing the utilization trends prior to the hearing. The second part of the study centered on-- centered on regulations. We asked a varied group of stakeholders to identify regulations, both state and federal, that presented barriers to utilizing telehealth. We received feedback from 23 different associations and their members, including the insurance industry, the managed care organizations, hospitals, health centers, physicians, behavioral health providers, speech and language therapists, occupational therapists, and pharmacists. The top areas of interest for these group with respect to telehealth were eliminating geographic and originating site requests. In other words, where can the patient be? Where can the provider be? And, and eliminating those requirements that have previously restricted telehealth. Expanding the list of allowable services that can be provided via telehealth and the types of credentialed providers that can utilize telehealth in their practice; allowing out-of-state providers to practice across state lines via telehealth; requiring payment parity and allowing for audio-only services. You should also have received a copy of a graph showing those responses. I wanted to focus on which regulations we could address at the state level, and interestingly enough, I found most of the restrictions were at the federal level and impacted Medicare services primarily. It's important to look at this issue as three different pools for reimbursement of telehealth services:

Medicare, Medicaid, and commercial plans, in which I am also including self-insured plans for the purpose of this study. As I stated, a great majority of the regulations that have been waived were barriers imposed by the federal government concerning Medicare payments. At the federal level, 135 temporary changes were made with respect to telehealth services, either through CMS waivers or provisions of the CARES Act. However, we found there were very few waivers needed with respect to providing telehealth services at the state level in Nebraska anyway. Medicaid did adjust billing codes to allow for the reimbursement of additional services, including dental triage, physical, occupational and speech therapies and behavioral health. A statutory provision in the Telehealth Act that requires written consent from a patient prior to the delivery of telehealth services and another section of statute that requires insurers to ensure compliance of the written consent provision have also been waived. In response to the public health emergency, commercial insurers made adjustments as well, which included expansion of the list of billable services and cost-sharing waivers. Some companies are maintaining these changes into the foreseeable future, while others adopted them for a specific time frame. All of these reimbursement sources, Medicare, Medicaid, commercial insurance, have relaxed regulations regarding the modes of technology used in the delivery of health services. An order by the Office of Civil Rights under the federal Department of Health and Human Services is temporarily allowing providers to provide telehealth services via any nonpublic facing audio or video project-- product, such as Skype and FaceTime, without facing penalties for noncompliance of HIPAA rules. Additionally, telephone-only telehealth services have been allowed, audio only, which has been particularly important, reaching people who do not have the ability to use or connect with video technology either due to lack of equipment or lack of Internet access. I might mention the need to expand broadband was also a recurring theme in the survey responses. Since the Nebraska Telehealth Act was adopted in 1999, it has been amended over the years, and those barriers that exist in other states and at the federal level simply don't appear to be present here in Nebraska. That's good news. For the most part, stakeholders have reported that from the state's perspective, transitioning to providing services through telehealth has been fairly easy from a regulatory standpoint. Essentially, Nebraska was well prepared to face the initial challenge of the pandemic and shift quickly to delivering services via telehealth. As part of an executive order, Governor Ricketts did waive licensing requirements to allow certain healthcare

providers licensed in a U.S. state or territory to practice in Nebraska without a license, including practicing via telehealth. There is a push by some national groups to completely open state borders for health practitioners or have a federal licensing structure. I think this issue is much broader than telehealth regulations and so for my purposes, I'm not considering this as an exclusively telehealth issue. Another issue that is getting a lot of attention as it relates to telehealth is payment parity. Again, my intention with respect to this study was to identify regulatory barriers and not create new mandates. I think that is a much broader issue as well that can't be adequately addressed as part of this study. But I'm sure you'll hear from providers their perspective on that. Having said that, I'm sure either issue may be mentioned in testimony this afternoon. I've not orchestrated the testimony, have no desire to prevent individuals from sharing information they believe to be important. Again, my intention was to identify overregulation. The importance of telehealth is obvious by a number of groups that have reached out to me asking to provide testimony, and so I'll stop talking so we can hear directly from those who have experienced the rapid adjustment to telehealth and have a better picture of what we can expect in the future. Thank you.

HOWARD: Thank you, Senator Arch. Are there any questions from the senators? Just raise your hand if you, if you have a question for Senator Arch. OK, seeing none, we'll invite our first testifier to unmute and speak for us. Please remember to state and spell your name for the record. Chanda Chacon, resident CEO of Children's Hospital and Medical Center. I apologize for butchering your name in advance.

CHANDA CHACON: You're OK, Senator Howard. Thank you so much. Thank you, Chairpersons Howard and Williams and members of the Health and Human Services and Banking, Commerce and Insurance Committees for this distinct honor to testify virtually before you today. My name is Chanda Chacon, C-h-a-n-d-a C-h-a-c-o-n, and I'm the president and CEO of Children's Hospital and Medical Center, the pediatric safety net provider for children throughout Nebraska and the region, serving over 150,000 unique patients annually. As I sit before you today, I embark on my 91st day at Children's as a proud new Nebraskan. In this short time, I have witnessed the extraordinary accomplishments the legislators-- Legislature has made to advance telehealth capabilities throughout our state, paving the way for providers ahead of the current COVID-19 pandemic. My previous experience in Texas, and most recently in Arkansas, proves Nebraska is helping lead the telehealth delivery promise and capabilities. At Children's, many families under

the care of multiple pediatric subspecialties often face geographic burden of care, as their complex chronic conditions often require regular visits to Omaha. Telehealth has grown as a strategic initiative to deliver high-quality care and increase the access of care, and will continue to be an essential tool for providers and patients to complement the quality of care we provide in person within our clinics and hospitals. I want to say thank you to Senator Arch for giving us the opportunity to discuss how the current public health emergency amid a global pandemic has strengthened telehealth delivery in Nebraska. To effectively illustrate what is working, we need a quick history lesson of where Children's was before COVID-19 impacted our ability to reach patients physically in person. In 2018, Children's was proud to accomplish 1,800 virtual visits, predominantly within child psychiatry, our first experience in mobilizing telehealth opportunities. In 2019, our volume went up to 2,300 with a goal to increase by 10 percent in 2020. When the world changed, both patients' and our providers' desire to use telehealth in the continuity of care accelerated rapidly. This year we have seen over 43,000 patients virtually with over 450 providers and staff trained in virtual care. The pandemic has changed our willingness to utilize telehealth, and it's actually difficult to imagine a future without this opportunity. At Children's, there are now over 32 specialties practicing telehealth alongside seeing our patients in their clinics, including primary care and urgent care. With over 17 different languages supported. It has allowed us to reimagine and return to providing care close to home. Our patient satisfaction scores suggest that telehealth is now an acceptable and frankly preferred means to access a provider when medically appropriate. And that to me, is really the key phrase: medically appropriate. Telehealth is a tool that helps deliver timely care to patients. It also serves as a means for families who otherwise would have difficulty maintaining an appointment or have concern over the cost of gas or the loss of work or school time. It will always remain necessary for providers to see their patients in person. But if we are able to maintain these flexibilities provided by the public health emergency, like our ability to now offer physical therapy, occupational therapy and speech therapy virtually, that we are much closer to ensuring that every child has access to care they need when they need it. When paired with our inpatient model, Children's workforce can be managed efficiently and effectively to allow patients access to specialists timelier, providing to-- and to be an exceptional tool for enhancing the continuum of care. I would be remiss if I did not conclude with offering Children's as a resource on

this important issue for the future. I look forward to working personally with each one of you in the future and thank you for your time and consideration, and I'm happy to take any questions. And I figure I did that good, T.J.. I didn't see any little cards go up yet. Awesome.

HOWARD: Thank you for your testimony. Are there questions from the committee? Senator Williams.

WILLIAMS: Thank you, Chairperson Howard. And thank you for your testimony. Since you're new to the state and also we're all new to COVID and the increase in, in usage, what challenges does Children's have in being able to meet the, the desire to do this, this number of telehealth visits?

CHANDA CHACON: I appreciate, Senator Williams, your question, and I think that the challenge was telehealth is a little bit different in pediatric healthcare because it's a parent, an adult accessing for the child and trying to manage that on both sides. And so there's a sort of an extended period of time that's needed for that in those visits. And I also think ramping up our infrastructure in telehealth proved to be, have some challenges. And we're working through those because we really believe that this is a lever that we must have in healthcare, especially in a rural state like Nebraska, where we want to provide care close to home. This gives us an ability to close the loop on that continuum of care and make sure that we have appropriate follow-up so that children come to the hospital when they need hospital care. And we can utilize a, a model where they can manage their other children and school and virtual life from their home. So I think it's the infrastructure capability that's, that's proven to be challenging and exciting.

WILLIAMS: Thank you.

