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Testimony to:
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Chairman Weisz and Committee members, thank you for allowing me to come before you today to discuss an important rural health issue. I am Brad Gibbens, Acting Director, Center for Rural Health and an Assistant Professor at the UND School of Medicine and Health Sciences. I do not claim to be an expert in telehealth, you have heard from many; however, after 37 years working in rural health I do know a few things in that area. My perspective today is rural health as it relates to telehealth.

To begin with just a review of the Center for Rural Health. We were created in 1980 by the UND School of Medicine as the North Dakota Office of Rural Health, and today we are official State Office of Rural Health as designated by the Federal Office of Rural Health Policy of the Health Resources and Services Administration of the US Department of Health and Human services. Over the 42 years we have grown significantly from about two employees to 60. We operate a number of programs that address ND issues and some are national in scope, our Rural Health Information Hub (RHI Hub) for example essentially serves as the “one stop shop” for rural health information, data, grant information, federal guidelines, and more. Actually, each state has its own page in RHI Hub. Another example is our National Resource Center on Native American Aging which has worked directly with over 350 or more of the 574 US recognized Native tribes or Nations. Today CRH has five divisions: 1) Information Dissemination; 2) Community Engagement, Education, and Outreach; 3) Indigenous Health & Aging; 4) Research and Education; and 5) Behavioral Health & Human Services (our newest division created in 2022). Much of our work takes place outside of Grand Forks and UND; I would estimate it is a rare week when no one from CRH is on the road in ND. We believe in going directly, as much as possible, to our clients. We help them understand their environment and to develop local/regional solutions. We approach rural health as a “community” issue. The solutions are found at the community level. We just help them. Our Mission statement reads as follows: ***Connecting resources and knowledge to strengthen the health of***

people in rural communities.

Process and Findings.

The approach I used blended two methods, primary and secondary data. The primary data was gained from interviews I conducted with 14 CAH CEO's and 4 representatives from associations, consulting groups, and/or academic centers. The CRH interviews spanned a period from August 24, 2022 to September 8, 2022. The secondary data was from gpTRAC (Great Plains Telehealth Resource and Assistance Center) gpTRAC is a federally supported telehealth training and technical assistance center located at the University of Minnesota. The regional area includes North Dakota. gpTRAC conducted a survey of 11 primarily rural health and human services providers in 2021.

CRH Interviews. I typically asked the CAH CEOs (and RHC) the following questions:

- How are you using telehealth?
- How much did it change during the pandemic?
- Do you see it continuing to develop?
- What are the issues/barriers faced for telehealth? If you can rank them.
- Overall, what are the workforce challenges?
- This is a presentation to state legislators, what areas should they address to improve telehealth?
- Looking forward, are you optimistic for telehealth?

I have a limited amount of time with you so I will focus on barriers and their policy perspective and recommendations. If you are interested in the other areas I plan write a more detailed report and can provide it to you. I did inform our congressional offices I would provide them more detailed information.

Barriers. The CAH CEOs raised multiple barriers. They all raised more than one or two. The barriers included the following:

- Payment/reimbursement
- Local provider culture and attitude
- Specialist provider culture and attitude
- Patient culture and attitude
- Broadband.

I will start by saying I was surprised in that I thought there would be more telehealth being implemented, but there isn't. Generally, respondents said it peaked during the height of the pandemic as they had to use it then for safety, (and facilities were basically shut down for a period) but now they are back to pre-pandemic levels.

Before reviewing barriers a few thoughts. Yes, there are serious barriers but respondents do see a place for telehealth. Likely not as a primary source of health care but as a

secondary source that can augment face-to-face. By-in-large they see it having utility in the ED for connections to specialists during an emergency. It is seen as a workforce boon in those cases as it provides specialized advice to primary care providers and boosts the confidence particularly of younger providers on their own facing an emergency at 3:00 AM. They see it continuing to develop, albeit slowly in the future. Payments need to be adjusted upward to create incentives. In addition to emergency care the likely growth area is helping to address behavioral and mental health access. Rural providers struggle trying to identify viable ways to help people with these conditions or places to refer them to for treatment. In some cases, by providing tele-behavioral and/or tele-mental health we can keep more patients in their local communities. It can help the patient, local health facility, and keep local dollars-local.

Payment was raised by all 14 CEOs and the 4 other representatives. In general, some of the federal changes during the Public Health Emergency helped and even improved payments; however, the overall climate is framed by many as being reimbursed at "below our costs" and well below a face-to face visit. Providers feel they have the same fixed costs for both, for example: physician/NP/PA salary and time away from other duties; nursing costs and time; equipment costs, set up, and testing; supplies; and billing. One described a situation where he has a RN who covers the ED but also would cover the telehealth room and if she was working with telehealth then they had to find another nurse to cover the ED. As he said: "So when we have a telehealth visit planned we have to plan around that for our staff. You can't drop your other areas, like the floor or the ED." He said he did not have the staffing where he could have one for telehealth and one for the ED. That is a luxury. At least two CEO commented on the implications for the ED. Another CEO commented that they are not doing a significant level of telehealth as they hear from other hospitals and clinics how low the payment is. For them to step into greater use they need more "assurances that the reimbursement level is supportive of it." A couple of CEO's commented on insurance companies directing subscribers to use out-of-state specialists. "Dollars leave ND for another state. This is an insurance company operating here in ND yet it is willing to support out-of-state business over ND." A few citied lingering issues with payment within a RHC and that better reimbursement (but still below their costs) occurs if they move the patient out of the clinic to a telehealth outpatient room in the hospital. This is a reflection on cost allocation within a cost-based provider such as a CAH. It seems like curious policy that providers have to physically move patients from one location to another in order to do a bit better on payments. Another response in answer to the question if there is much difference between Medicare, Medicaid, and the commercial payers responded "in general it is too low to rely on to consider expanding. Why would we? Payment seems to be about the same from all three….You really need to look at the services and what payers will cover, what is allowed." And finally, a respondent commented that payment "is very impactful for decision making. We need to be incentivized to set it up and use it. Sometimes you have to use it even if you lose money." There were comments that telehealth is a "loss leader" in that sometimes it is the only real option even if it costs money. It is important to get the care to the patient. However, they tended to contrast themselves to tertiary providers in

that the tertiaries can cover loss leaders more easily from other services that produce revenue. The rural providers do not have that level of flexibility.

Local provider culture and attitude. Fifteen of the 18 raised local provider attitudes. This is generally phrased as preferring face-to-face interactions with patients as that is the perceived as the best form of medicine. Face-to-face was characterized as "optimal care." It was sometimes called "touch medicine" in that providers like to be able to touch the patient, feel the skin, manipulate a body – it is how they are trained. As one said of his providers "some feel medicine is 'I put my hands on you it is to heal you' so they have to touch the patient." One framed it as "not so much they do not like telehealth but as providers they feel better care is face-to-face." Telehealth was described as "a secondary approach" and used to augment face-to-face with a specialist. A respondent said of his local providers "they do not see it as the answer to rural health workforce or access issues." Another commented that the local providers "understand they are not incentivized to use it. So, they shy away from it." The use of telehealth in the ED was praised as many have a telehealth agreement with Avera Health in SD that operates an extensive ED specialist outreach to rural hospitals in ND (and other states.) Some respondents commented that their younger providers were more accepting but even they prefer face-to-face but are more willing to use telehealth when necessary. The area seen as "ripe" for telehealth expansion (if the payments are positive) is in tele-behavioral or tele-mental health. But it was stressed payments need to improve.

Specialist provider culture and attitude. There were a number of specialist-related comments. Many respondents stated it is not as easy as some think it will be in that many specialists also prefer face-to-face and prefer to come out to the rural area or expect patients to come to them. The specialty issue was commonly framed as it depends on the provider or the specialty discipline or the tertiary. Not all tertiary providers are stressing telehealth. And ultimately it is the individual specialist who will decide how they want to conduct medicine. "It takes time, effort, and [the specialists] do not like being pulled from their primary practice to do a telehealth consult." Another stated that "Telehealth is a tool, it can help but not replace direct patient face-to-face. Providers are trained to interact directly, look patients in the eye, touch them not just for medical care but being human." There was some concern too that specialists may conduct a series of visits with a patient via telehealth but will require one face-to-face meeting a year and if you have a relationship involving a patient out west and they are expected to travel once a year to Fargo, that is a problem for the patient and their family. Another respondent had commented about cherry picking in that specialists seek the right patient for telehealth and the right patient for face-to-face, it is not simply a matter of having it available for all patients.