HOWARD: You're on mute.

WILLIAMS: Senator Walz.

WALZ: Thank you, Senator Williams. And thank you, Chanda, for being here today. Hey, you mentioned something about bilingual services. Have you seen that the use of telehealth has been able for you to better provide bilingual services to people?

CHANDA CHACON: Thank you for your question and we're, we're offering over 17 languages over telehealth and we have a pretty facile tool that we use currently in the hospital. But I think what telehealth allows us to do is plan in advance in a very different way and have all of those technologies integrated. So it doesn't feel like you're in person for this part of your visit and virtually for the translation services, that it all kind of links together in a really nice model. So I think it allows us some ease of allowing us to provide care in the language that is most appropriate for families and that they feel the most comfortable with.

WALZ: Thank you.

HOWARD: Kolterman.

KOLTERMAN: Thank you, Senator Howard. Yeah, I have a question. Have you seen any negative effects on the Medicaid reimbursements as a result of telehealth? Has that made a difference, Medicare or Medicaid? Obviously, you don't have Medicare, Medicare reimbursement rate.

CHANDA CHACON: No, we have not. We've seen pretty much parity with Medicaid reimbursing for telehealth. And because they're about 42 percent of the patients that we see here, that's been helpful, but that it's not been, not created any barriers for children and families who we see that have Medicaid.

KOLTERMAN: OK, thank you. Thank you, Senator Howard.

HOWARD: Other questions from senators? All right, seeing none, thank you for your testimony today. Our next testifier will be Dr. Sam Pate, the acting medical director for telehealth at Nebraska Medicine.

SAMUEL PATE: Thank you very much for the opportunity to speak today at this interim study to examine the role of telehealth services during the COVID-19 pandemic. I am Dr. Samuel Pate, S-a-m-u-e-l P-a-t-e. I'm a practicing ENT specialist, as well as the acting medical director for telehealth at Nebraska Medicine. Today, I'm representing Nebraska Medicine to help discuss the importance of telehealth efforts in our state. Prior to the pandemic, Nebraska Medicine was conducting traditional telemedicine with over 16 subspecialties. With the pandemic, however, more than 50 medical and surgical subspecialties--specialties and subspecialties have offered telehealth visits to

ensure both patient and provider safety and to continue to provide the highest quality of care, resulting in over 85,000 synchronous visits since March. We also implemented asynchronous services, allowing patients to provide answers to symptom questions, which permitted our providers to assess, diagnose and treat almost 3,000 patients. Additionally, we expanded our e-consult volume significantly, supporting providers throughout the region. This allowed for more rapid evaluation of both COVID and non-COVID-related issues. We recognize that when it comes to the benefits of telehealth, many are on the patient side. Telehealth allows for patients to remain within their own communities, enhancing their support system, bringing revenue to local facilities such as pharmacies and hospitals, reducing travel, time off work and stress. Additionally, this significant improvement in access to healthcare cannot be emphasized enough. It should not be assumed, however, that costs related to providing telehealth services is less per visit than face-to-face services. If our providers are doing the same E&M service with the same documentation, the same provider time and the same outcomes, we need to be paid the same. We agree with CMS's recent statements to continue payment parity. We would, we would encourage that we keep this going. From a payor value perspective, we know that optimizing patient access to high-quality care in both urban and rural areas expands our reach and improves overall population health. We recognize that over time, facility expense could decrease, but not in the short term. There's a strong possibility that without payment parity, this will decrease incentives to providers and healthcare systems from continuing to offer virtual services and the expanded access this affords more patients. We anticipate that patients will still be hesitant in seeking in-person care. Without telehealth, there is already clear evidence that patient outcomes are being impacted. We are hearing loud and clear from both our patients and our providers that they want to continue these services. Federal and state level policy changes are critical to allowing us to provide the right care to the right patient at the right time. Our state and its citizens would benefit from legislation ensuring private payer payment, not just coverage parity, and clarifying that all telehealth services, including asynchronous store and forward, shall be equitably reimbursable when deemed medically necessary. Thank you very much for your time.

HOWARD: Thank you. Are there questions for Dr. Pate? Oh, Senator Williams. Oh, you're muted.

WILLIAMS: I'm sorry about that, I thought I hit that. Thank you, Senator Howard. And thank you, Dr. Pate. You make a strong case for payment parity. Would you like to address the issue of should there be payment parity in all cases and in all types of practices?

SAMUEL PATE: So definitely in order to provide adequate care to patients across the continuum, continuum, there should be payment parity across all practices and all occasions of patient-directed care.

WILLIAMS: Do you think we could potentially be opening ourselves up to a type of practice that would be entirely based on telemedicine with, in essence, no walk-in traffic?

SAMUEL PATE: I do not. I, I don't think that will happen for a number of reasons, but I think Chanda lined out pretty eloquently the fact that there is still a vital role for in-person visits to manage the overall care and the continuum of care for patients from the first visit to the eventual end, end of the, end of the care continuum.

WILLIAMS: Thank you, that's helpful.

HOWARD: Other questions for Dr. Pate? All right, seeing none, thank you for your testimony.

KOLTERMAN: Wait, wait, wait.

SAMUEL PATE: I think there's one more.

HOWARD: Senator Kolterman.

KOLTERMAN: I'm sorry, I didn't hit the right buttons. Thank you for participating today, Dr. Pate. My question is when we, when we're dealing with the billing process, we passed some legislation last year that dealt with what was called asynchronized billing. That's a little bit-- is that, is that different than parity or is that very similar to parity? We did that only for dermatology and we did it with the idea that perhaps we would bring that back this year and look at asynchronized billing across the board. What are your thoughts on that?

SAMUEL PATE: So my, my thoughts are that there would be parity across all visit types, both synchronous and asynchronous visits. The, the underlying-- let me tell you my experience as a physician. So the

bottom line is, if you, if you can think of it this way, is that the physician is providing their expertise and providing care to a patient in one form or another. And, and they're, they're doing that at a high-quality rate, so providing high-quality care to, to the patients. So regardless of the method with which you're providing care, I think it's important that, that we understand the value of that care across all different ways of providing that care. And, and if I could expand even further on the previous question by Senator Williams, you know, we will not only not have exclusive telehealth visits and telehealth for patients moving, moving forward, but, but we can use this opportunity of telehealth to modify care to continue to improve patient care moving forward into the years and decades to come. So I think there's, there's more of an opportunity side of this than anything else.

KOLTERMAN: Thank you. Thank you, Senator Howard.

HOWARD: OK. Other questions from senators? All right, seeing none, thank you for your testimony today. We will now invite Dr. Cliff Robertson, the CEO of CHI Health, to unmute.

CLIFF ROBERTSON: Good afternoon, members of the Health and Human Services and Banking and Insurance Committees. My name is Cliff Robertson, spelled R-o-b-e-r-t-s-o-n. I'm a former family physician and the CEO of CHI Health. As you know, CHI Health is a regional health system consisting of 14 hospitals, two stand-alone behavioral health facilities, over 150 employed physician practice locations, and more than 12,000 employees in Nebraska and southwest Iowa. I very much appreciate the opportunity to speak to, speak with you today about the impact of telehealth on the future of healthcare delivery in Nebraska. I will quickly share some of our experiences that demonstrate how this technology has become a critical tool in our response to the COVID-19 pandemic and how I believe it will be a tool for healthcare going forward. It is truly remarkable that in the first few weeks of the pandemic how many legislative and regulatory barriers were removed to allow for rapid expansion of telehealth services across the country. And while we've always believed the expansion of telehealth is key to not only improving access to healthcare in our rural communities, but we also believe expanded telehealth is key to our ability to improve, improve healthcare affordability in Nebraska. I thought I'd share some updated usage data that shows a little bit about how telehealth has played a critical role through our pandemic response and, and then close with just a few policy observations that I think are critically