Patient culture and attitude. In general, the patient culture was framed as they prefer, they expect to see their medical providers "at the doctor's office" face-to-face." Some accepted telehealth during the peak pandemic period as the only real option they had. And there were some who simply did not keep up with routine care and did not use

telehealth. It was sometimes phrased as patients are not comfortable with the technology, did not trust themselves to use it correctly or did not have confidence in the technology. Older patients were generally seen as less open, but even younger patients prefer face-to-face. “They need direct reassurance.” Another comment “they want to see the provider, be in an exam room, that is medicine to them.” Access to technology was raised particularly for older patients “do they have it, have the right kind, have enough of it and then their acceptance of it and confidence to use it.”

Broadband. Broadband availability was generally assessed as adequate to good. It was not seen as a significant issue; however, that too depends, primarily on location. There are what can be called “broadband deserts” or pockets. Most of the CAH CEO’s stated that while it was generally good they had some possible open areas and not all, especially older patients, had Internet access. Thus, it is a barrier but not seen in the same light as the previously discussed barriers. It is more situational.

gpTRAC Study. In 2021, gpTRAC surveyed 11 CAHs, RHCs, and Human Service Centers in ND. They too found “insufficient reimbursement” as the number one barrier with 6 of 11 identifying this issue. This process did identify a possible higher level of technology issues with 5 of the 11 identifying “patient challenges using technology” and 5 indicating “bandwidth, connectivity for patients.”

State Policy Recommendations

Payment. This was by far the number one recommendation with 15 of the 18 respondents identifying it, many said it was the number one area. The issue faced by rural provides is the payment rate is below what they feel is their cost of care (staffing, equipment, time to test the connection, time to set up, the same amount of billing and paper work). From a policy perspective for ND legislators this essentially means Medicaid payments as Congress will have opportunity to review Medicare. I would suggest in examining Medicaid parity you would need to be judicious in terms of considering provider groups that would be eligible. Recognizing the financial impact to the state some essential providers should be examined first, and additional ones in later years. A phased approach. As one CEO said “we should want to see more patients being able to use telehealth” and that would require improved reimbursement. Another stated “if we want quality and access we need appropriate payment, not to make rural providers rich but at the very least hold us harmless, that we not lose money on every telehealth encounter. It is hard to grow it if there is not adequate payment.” This same CEO said “if we put patients in the middle of the focus it will be ok. Patients first.” Another also stressed the connection of payment and additional access: “Payment is very impactful in our decision making. We need to be incentivized to set it up and use it. Sometimes you have to use it [now] even if you lose money.” Another comment “we need help to do this. We used some telehealth but not to the full potential as there are too many barriers and we cannot be expected to do it and lose money on the care. It [telehealth] can help, but we need to work together, the state with the providers.” And finally, this comment: “We need to be

fairly compensated at a level that reflects our fixed costs. And telehealth fixed costs do not vary from face-to-face. If we want to see more telehealth used then Medicaid, Medicare, and the commercials need to increase the payment. We cannot take on the same level of risk as the tertiary hospitals, they can spread more risk in ways we cannot. Our workforce problems are also a telehealth problem."

Patient Education. A rather intriguing idea that was raised by at least 5 of the respondents related to state funds to support patient education on using simple technology. It is possible this already exists. The idea is the recognition that many rural patients, particularly older patients are unsure, uncomfortable, and even intimidated by even connecting over a lap top to their provider. And, yes, some do not have either Internet or devices, but more on that issue later. As was previously stated they are more comfortable with face-to-face. A CEO commented "We need state dollars for patient education. Help with their confidence, show them how to use it and practice with them. Telehealth seems designed for rural area yet we have a patient base that is not designed for telehealth. This is something that goes beyond what any one hospital can focus on." The general theme is this: is there a way to fund an entity or a group that could provide direct training to rural residents? To come to the community and not make them travel to the large cities. The idea is to bring the training out to rural communities. There could be a train-the-trainer approach.

Technology grants. There was some, not a lot, of discussion on the cost of equipment and the need for more funding. I do not want to dismiss this issue; however, there are currently a number of federal grants available that may not be used to their full opportunity. CRH sends out notices but sometimes opportunities are missed.

Workforce. Not simply the workforce for telehealth but the general idea that rural health providers (hospitals, clinics, nursing homes, public health, and behavioral/mental health) are facing severe problems. With regard to telehealth and hospitals, shortages of nurses and physicians influence how seriously they can address telehealth opportunities. I would anticipate that the next session will have significant focus on not just health workforce but many strata in our employment struggles.

Federal Legislation and Policy.