important to our success in the future. First, just some usage data. We saw tremendous growth, as did everyone, in the total number of virtual visits throughout our system. Just for a point of reference, in January and February of this year, of 2020, we had fewer than 500 virtual visits per month. In March, we had 3,000. In April, we had over 18,000 visits. Even as our hospitals and clinics have now returned to full service, we continue to have between 9,000 and 10,000 virtual visits delivered per month by our caregivers, and that is through the end of November. I'd also like to note that the increase has been especially prevalent within our behavioral health services. You know, we're the largest behavioral health provider in the state and our system, so CHI Health had 43 outpatient behavioral health virtual visits between March and the month of May. So between March and May of 2019. And that's compared to 17,640 virtual visits during the same period in 2020. So our virtual visits went from less than 1 percent to up over two-thirds of all of our behavioral health outpatient visits in that, in that few-month time frame. We also project this trend will continue as 50 to 60 percent of our behavioral health visits today are still being delivered virtual. That's the usage data, but I think it's also important to provide some real life examples of, of how impactful these policy changes have really been on, on our ability to provide care and more importantly, on our patients. There are numerous stories that I could share, but being, you know, respectful of our time, I'll simply say that the increase in telehealth has been critical to our providing care to patients in nursing homes and assisted living facilities throughout the state. It's been critical for us being able to reach those with transportation or distance challenges; and it's been critical to reaching, you know, those experiencing the stress of either financial challenges or kids home from school or even the inability to get away from essential work duties. As important during this pandemic the-- we use the very same technology that we are using today to allow our caregivers to communicate with loved ones of patients who are admitted to our hospital with COVID. And I can tell you a, a handful of stories where the ability to connect care teams and loved ones around the country and patients, in many cases who were at the end of life, would not have been able to occur and would not have happened in the way in which it happened without, without this technology. So not only is healthcare, but pastoral care is being delivered virtually. From a policy perspective, you know, I would hope that you would know that really none of these advances would have been possible without the Medicare 1135 waivers and the flexibilities allowed in both federal

and state public health emergency orders. And while they're all important, there are a few that I would just call to your attention that we feel are critically important to continue even after this pandemic is behind us. Senator Arch referenced the geographic and originating site requirements. That is a large, huge barrier for those of us that deliver care and so we would, we would hope that those requirements do not return. What we've been able, because of the, the relief we've been able to deliver care not only in our hospitals, but directly into patients homes or, as I mentioned, other facilities like nursing homes through this telehealth technology. Reimbursement parity, others have already commented on. We believe that all services provided via telehealth that have been reimbursed at the same rate as delivered in person should continue. We believe it's critically important to create-- continue the viability and expansion of these services, particularly under Medicare and Medicaid, as, as we think that individuals and constituents in Nebraska will demand that their private insurance will continue to cover this, these services into the future. One of the other things that we believe is very, has been very helpful is the allowance of additional practitioners, where all healthcare professionals who are eligible to bill Medicare for professional services have been able to deliver and bill for services provided via telehealth. And that has allowed providers to offer services across the state as well as state lines. And we think that's been very beneficial to patients. So we've always believed strongly in telehealth and we believe it's the future for affordable and accessible healthcare in, in rural markets in particular, but across the region. But we also believe it's proven that it, it's a technology whose time has come and this current pandemic did nothing if it did not highlight that fact. I'd like to close by saying we appreciate the partnerships that have been developed with the state of Nebraska, our local public health districts, and we stand ready to serve Nebraskans during the pandemic and beyond. I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions from the committees? Seeing none, thank you for your testimony today.

CLIFF ROBERTSON: Thank you.

HOWARD: Our next testifier will be Dr. Brian Bossard, CEO, founder of Bryan Telemedicine at Bryan Health.

BRIAN BOSSARD: Yes, thank you, Senator Howard, Senator Arch and members of the Health and Human Services Committee, as well as members

of the Banking, Commerce and Insurance Committee, for the opportunity to offer my testimonial. My name is Brian Bossard. I'm an internal medicine physician. My past includes co-founder of Lincoln Internal Medicine Associates, a traditional internal medicine practice, and founder of multiple hospital medicine practices throughout the state of Nebraska, including Inpatient Physician Associates at Bryan Medical Center. And most recently, co-founder of Bryan Telemedicine and Teledigm Health, where I currently serve as president and CEO. In addition to this testimony, I've offered-- I've provided written testimony offering some comments supportive of items such as the metropolitan statistical area waiver, supportive of maintaining the home as the originating site and supportive of licensure opportunities across state lines, particularly for physicians through the Interstate Medical Licensure Compact. And I would offer support for an expansion of that model to other healthcare occupations. We've found some difficulties in offering services across state lines for other healthcare occupations. There's been discussion already today regarding payment parity. I would echo the comments of those who have already discussed the items related to payment parity. And I think finally I would offer relative to my written testimony, HIPAA compliance and high-tech compliance as we offer these services is incredibly important. It's been important to waive those requirements in order to expand services during this pandemic, absolutely. But it's equally important as we look to the future to understand that the integrity of the rapidly emerging healthcare environment that we're now examining needs to be maintained and protected. Health information, protected health information is extremely vulnerable if left unregulated. So I think those are some key comments. Bryan Telemedicine, our focus, our mission is in rural communities. Our focus is the state of Nebraska. We operate 50 unique service lines via telemedicine. Our platform is now in 60 percent of the state's critical access hospitals. So we're offering telemedicine services throughout the state in 60 percent of critical access hospitals and multiple additional hospitals that are not critical access hospitals. We're also offering services outside of the state of Nebraska. We offer thousands of consults monthly. Among those 50 service lines, I'd like to just identify a couple to speak to briefly here. During this pandemic, we've had an expansion in pulmonary critical care services that we've offered throughout the state. We've expanded locations so that we're now offering those services in a dozen locations in Nebraska and the western corridor of Iowa. I mentioned that during this pandemic because what has happened through those services and the

expansion of our services in rural locations such as Columbus, Nebraska, and many other locations around the state, we are now caring for any particular day, up to 40 patients, COVID-positive patients, that are able to be maintained locally in their communities, thus protecting the very valuable tertiary healthcare communities, hospital beds in Lincoln and in Omaha and the case where we're providing these services in the western corridor of Iowa and taking care of those patients locally. So the expansion of telemedicine, those services, particularly pulmonary critical care in this pandemic, has been exceedingly important. And the cost savings related to keeping those patients local is almost incalculable. We also have hospital medicine services which have expanded services that are providing care for COVID-positive patients again in communities throughout Nebraska, including Alliance, Lexington, Crete, Osmond, Red Cloud, Friend, St. Paul and many, many other locations. And those services have likewise served to keep patients local, preventing outmigration, creating health in communities, health for rural hospital systems, critical access hospitals, and ultimately providing an opportunity for rural communities to offer access to specialty care for years to come. So I would close simply by offering my gratefulness for being able to provide this testimony and happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Doctor, for being on the call today. We've heard a couple of terms thrown around, equitable reimbursement and payment parity, two that we have heard. Would you describe those so that I could better understand those? Are they used to be-- are they meant to mean the same thing or are they different?

BRIAN BOSSARD: They're meant to be the same thing. In, in legal language, sometimes they're not. Payment parity sometimes has been, has been stated to mean that for one particular service where payment is offered for face-to-face visits, a visit that's offered by telemedicine, there will also be payment, but not necessarily equal payment. And so when I reference payment parity, I would imagine when other providers on this call reference payment parity, we're suggesting that the payment should be equal, that it should be the same for a face-to-face visit as it is for a telemedicine visit.

WILLIAMS: So equal reimbursement could be different than equitable reimbursement. Is that true or is that-- would you still have those be the same?

BRIAN BOSSARD: In my mind, I would have those be the same, but I have not used the equitable term, so I'd have to defer to others who are using it.

WILLIAMS: OK, thank you.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

BRIAN BOSSARD: Thank you.

HOWARD: Our next testifier is Dr. Ed Discoe on behalf of the Nebraska Medical Association.

ED DISCOE: Yeah, thank you. Yeah, it's Ed Discoe, D-i-s-c-o-e. Don't forget the E. Thank you for allowing me to testify here in front of the legislative committees for this interim study to examine telehealth. I don't know that I'm necessarily representing the Nebraska Medical Association with my thoughts, but they did ask me to testify from a rural physician's perspective. So please don't hold some of my comments as those of the Nebraska Medical Association or any of their members. So my name is Ed Discoe. I'm a family medicine physician practicing in rural Nebraska for over 20 years. Together with my three partners, we own a private family medicine practice and urgent care in Columbus, Nebraska. We employ three physician's assistants and one nurse practitioner. When the pandemic hit in March of 2020, we were able to quickly optimize an existing secure telemedicine platform to meet the needs of our existing patients in order to continue caring for their chronic and acute problems. This quick shift, which was not easy, to telehealth has allowed us to care for thousands of COVID-19 patients, as well as patients with chronic medical problems that otherwise may have transitioned to acute exacerbations, thereby easing a flooding of the already overburdened medical community. I have the awesome opportunity to work with patients from many walks of life. They travel the world, farm and ranch, work in factories, run large and small businesses, or manage their family's home. My practice and patients' needs and technical acumen are very diverse. Telemedicine offers the ability to meet my patients where they are at their convenience and provide them with a

high quality of care due to my existing relationship and knowledge of their ever-changing and intricate medical histories. At no other time in history has there been a crossroads where technology was waiting at the gates to aid with the new and changing needs of patients, due to the pandemic and associated complexities. Patients and their physicians have become more comfortable and astute at providing care outside the traditional means. I am thankful that historically the state of Nebraska has been ahead of the curve and has provided for the opportunity of parity of play regarding telemedicine. I'm also thankful that health insurance insurers realize the necessity of parity of pay during the SARS-COVID-19 pandemic so that patients can continue to be seen by their private physicians. However, once the pandemic has subsided, reverting to parity of play without parity of pay will negate the progress that the state's medical community and our patients have made in their last, in the past nine months. It is not feasible that medical practices be asked to provide the intimate care at the reimbursement level previously allowed, if allowed by insurance companies. Fixed overhead for traditional medicine clinic with a deep relationship with its patients is known to be 50 to 70 percent. These costs change minimally when a patient is seen by the physician with telemedicine infrastructure must be in place to treat patients when their needs exceed a telemedicine visit. There's no feasible way that a $30 to $40 visit can adequately cover these overhead costs. This does not allow the comprehensive care patients deserve. To provide the high-quality, quadruple aim personalized care described above, it typically takes four to five minutes of a nurse making $25 to $30 an hour to reconcile patient's chart prior to a 5- to 30-minute visit with their physician. A receptionist making $15 to $20 an hour must juggle the schedule to account for all visits. It is essential that parity of pay continues so that optimal care can be provided in the future. The cost of providing the type of care that Nebraska, Nebraska-based clinics of family medicine, internal medicine and its subspecialties provide requires additional amenities beyond what an on-demand national entity that has no past, current or desired future personal relationship with the patient can provide. On-demand patient care from an outside nationwide entity fragments patient care and could lead to medication and plan of care confusion for the patient and their private physician. Without the adequate telemedicine options that patients have now become accustomed to, the patient-physician relationship will become [INAUDIBLE] restrictive and perhaps fragmented, lending to a higher cost and lower quality of care. Allowing telemedicine in Nebraska to progress without the

artificial restrictions and diminished payments will let it mature into a viable product for all involved, which may ultimately lead to a reduction in costs overall to the healthcare system. It may be bumpy, and nefarious players will need to be culled from all sides of the fence. We cannot let the granular fears of short-term thinking players and entities negate the advantages that under-- undeniably exist for a higher quality of care for all Nebraskans. Telemedicine by the patient's position can meet the patients where they are and provide high-quality, timely care due to existing relationships with deep knowledge of patients' past medical history. This can only be provided by physicians who have an existing or developing relationship with the patient, either through prior visits or consultations with adequate background information supplied by previous visits with the patient's physician or consult-- consultants, sorry. High-quality, timely care lowers the cost to the patients and their families. It mitigates barriers of transportation and added cost for the patient and their family due to travel and time off of work. This is apparent in rural areas like Columbus. It is even more apparent when you view communities and people with greater distances from their position, like those in the Sandhills and Panhandle. Telemedicine should be able to eventually decrease added cost to patients, insurance companies, employers and state and national services when acute and chronic disease processes are monitored and treated in a timely fashion, preventing future visits, additional procedures and costly emergency room visits and hospitalizations. Adequately reimbursed telemedicine allows for creative future models of providing medicine, some that are evident now, currently materializing and some not yet realized. It helps to allow advances in technology being developed for patient care. Like the transistor to the radio and the Internet and everything that followed, telemedicine is vital to the future of modern medicine, but only if it can materialize and thrive in the marketplace. Thank you.

HOWARD: Thank you. Are there questions? Senator Walz.

WALZ: Thank you. Thanks for coming and visiting with us today. You know, as you were talking it occurred to me, and I don't know if this is the same for a lot of other people on the call today. But it occurred to me that I, I don't know much about what a typical telehealth visit sounds like or looks like. Luckily, knock on wood, I have stayed pretty healthy. So I was wondering if you could just explain that for us, because I, I really I don't know what it looks like.

ED DISCOE: It looks a lot like this, only about 24 less people. There are a lot of different platforms that, that exist. I can only speak about the platform that we use. We use a product called Spruce Health, which is actually a product that's fit up, fit for direct primary care, which is a whole different topic. But generally what happens when we do a, a telehealth visit is that we connect with that patient via telephone to start with, and we let them know that we are going to be sending them information so that they can download an app to their phone or to their computer. If that's not available, which is the case in some instances, then we have to do it in another form. Because there's been some expanded capabilities, we can either do that by FaceTime or sometimes just the telephone is the only option for us to do, do that. But let's say the patient is, does have the capabilities of downloading an app to their phone. They download that app to their phone, it takes, oh, probably less than five minutes. And, and then we get on our side of that app and connect with them. It's the push of a button, they have to tap on their app and then a picture comes up very similar to what we're doing now. And then we converse about their, their, their medical problem at the time. A lot of that has been COVID, some of that has been some annual wellness visits, which is a Medicare visit. Some of there are other acute and chronic problems because patients don't want to come in and be seen because they're fearful of the COVID. But let me back up for a minute, because that would be like the initial visit. Typically, if we have subsequent visits, what happens is my nurse will contact them initially by telephone and review any of their past medical history that has maybe changed, make sure that their medicines are all accurate and any other topics of information. They do add stuff to their electronic medical record so that when I then meet with them virtually, I have a little bit of basic information set up before my discussion with the patient. We carry through with the, with the visit. That, as I indicated, can last anywhere from five to sometimes generally about 15 minutes. But it's not uncommon. I actually used it as a patient recently. My visit was probably the longest visit ever, it was 30 minutes with my pulmonologist. But so they can vary in, in length and duration. Afterwards with our app, what we do is we can send the patient instructions on everything that we talked about so that they receive a written record of what, what the plan is moving forward. And then electronically, we can, you know, within our EMR, we can send out medications. Generally, I'll leave a message to my receptionist within our EHR that she needs to call that patient back and schedule them for an appointment.

WALZ: Thank you. I appreciate that.

ED DISCOE: Sure.

HOWARD: Thank you.

ED DISCOE: Senator Kolterman.

HOWARD: Senator Kolterman.

KOLTERMAN: Thank you, Senator Howard. Appreciate you coming on today, Doctor. You mentioned something that caught my interest. You work in direct primary care?

ED DISCOE: I do not work in direct primary care. That's kind of a dream of mine, but it's not materialized. But the app that we use is, is a direct primary care telemedicine platform. It allows for some maybe more intimate discussion with the patients than otherwise just a straightforward telemedicine platform. It allows them to email us, call us within that app and also we can text back and forth about the, their past visit or future visits. So it's an immediate-- with direct primary care that is, the thought with direct primary care is that you have some immediate access to your physician.

KOLTERMAN: So, so I guess the concept is that they've already created, they've already created the software to utilize it in, in a patient setting. So you could get-- do you know if they're using that and they're getting parity with their billing through this crisis right now for telehealth?

ED DISCOE: Are you talking about a direct primary care practice or with our practice?

KOLTERMAN: That-- I just was curious if you knew if they're, they're getting reimbursed the same way.

ED DISCOE: Direct primary care works on a kind of a subscription. So their--

KOLTERMAN: Monthly basis.

ED DISCOE: They're outside of-- I imagine they're getting paid whatever they've agreed to be paid for.

KOLTERMAN: All right. Thank you.

ED DISCOE: Yes.

HOWARD: OK, other questions from the committees? All right, seeing none, thank you for your testimony today. Our next testifier will be Chase Francl, the president of the Nebraska Association of Behavioral Health Organizations.

CHASE FRANCL: Good afternoon, Chairpersons Howard and Williams and members of the represented committees here today. I want to thank you for this opportunity. My name is Chase Francl, C-h-a-s-e F-r-a-n-c-l. I am testifying today on behalf of the Nebraska Association of Behavioral Health Organizations, known as NABHO, as well as representing my employer, Goodwill Industries of Greater Nebraska, located out of Grand Island. NABHO's membership probably represents a diverse group of 49 providers across our state. We have a full spectrum of frontier, rural and metro areas being served. We're a group who are dedicated to ensuring that quality behavioral health services, including both substance use and mental healthcare, are available to everyone throughout our state. Over the past year, this has become a responsibility that's never been more important. Frankly, it's never been more challenging. I want to begin today by acknowledging that telehealth is not a panacea, it is not a cure for all the problems that we have or will continue to encounter when it comes to providing our services. There are a range of services across our spectrum that members provide that are both well and poorly suited to this delivery model to varying degrees. The reality is that COVID-19 has required a rapid transition to telehealth in some capacity for nearly every one of our member organizations and in nearly every one of our services. And they should not only be applauded for their efforts, but so should the funders and regulatory bodies of our state who have banded together to support Nebraskans throughout this crisis. The Division of Behavioral Health, Medicaid and private insurers have all risen to the challenge, and for that we are deeply grateful. As we look ahead to the future of telehealth in Nebraska, I think it's vital that we recognize the appropriate position that intervention should continue to occupy. Some services are ideally suited to this delivery model: medication management, outpatient therapy and assessment, family integration into residential services, just to name a few. Telehealth has also given us the ability to extend services to individuals who live in rural and frontier Nebraska or to those who experience severe anxiety, transportation