Today we are still operating under a public health emergency which has been extended for 151 days beyond the PHE in March 2022 and could be slated to end October 15, 2022; however, it is our understanding that if necessary the Secretary of USDHHS would extend it another 90 days, and has said that when it is in sight there will be a 60 day notice. Much of rural health advocacy at the national level has focused on continuing many of the positive regulatory changes made during the pandemic. Telehealth is no exception. Two congressional bills are worth a comment. There have been many telehealth bills but much of the work has concentrated on **H.R. 4040, the Advancing Telehealth Beyond COVID-19 Act of 2022** which extends telehealth provisions until December 31, 2024. In July 2022 the bill passed the House with a 416-12 margin and is now in the Senate. This would continue things such as audio-only telehealth services; RHC and FQHC serving as a distant site (where the provider is located) to better serve

patients who could be at an originating site even if in their home; the waiver of geographic site restrictions so Medicare beneficiaries can receive care where ever they are located; OT, PT, and speech therapies allowed via telehealth; behavioral and mental health access via telehealth; and more. It **does not** amend the payment methodology for RHCs and FQHC so those providers do not receive payment parity equal to a face-to-face. However, there is another bill that does. **H.R. 7876 Connecting Rural Health to the Future Act** (co-sponsored by **Congressman Kelly Armstrong, ND**) would not only extend the emergency provisions as does H.R. 4040, but would also, according to the National Rural Health Association (NRHA) "amend the reimbursement structure to attach it to the same as in-person reimbursement." In other words, parity. NRHA continues on about the reimbursement changes "we believe are critical to ensuring utilization is the same at RHCs as other rural hospital settings, and their urban and suburban counterparts." They further state "As the reimbursement gap [which is occurring now] continues to widen, the incentive to provide telehealth services at RHCs is not there." Reimbursement, for RHCs, is compounded based on being an independent RHC which as a different methodology than provider based RHC. All 55 ND RHC are provider based, meaning they are owned by a hospital. We are optimistic. And thank you to Congressman Armstrong.

Federal Technology and Broadband.

The **Bipartisan Infrastructure Investment and Jobs Act (IIJA)** provided substantial investments in our communications infrastructure primarily through what is called the **Broadband Equity, Access, and Deployment (BEAD) program**. Nationally this is over $42 billion that will be distributed to states and territories to help finance broadband deployment projects. The program focuses on underserved areas first and this benefits rural America including North Dakota (and our tribal Nations). As was noted previously in my findings, broadband was noted as a barrier but less important than found with payment and local provider/specialist/patient culture and attitudes. Still this will open a door to address our ND broadband pockets. All 50 states have signed up for BEAD funding and one document indicated ND was one of the first 32 states to do so. This is promising.

Personal Internet. Another federal effort that originates from the Infrastructure Investment and Jobs Act is the **Affordable Connectivity Program**. This program helps lower income households pay for internet services and connected devices like a laptop or tablet. Nationally, one estimate is about 28 million American households do not have Internet access while others peg it at over 44 million. A General Accounting Office (GAO, 2020) report found that over four times as many people living on tribal land did not have broadband in comparison to people not living on a reservation. The Federal Communications Commission found that 22 percent of rural Americans and 28% of Native Americans on tribal lands lacked access to broadband compared to 1.5 percent of people in urban areas. Different sources and numbers but the evidence seems to

indicate both rural populations and Native populations on tribal lands have more access concerns.

The Affordable Connectivity Program would provide up to a $30/month discount for internet access and up to $75/month discount for a qualifying household on tribal lands. Additionally, a one-time discount of up to $100 for a laptop, tablet, or desktop computer with a copayment. Any of the federal programs meet eligibility: SNAP, Medicaid, WIC, SSI, housing choice, rental assistance, Veteran's pension or spousal benefit, Lifeline, and a number for those on tribal lands including Tribal TANF and Tribal food distribution.

Conclusion

Rural health providers appreciate the opportunities found through telehealth. They see it as an effective tool in the right circumstances. They see growth, likely slower than some have anticipated, but they see continued development. As previously stated they see it playing a role in how we approach rural access for tele-behavioral and mental health. There are issues revolving around payment, local provider culture, specialist culture, and patient culture. Some to the technology issues may be addressed via BEAD, the Affordable Connectivity Program, and technology grants. However, there is a role for state government in this process. I am reminded of the CEO who said "put the patient in the middle of the focus and it will be ok. Patients first."