barriers and a myriad of other nontraditional barriers. Other service models rely on in-person group settings to build and practice social skills, coping skills or to build the structure and habits into their lives that will cultivate natural supports, promote independence or gainful employment. In these settings, telehealth has been a lifeline that's kept our individuals afloat but ultimately cannot replace the human interaction that's fundamental to learning and practicing new skills a long time-- alongside supportive peers. Commonly, these services are accessed by the most severely impaired as a way to divert hospitalization. And we've seen firsthand that those suffering from auditory hallucinations, from paranoia, particularly our older generations with hearing loss or difficulty with technology, have often struggled to access or have not been comfortable participating in services in this way. For most, however, telehealth has offered a path forward that was far better than the alternative. I want to very briefly address several of the remaining challenges that provider agencies within NABHO face, that's regulation, reimbursement and quality of care. At the onset of COVID-19, regulations were rolled back to provide exceptions for things like timeliness of client signatures on documentation, the use of telehealth platforms that hadn't been certified as HIPAA compliant, and allowances for services to be provided by telephone if the client did not have the means to participate in a telehealth appointment. Over time, whether through grant opportunities such as the CARES Act or through other network resources, such as Optum's free telehealth platform, providers have largely been able to find resources to overcome our side of the technology barriers. But for our clients, this still presents a challenge for many who may not have the needed devices, do not have sufficient cellular data plans, may not even have a private space where they can effectively and privately engage in a telehealth appointment. In these cases, the ability to provide a billable service via phone call has been a tremendous benefit. NABHO would strongly advocate that these would be allowed to remain billable services under these certain conditions. It's our position that regulations that protect confidentiality of records and signature timelines should be appropriately reinstated at the conclusion of the present public health emergency to ensure the protection and privacy of those we're privileged to serve. These have proven an important step for removing barriers throughout this rapid transition. As regards reimbursement, I just want to caution the committee against the assumption that providing telehealth is a cheaper alternative for provider agencies. For many of us in behavioral health, our business models routinely

operate on a payment structure that's below the actual cost of providing services and our limited resources have been stretched even more thin with the addition of telehealth. Most of us will not and should not eliminate or reduce our primary cost drivers such as physical buildings or workforce. And the infrastructure needed to support the billing, regulatory compliance, and backend functions associated with telehealth only increases in complexity by adding new service delivery methods. For many, the gains that we experience through reduced travel time or community-based treatments or slight reductions in no-show rates is generally a wash when compared against the added cost of telehealth or the reduction in session lengths. Finally, the most important, and unfortunately I think still the most unknown, is the impact that telehealth has on the quality and effectiveness of our services. This is a complex issue that, that really cannot be boiled down to a single broad statement, and trying to do so, I think would be to offer disservice. The treatment environment that's been created by COVID-19 has, has really been defined by unknowns. And where some services and individuals really have thrived in a telehealth environment, we know others have suffered despite our best efforts and resources. My belief is that where gains are identified, they should absolutely be encouraged and promoted. But likewise, where we see our clients' hard-earned progress being lost, we should be equally eager to abandon and accommodate those who need in-person care as safely as we can. I suspect the path forward lies somewhere in between, and NABHO recognizes the importance of leading down that path wisely. To that end, whatever assistance we can offer, we're certainly willing to do. While I know we're all eager to get back to the way things were, we must admit that COVID-19 has forced growth and innovation on our sector that badly needed it and we would do well to be deliberative in our evaluation of the opportunities and challenges still before us. We're supportive of continuing to explore and refine an expanded role of telehealth while at the same time acknowledging that further evaluation must take place to ensure that quality continues to hold precedence over quantity. Thank you very much for your time.

HOWARD: Thank you. Are there questions from the committee, committees? Senator Walz.

WALZ: Thank you, Senator Howard. Thanks for being here today. I'm just wondering if telehealth can be used in schools for behavioral and mental health services to students. And if so, are they reimbursable?

CHASE FRANCL: My, my knowledge of that is that, yes, they have been, and certainly throughout this pandemic, I've heard from providers that have been providing those remotely with the providers external to the school and the students in the school. I believe that there hasn't been any issues, I'm aware of for, for reimbursement for those services delivered in that way.

WALZ: All right. Thank you.

CHASE FRANCL: Yep.

HOWARD: Senator Murman.

MURMAN: Thank you for testifying. I think you touched on a couple of the issues I'd like to ask about. It's a great thing that virtual medicine is available, I totally agree with that. But it virtually isn't appropriate in-- for all services or even each appointment and, and particular type of service, as you mentioned also. How can a patient be assured that when, when in-person services are more appropriate that that will always remain available, even when telehealth is more available? And then also from a reimbursement from insurance point of view, how could a patient be ensured that insurance companies will always reimburse for in-person visits when that is more appropriate?

CHASE FRANCL: Thank you for that question. I think one of the most important tenets in behavioral health we talk a lot about is individualized service plans, is recognizing that there isn't a cookie cutter approach, that folks come in with a wide array of different dynamics that need to be addressed differently. The services we provide at Goodwill in our behavioral health side aren't those that were particularly well-- lent themselves well to telehealth. And so it was really a challenge for us and we really wanted to watch closely how our consumers reacted to those. Initially, there was a lot of excitement, there was a lot of, of-- they enjoyed coming in that way, but we also started to notice over time that folks also decompensated. And what we realized is that sometimes even though they said, wow, we really like these services, we could see that these services weren't meeting their needs as well as, as our traditional services were either. And so we had to make the decision of how early we felt comfortable coming back and protecting the safety of our, of our staff and clients. What I think is important to recognize is, certainly on our side, we provide a lot of services that simply aren't billable,

whether because it's been done by the phone or because we're advocating for the individual when they can't be present. Telehealth has opened, I think, more of a door to be able to allow those to be billable, so we don't have so much time that we're spending doing what we're paid to do, but in a way we might actually be paid to do it. I think something with telehealth that really offers an advantage is when you're doing it alongside somebody, it gives them that opportunity to, to experience what that advocacy looks like so they're in a better position to advocate for themselves, to feel comfortable asking those questions on down the road. When I look at a service of ours like community support, typically we're meeting with somebody about once a week, trying to spend an hour, hour and a half with them, building skills, connecting them with resources in the community. I think it would be really appropriate that, you know, maybe less than 50 percent of our contacts can be done by telehealth in those cases. But I think to, to exclusively move that direction, we would really miss, risk missing a lot of, of key indicators that you wouldn't if you were in person. So I think there's a way to be really thoughtful about that. At this point, it's just almost too early to tell what our outcomes really are going to look like. Given the circumstance, it's just kind of, COVID has just sort of introduced one giant confound in any evaluation. And I think it's important to recognize that, but also important to still hold yourself to a standard that we're responsible for overcoming that.

MURMAN: Thank you.

HOWARD: All right, other questions from committee members? All right, seeing none, thank you for visiting with us today.

CHASE FRANCL: Thank you.

HOWARD: Our next testifier is Amy Behnke, CEO from the Health Center Association of Nebraska.

AMY BEHNKE: Thank you. Chairwoman Howard and Chairman Williams and members of the Health and Human Services and Banking, Commerce and Insurance Committees. As Senator Howard said, my name is Amy Behnke, that's A-m-y B-e-h-n-k-e, and I am the CEO of the Health Center Association of Nebraska. I'm here today on behalf of Nebraska's seven federally qualified health centers and the 115,000 patients they serve annually. Nebraska's health centers provide primary medical, dental, and behavioral healthcare, as well as enabling services like

transportation and translation services across 70 service locations in the state. And they provide those services regardless of insurance status or ability to pay. Nearly 50 percent of health center patients are uninsured, and uninsured and underinsured patients contribute to the cost of their care based on a sliding fee scale. We're grateful to Senator Arch for introducing LR350 and continuing this vitally important conversation on telehealth and the key role it can play in advancing access to healthcare in Nebraska, particularly during such incredibly trying times. The COVID-19 crisis has magnified the racial and economic disparities that hinder access to healthcare. Telehealth has helped health centers respond to that divide in the midst of this COVID-19 crisis. In 2019, slightly less than one half of one percent of health center visits in the state were performed virtually, the majority of which were related to behavioral health. Since the end of March, over 42 percent of health center visits have been performed virtually. Those services have expanded far beyond behavioral health, into medical care, oral health, and enabling services. And I would echo much of what the previous testifiers have commented on with respect to the importance of telehealth and telehealth parity. So what I'd like to focus on is really how telehealth has impacted the unique patient population served by health centers. And one of those areas is teledentistry. This change has been welcome as it has allowed for greater flexibility for health centers, allowing for the provision of care in a safe and efficient environment. As you know, dental services were shut down at the outset of the pandemic in the state, and health centers were very slow and cautious to reopen those services. That had a very profound impact on our health centers. And while they waited for supplies and necessary equipment to ensure that they had safe space, it just took them a while to reopen. And so having access to teledentistry allowed them to return to care in a safe manner and also allowed for things like making sure that they were using PPE judiciously at a time where it was hard to come by and in a service line that requires quite a bit of PPE. It also provided them the opportunity to work directly with clients who faced barriers like transportation and really assess prior to the individual coming into the health center. The second piece is really around telephonic services and those have been critical throughout the COVID crisis. Health centers have found that many of their patients have limited access to technology, which can make synchronous video technology difficult to implement and access for low-income populations. Experiences with telephonic services have been incredibly positive for our health centers and their patients. One health center has found,

for example, that medication management is very well suited to telehealth because the patient has direct access to those medications while receiving instructions from providers. A final area is around case management programs and increasing access to telehealth has also supported health center efforts to develop case management programs for their COVID positive patients. One of our health centers provides pulse oximeters to patients who have tested positive for COVID-19, allowing for ongoing patient monitoring while keeping patients in their homes. Full implementation of telehealth was a goal for all Nebraska health centers prior to COVID-19. Since the onset of the pandemic, health centers have sped up those efforts to quickly and effectively react to the unprecedented healthcare landscape while protecting the health of some of Nebraska's most vulnerable and underserved populations. Payment regulations and policies need to be put in place to support ongoing use of telehealth beyond the pandemic. And tools and technology must also be in place to ensure that low income and marginalized populations have adequate access to telehealth. This requires continued flexibility in order to be able to meet the needs of a diverse group of clients. Again, we offer our sincere thanks to Senator Arch and to the members of this committee-- of these committees, and we welcome the opportunity to work together to innovate how healthcare is delivered to all Nebraskans. With that, I say thank you and I'm happy to answer any questions you may have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. All right. Our next testifier is Candice Mullendore of-- from the Nebraska Occupational Therapy Association. Welcome, Candice.

CANDICE MULLENDORE: Thank you, Senator Howard. And thank you, Senators, for the ability to testify today in support of LR350. Instead of echoing a lot of things that's been covered before, I'm going to focus on a couple of things related to statistics and some patient testimony. My name is Candice Mullendore, C-a-n-d-i-c-e M-u-l-l-e-n-d-o-r-e, and I'm here representing the Nebraska Occupational Therapy Association, as well as myself as an occupational therapist and a private practice owner of a pediatric outpatient clinic in Papillion, Nebraska, that offers services to children and youth with disabilities for occupational, physical, and speech language therapy services. In our clinic, we provide over 22,000 visits a year. In four months from March and through July, we provided over 4,000 synchronous telehealth visits and approximately a third of our patients are Medicaid. Without the access to telehealth services

during the pandemic, our occupational therapy clients would not have been able to safely continue with their therapeutic plans of care. This potential gap in services could have impacted the outcomes and increased the overall cost of therapy services to Medicaid and private insurers. Telehealth allows practitioners to continue to deliver cost-effective services in the most appropriate environments for the client. A recent study by MedBridge indicated that by using a hybrid model of telehealth and in-person visits, the cost of care was reduced 47 percent. The number of patient visits required to achieve their goals was reduced by 32 percent. Creating the ability to provide telehealth services would break down many barriers for Nebraskans, including accessing specialists, decreasing the cost of transportation, decreasing unpaid out-of-work time for our clients, parents and or caregivers, and decreasing the risk of illness to those with compromised immune systems or, in this case, in the case of the national health emergency, COVID-19. I'd like to share with you a success story that will help you better understand how the implementation of a hybrid model has been effective. I work with children and a very common diagnosis is children that struggle with feeding, including having a very limited diet. We have-- or therapy is a small part of a child's everyday life. And the [INAUDIBLE] of the home is so important for a long-term positive result that is often difficult to achieve in the clinic. We have a four-year-old child, John, who only ate eight items, literally eight items; and they were poor nutrition such as chicken nuggets, fries, and pasta. John's physician was concerned about his low weight gain and discussed with the parents a possibility of having to supplement his diet or consider placing a G tube which would be expensive. In our clinic, John would eat 80 percent of the new foods that a therapist presented to him. However, he refused all new foods at home with the parents. We used a combination of telehealth and in-person therapy over the course of six months. As a result of this hybrid therapy, John now has 23 foods in his diet, including more nutritious foods such as yogurt, lunch meat, and even an apple. This may not seem like very many foods, but to add 15 foods over 6 months is huge because children need to be presented with new foods from 10 to 20 times before they will add the food to his or her diet. He hasn't had his appointment yet, but it's later in December. We're excited to see what the weight gain will be because Mom's been weighing him. So we're, we're cautiously optimistic that we've avoided a very expensive surgery. Through the hybrid model, we gained a lot of insight into the home environment at mealtime, and we're better able to address and support the eating and behaviors the

parents experience in the homes. We never saw these in the clinic. The mother told us how much more comfortable she now is with pushing John while maintaining a supportive environment. I had a section on HIPAA compliance, but a lot of people have covered it. So I will just tell you that less than 3 percent of our patients had access issues for telehealth services, which are mostly related to Wi-Fi or technological problems that we just couldn't solve. So less than 3 percent of 4,000 visits is not very many. It is the position of the Nebraska Occupational Therapy Association and the American Occupational Therapy Association that when telehealth is used appropriately, according to the skilled and licensed therapists' clinical judgment, evidence demonstrates that clients can be effectively treated through telehealth methodologies. Thank you for allowing me to testify today. I'd be very happy to answer any questions that you have.

HOWARD: Thank you. Are there questions? Oh, Senator Williams.

WILLIAMS: Thank you, Senator Howard. Thank you, Ms. Mullendore, for testifying today. I want to be sure I understood the first part of your testimony when you were talking about the cost of providing services. Were you indicating that the cost of providing telehealth services was reduced over in-office visits?

CANDICE MULLENDORE: No, the overall cost, just let's give you an example of something like let's say you sprained your ankle and the overall cost reduction for providing telehealth and in-person visits was down 47 percent by using both telehealth and in-person visits. So they were able, let's say it cost you $100. Well, they were able to get it down to $47 for that episode of care.

WALZ: With a combination of inpatient and telehealth.

CANDICE MULLENDORE: Yeah.

WILLIAMS: OK, thanks.

CANDICE MULLENDORE: I focused on that because I think it's a very valuable tool that healthcare providers can use as the combination.

WILLIAMS: Thank you for helping me understand that.

CANDICE MULLENDORE: Yep.

HOWARD: Other questions? All right, seeing none, thank you for your testimony today.

CANDICE MULLENDORE: Thank you.

HOWARD: Our next testifier is Laura Moody from the Nebraska Speech-Language-Hearing Association.

LAURA MOODY: Thank you. My name is Laura Moody, L-a-u-r-a M-o-o-d-y. I am a speech language pathologist and the clinic coordinator in the communication disorders department at the University of Nebraska in Kearney. I'm testifying on behalf of the members of the Nebraska Speech-Language-Hearing Association. The UNK clinic, RiteCare Clinic here in Kearney began providing telepractice speech therapy in September of 2012. We've been providing these services across the state of Nebraska for many years before COVID-19 and have seen the benefits of reaching Nebraskans in their rural-- in their natural and in rural environments. When the onset of COVID-19 came, our clinic tripled our provision of telepractice speech therapy with overwhelming gratitude from our patients. One family in western Nebraska was traveling over an hour and a half one way twice a week to receive speech therapy. They found their daughter to be more attentive and less tired when she began her telepractice services through our clinic and wasn't needing to travel so far. They also found her to have increased positive outcomes as she was getting those services directly into her natural environment. Another family in eastern Nebraska didn't have local access to supplemental speech therapy needed for their 12-year-old. He received speech therapy from our clinic only via telepractice and made gains in his skills where he was initially struggling to write even a single paragraph, and he grew to being able to write an entire page. Telepractice provides access to these services by breaking down geographical barriers. Professionals are also needing support and removing those regulatory barriers. There is currently no reference to audiologist and speech language pathologists being able to provide telehealth or telepractice services in state regulations. The Nebraska Speech-Language-Hearing Association membership respectfully requests that this would be added. We would also request expansion of the CPT codes that speech language pathologists can bill for via telehealth, such as swallowing treatment with guidelines, of course, on how this therapy could be administered via telehealth in a safe way. Nebraska Medicaid started allowing this, but other insurance companies are not and there isn't uniformity from plan to plan. UnitedHealthcare, for example, has suspended the double

prior authorization requirement during COVID-19, thus increasing how quickly patients can receive care. Suspending rules limiting telepractice services for those with Medicare and Medicaid would also increase access to appropriate services. Adults needing therapy following a stroke or traumatic brain injury often struggle to access services in rural areas once they are discharged from the hospital. One professional sought services through our clinic via telepractice after a car accident. That professional was able to return to work with the support strategies that she needed in order to be successful in the workplace following telepractice speech therapy through our clinic. Support for reimbursement for speech language pathologists and audiologists is also needed to cover the costs for those professionals to provide these services. Patients achieve positive outcomes via telehealth and cost savings are incurred by the professionals and families when travel is removed from the therapy process. We have learned that telepractice provides benefits to patients and their supporting family members, along with extending the breadth of Nebraskans that professionals in these areas can reach. Thank you for your time.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today. Thank you for sharing your patient's story. That was great. OK, our next testifier is Amanda Holst from the Visiting Nurse Association in Omaha on behalf of the Nebraska Association for Home Healthcare and Hospice.

AMANDA HOLST: Afternoon, Senator Howard, Senator Williams and members of the committees. Thank you for the opportunity to be able to testify today. My name is Amanda Holst, A-m-a-n-d-a H-o-l-s-t, and I'm the vice president of Home Health with Visiting Nurse Association in Omaha. And today I'm testifying on behalf of the members of the Nebraska Association for Home Healthcare and Hospice. During my testimony, I'm going to refer to telehealth, how we use it in the home health setting as remote patient monitoring or RPM. So with the aging population that continues to grow, the demand for healthcare personnel and services intensifies. Individuals are living longer with chronic diseases, but yet they want to be able to age in place. And as evident during the COVID-19 pandemic, implementation of innovative and new approaches to the delivery of healthcare has been more critical than ever. During this pandemic, home health has really played a vital role for communities as hospitals have turned to home health agencies to provide services to patients whom otherwise would have been treated in the hospital. But they're allowing for the capacity and the rise of

COVID-19 patients. In addition, home health has provided interdisciplinary care to patients with COVID-19 in their home, and the use of remote patient monitoring has been a key intervention in the plan of care and keeping these individuals in the recovery process, being able to stay home and healthy. The use of remote patient monitoring enhances patient care by supplementing the in-home visits as provided by home health agencies with monitoring technology, allowing for daily monitoring of key biometrics such as blood pressure and heart rate pulse oximetry, weight, temperature. The use of RPM not only impacts quality and service outcomes, but it also helps to contain healthcare costs. Patients with increased knowledge and engagement related to their own health conditions improves to overall improved self-management, particularly of those chronic conditions. And during a home health episode of care, the care management of these patients is enhanced by being able to specifically target visits and provide the appropriate interventions when they most need it based on that data and the information we're getting from remote patient monitoring. Remote patient monitoring can detect early signs and symptoms to help prevent an unnecessary trip to the emergency department or reduce the number of hospitalizations or decrease the length of hospitalization stays. RPM is particularly beneficial for our rural elderly and our frail, vulnerable population who have increased barriers to access healthcare. There's currently no reference to home health professionals being able to provide telehealth services or using telehealth technology in state regulations. The Nebraska Association for Home Healthcare and Hospice membership respectfully requests that this be added. This would need to be added to 175 NAC 14 for home health agencies and added to 471 Nebraska Medical Assistance Services NAC 9. Here in Nebraska, we are in a position to lead by innovation, leveraging technology to transform and enhance healthcare for those in the home recovering from acute illness or injury or living with chronic conditions. VNA has invested and provided remote patient monitoring services for over 15 years now because of the positive impact on the delivery of care and the outcomes for patients that we have seen. We primarily have placed this technology in our most complex patients, whether that's our older adults and elderly population who are recovering from an acute illness or exacerbation, and those who are significantly impacted by social determinants as it helps with social connectedness and helps with prompting for connection with community resources, physician follow up, medication adherence, home exercise programs, and particularly with the use of patients who are diagnosed with COVID-19 or may have

been exposed in their home and are monitoring for potential signs and symptoms. These individuals are engaged and have been engaged with this technology as part of their healthcare plan. The greatest hurdle in expanding the use of remote patient monitoring and home healthcare is the lack of sufficient reimbursement. RPM allows technology for easier access to critical patient data, the ability to reach and provide high-quality care to more patients. It lowers costs and increases efficiency for healthcare providers and can help keep our older and disabled individuals live at home longer. Thank you for your time.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for visiting with us today. Our next testifier is Dr. Debra Esser, Deb Esser, the chief medical officer at Blue Cross Blue Shield of Nebraska. She popped on a minute ago. There she is. Hi.

DEBRA ESSER: Here I am. Here I am. Thank you. I would like to try to share something, but I have not done this over Zoom, so we'll give it a shot. Can you see a COVID-19 and telehealth presentation?

HOWARD: Yes, we do.

DEBRA ESSER: Perfect. Thank you so much. Thank you to the committee members of the Health and Human Services Committee and the Banking, Commerce and Insurance Committees. I am Debra Esser, D-e-b-r-a E-s-s-e-r, chief medical officer for Blue Cross Blue Shield of Nebraska. And I would like to share with you what we have learned during the COVID pandemic. No one knew exactly what to anticipate when COVID hit. We knew that there would be a big demand for health services, but also a limitation of being able to see those patients in an enclosed area where the spread of the virus is a threat. This means that we had a big challenge for health service delivery and access to health services. And there is also a big challenge to help keep providers or help keep those providers open during the pandemic. So telehealth was an immediate and successful option to maintain the continuity of care and provide access during the pandemic. Telehealth allowed the safe delivery of healthcare so patients and providers could feel confident in their ability to seek and deliver healthcare. So what happened? On the insurer's side, we were amazed at the smoothness of the transition. Patients love the convenience of telehealth with an option to take delivery of healthcare in their homes. And physicians and providers love the ability to maintain contact with their at-risk patients, indeed all their patients through

telehealth. Each month through the early pandemic, we saw huge increases in telehealth uptake, with the highest being in April and May of 2020, an increase of 4,000 percent and 3,000 percent were seen. We have again seen this same telehealth jump in the fall as we've experienced our second spike in COVID. This slide just shows the use of telehealth in a members per thousand view, and it shows that from 2018 to 2019 as compared to 2020, telehealth has become a preferred service. I would love to see telehealth remain as a viable option for providers and for patients well after the pandemic. Telehealth can be managed in the office with scheduling and the patients save time in their travel and appointment wait times. Informally, we have noted a high satisfaction with telehealth as an option for our Blue Cross Blue Shield membership. Interestingly, behavioral health delivery of tele-- through telehealth had the greatest growth, with 57 percent of the claims as of our summer, July, being for telehealth claims. I feel that a strong telehealth option will greatly expand behavioral health access across the state; and while the technology has been available for some time, it did take an external impetus for us to fully explore the options that have been available. So what have we learned? We've learned that patients love telehealth and we've learned that telehealth can be very successful in expanding access, especially in times of extreme need when face-to-face care is discouraged. We've learned that physicians and providers and provider offices have adapted to delivering telehealth. And we've also learned that services such as speech and physical therapy can be delivered through telehealth successfully. So will we be able to sustain telehealth as a viable delivery option in the future? That remains to be seen, but I really think that it is a viable option. Blue Cross Blue Shield has expanded the number of codes that we cover for telehealth; and with input from our provider network, we're looking for additional ways to support telehealth expansion. We really feel that improved access, particularly in the field of behavioral health, is well worth the investment. We've seen a huge increase in telehealth during 2020, and we've been able to support that growth without legislation mandating change. Blue Cross Blue Shield feels telehealth will continue to grow and expand offerings in the future. So with that, I'll take any questions.

HOWARD: Thank you. Would you stop sharing your screen so that--

DEBRA ESSER: Yes, I will.

HOWARD: And this is the first time we've done this. So this is very-- wonderful.

DEBRA ESSER: Yay, it worked.

HOWARD: All right, Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Ms. Esser, for being with us today from Blue Cross. And first of all, a big thank you to Blue Cross as being one of the providers that stepped up very quickly providing payment parity when, when we ran into the pandemic. And that, as you know, from the conversation we've had today, seems to be the elephant in the room. My question to you is twofold. Where do you think Blue Cross will be going forward with the issue of payment parity?

DEBRA ESSER: Um-hum.

WILLIAMS: And in your definition, is equitable reimbursement the same as equal reimbursement?

DEBRA ESSER: Thank you very much for your question. Blue Cross Blue Shield currently pays at parity office visit to telehealth visit. And for the future, for the foreseeable future, we have no plans to change that. And as to the second question, I don't know. I don't believe that equal and equitable are probably the same.

WILLIAMS: Would you agree that if we-- if you maintain payment parity, the difference between equitable and equal doesn't matter?

DEBRA ESSER: That I would agree.

WILLIAMS: Thank you.

DEBRA ESSER: To obtain parity, then I think they are the same.

WILLIAMS: Yeah.

HOWARD: All right. Other questions from the committee? All right, seeing none, thank you for visiting with us today.

DEBRA ESSER: Thank you.

HOWARD: All right. Our final testifier for today is Jay McLaren, vice president of public policy and government relations at Medica. Welcome, Jay.

JAY McLAREN: Thank you, Madam Chair and members of the committee. And Dr. Esser is very adept at technical-- technological capabilities. I evidently am not because my audio is showing up separately from my video. So give members time to orient themselves to the audio versus visual. But, Madam Chair, members of the committees, thank you very much. Again, my name is Jay McLaren, first name, J-a-y, last name M-c-L-a-r-e-n, and I'm vice president of public policy and government relations at Medica, which is a company that does about $4.5 billion in annual revenue based in the Twin Cities in Minneapolis, Minnesota. We have been in the Nebraska market since 2016 very proudly and serve to date approximately 100,000 Nebraskans through our multiple lines of business that we offer there. And again, Madam Chair, thank you for the opportunity to testify. We really also want to thank the care systems that had previously testified as well. We collaborate with many of them to improve the quality of care that's delivered to our, our members, including via telemedicine. And we appreciate their collaboration in the Nebraska market. Telemedicine, as you've heard from previous testifiers, has been a very powerful tool to help providers connect with our patients during the pandemic. And quite frankly, it's been a lifeline to a lot of their patients as they had hesitancy of coming in to see their provider, and particularly for people that are most vulnerable and most at risk of acquiring or having complications from COVID as well. And it was really important for these tools to be available to providers to check in with their patients. We at Medica expanded our reimbursement policies in a number of ways in order to make many-- more of these tools available, such as we broadened the services that were available via telemedicine. We are aligning with what Medicare allows, which has been widened quite a bit since the pandemic started. We reimburse for audio only if video capabilities are not available, particularly to help with folks in rural areas who may not have the capability to connect via video as well. And we pay for telemedicine services at the same rate as in-person services. So we do pay at parity and we changed that at the beginning of the pandemic and intend to continue to do so through the public health emergency. And we're proud to do that again to help ensure access to services for our members during the pandemic. We saw similar utilization changes as Blue Cross just shared. I mean, our utilization across our service area increased about 3,000 percent in

March and continues to, to represent a much larger percentage of the services delivered to our members than previously. Back in March, telemedicine represented approximately 26 percent of the services delivered to our members in the state of Nebraska. And we saw since about July, it's starting to tail off to be more in the 10 percent range. So when others are talking about this being a trend that continues into the future, we do expect, not necessarily 10 percent, but that larger utilization will be a trend that continues into the future. As we have gone through different phases of the pandemic response, you know, I've talked about what Medica has done to, to respond. We're now really in the phase of trying to figure out what we should be doing now to help support the delivery of healthcare services to our members and patients. And then the question for you all is what to do on a more permanent basis? And I think I'd probably go back a couple different things I want to touch on, but I want to go back to what Senator Arch talked about at the very beginning, which is that there are several big pools of federal and state and other areas where there are being-- decisions being made on how these things can be delivered. I think he did a good job of outlining that there were a lot of flexibilities afforded by the federal government, particularly for the types of technology that can be used. Basically, they said they're no longer enforcing HIPAA and, and the privacy requirements around that for telemedicine, which again gave providers a whole new spectrum of technologies to use to deliver telemedicine. We need to see what the federal government does on that on a more permanent basis in order to make wise decisions. You know, the impact that this can have, telemedicine can have on member access and engagement, you know, what can it do for people in rural parts of the state? And also what can it do for things like mental and behavioral health? Blue Cross has some really good data that they share on that. From our perspective, we saw an increase in utilization in mental health and started asking our network providers why and found out it largely has to do with a reduction in no-shows. If there is larger patient engagement, particularly in mental and behavioral health, that can have tremendous value and drive tremendous value to our care system and increase outcomes for those patients. When it comes to payment parity, I would just remind the committee that telemedicine services are not inpatient services. They're much different and requires much more study to see what's appropriate to be delivered via telemedicine and what's appropriate to be delivered via in-person services. I see my time is up. I thank the committee for the opportunity to testify. Thank you, Madam Chair.

HOWARD: Thank you. Are there questions? All right, seeing none, you've brought up the rear. Senator Arch, you are welcome to close.

ARCH: Thank you. And thank you for everyone today participating. I think to the senators I speak and say that you obviously have seen a lot of interest in this topic. I think we could have had twice as many testifiers. It, it, it is-- it is of great interest. And, and I think what we're witnessing is a real-- the potential of a transformation in the delivery of healthcare. Healthcare providers have been talking about and doing telehealth for some time. And gratefully, because I think the infrastructure was there then when, when this pandemic hit and we needed that infrastructure, the infrastructure was built. And so we, we got on it. Patients accepted it quickly. Providers accepted it quickly when there had been some reluctance in the past on the part of providers to, to provide in this way, a lot of adaptation. Well, no matter what, what phrase you use, whether the horse is out of the barn or the genie is out of the bottle, it's not going back. It's-- we're seeing as, as, as Jay was just talking, we've seen-- we're seeing some return to some lower numbers in the use of telehealth. Patients are coming back into the office. But, but I think that we're seeing the potential of a transformation in the providing of outpatient clinic services similar to what we saw in the transformation when, when hospitals moved from inpatient to outpatient. We may be witnessing-- and it's, of course, not all out, not, not all care is appropriate on an outpatient setting. So inpatient remains. We may be seeing something very similar in the transformation now of clinic services for, for more of the blending of telehealth, which would be considered that outpatient piece if you were looking at the hospitals, compared to that in-person care. So over time, we're going to see more evolution, maybe not revolution, but more evolution where we're going to see more services provided. Electronics are going to develop, more instrumentation is going to develop, remote monitoring is going to develop. We're going to have as a result of technology developing more opportunities for other specialties. Right now, right now we saw a big increase in behavioral health utilization of telehealth because that is, that is what is most appropriate right now with the face-to-face interaction, doesn't require a lot of instrumentation. So, so that, that makes sense. But we'll see more change coming here. And I think for Nebraska as policymakers, we just need to be ready for it. We need to-- we need to be positioned in a way that as technology develops and, and provider, providers are saying we now can deliver this type of medicine safely, effectively, and perhaps even at lower cost. But

we'll, but we'll see how all that evolves. We just need to, in our policies, be considering what needs to happen so that we're prepared for the future. And so with that, thank you very much for your time this afternoon. More to come. We'll, we'll-- telemedicine will be a topic for our future. So thank you.

HOWARD: Thank you, Senator Arch. Are there any final questions for Senator Arch? Well, oh, Senator Kolterman. Senator Kolterman.

KOLTERMAN: Yeah, thank you, Senator Howard. Senator Arch, you indicated that we need to be prepared for it as it comes forward. Do you anticipate any kind of legislation for the coming year in regards to payment parity or how we might move forward with anything like this?

ARCH: Yeah, we're taking a look at all those. As I, as I said in my opening remarks, my, my, my goal with all of this was just to make sure that we weren't in the way, that our policies were such that, that we weren't-- that we weren't regulating in a way that would prevent when a provider says, I can do this and I can do this safely and with quality of care and, and the patient wants that and the insurance companies are on board, we're not, we're not standing in the way. So that was my first goal. I think we heard a lot of things today to give us a lot of, a lot of consideration. We're drawing up a list and perhaps other senators are taking a look at it. We wanted it for this to be both HHS Committee as well as insurance and banking because it touches both of our committees. And so we'll, we will have more discussions before the session begins as to, as to what would be appropriate for legislation.

KOLTERMAN: All right. Thank you.

HOWARD: That's great. Any other questions for Senator Arch? All right, seeing none, this will conclude our hearing on telehealth for Senator Arch for LR350. Just a reminder to HHS Committee members, we start our hearings tomorrow at 2:00 p.m. We'll be talking about maternal and infant health and service animal fraud. I can tell our Banking, Commerce and Insurance colleagues are jealous. Thank you so much for your time today. And thank you so much for visiting with us to all of our testifiers. All right. Have a great afternoon.