MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-first Session
February 15, 2021

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:00 a.m. on Monday, February 15, 2021, Online. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Dina Neal, Vice Chair
Senator Melanie Scheible
Senator Roberta Lange
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Keith F. Pickard

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Wil Keane, Counsel
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Char Frost, Chair, Clark Regional Behavioral Health Policy Board
Lea Case, Nevada Psychiatric Association
Michelle Sscot
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Steven Cohen, Disability Self-Advocate
Jacqueline Harris, Licensed Marriage and Family Therapist, Licensed Alcohol and Drug Counselor
Robin Reedy, Executive Director, National Alliance on Mental Illness Nevada
Nancy Bowen, CEO, Nevada Primary Care Association
Joan Hall, Nevada Rural Hospital Partners
Adrienne Michelson
Barry Gold, AARP Nevada

Tom Clark, Nevada Association of Health Plans
Marcus Conklin, Teladoc Health
Claudia Tucker, Teladoc Health
Joanne Malay, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 56.

SENATE BILL 56: Revises provisions governing insurance coverage of behavioral health services. (BDR 57-124)

CHAR FROST (Chair, Clark Regional Behavioral Health Policy Board):
In March 2020, all of us were thrust into a new reality. At times, it felt like all the rules were thrown out the window. This is what happened to the rules regarding telehealth. All of us had to adjust to new ways of living and working, and consumers suddenly found themselves disconnected from their mental health professionals. Others who had not previously accessed mental health services went looking for them for the first time. Telehealth, while not perfect for everyone, provided the means to keep us safe in more ways than one.

The Covid-19 pandemic has been very difficult for all of us, but the difficulties of this new reality have also taught us some lessons along the way. The Clark Regional Behavioral Health Policy Board feels strongly that treating behavioral health via telehealth is one of the lessons we have learned during the pandemic that needs to be continued. We have seen telehealth make things possible that were probably possible prior to the pandemic, but there is always resistance to change. The Board decided to take policy recommendations from an American Psychiatric Association paper titled, "Support for Permanent Expansion of Telehealth Regulations After Covid-19" (Exhibit B contains copyrighted material. Original is available upon request of the Research Library).

This paper guided us in developing policy to create payment parity between seeing a mental health professional in person and seeing that same mental health professional via telehealth. This policy would also allow for the use of telephone or other audio-only communications for evaluation and management of behavioral health patients with mental health and substance use disorders across the various insurance provider types.

In addition, S.B. 56 adds a definition to the *Nevada Revised Statutes* (NRS) that defines behavioral health services as services for the evaluation, management or treatment of a mental health condition or an alcohol or other substance use disorder. Nevada is currently fifty-first in the Nation for mental health, according to the last Mental Health America report. Increasing access to mental health services is vital to moving the dial in the right direction. There are a variety of reasons consumers cannot or do not access services. Barriers to care include transportation, time constraints and competing life priorities.

The fiscal note submitted by Medicaid anticipates that this provision will increase utilization of behavioral health telehealth services by approximately 10 percent. I draw your attention to this only because one of the other lessons we have learned during the pandemic is that not everyone, especially those who are economically disadvantaged, has internet access in their homes. In addition, in the rural and frontier areas of the State, infrastructure does not exist in all areas to allow reliable, stable broadband. I realize this is a policy committee, but the projection of increased utilization is telling.

I want to briefly touch on the idea of payment parity. The behavioral health services provided by telehealth are the same as those provided in person. The Board felt this was an important step in breaking down some of the barriers previously mentioned. Some consumers may prefer to attend in person after things go back to normal while others will not, whether due to barriers or choice. Providing payment parity helps ensure that consumers have a choice without negatively affecting providers and their ability to cover their own costs.

LEA CASE (Nevada Psychiatric Association):
We strongly support S.B. 56. We have a letter of support (Exhibit C) from Dr. Lesley Dickson, a Las Vegas psychiatrist who is a member of the Board. As mentioned by Ms. Frost, the foundation of this bill is Exhibit B.

Although the pandemic has been devastating in many ways, it does highlight the benefits of pivoting to the greater use of telehealth, particularly in the provision of mental health services. The federal and State governments wisely loosened restrictions on the use of telehealth when patients and their mental health providers were subject to shelter-in-place mandates. The advantages of these decisions were significant and provided the opportunity for care to continue, despite the challenging times.

Dr. Jeffrey Geller, president of the American Psychiatric Association, testified before the U.S. Congress last June regarding the importance of telehealth. He stated:

> The lifting of geographic and site of service restrictions, including allowing the patient to be seen in the home, and the use of audio-only for telehealth, when a patient lacks the technology or bandwidth for video have enabled large numbers of patients, including vulnerable populations to receive care.

Other benefits were the reduction in no-show rates and improved patient satisfaction based on a survey of 600 Association physicians.

Once this pandemic is behind us, what lessons will we take away? We submit that one of these is similar to the experience the Legislature has had this Session. Giving the public the opportunity to provide testimony remotely has created another avenue for participation in the process. Likewise, enhancing options for patients increases the opportunities for the delivery of care.

I would like to focus on the use of the telephone to provide mental health services. In the age of smart phones, smart watches and tablet computers, it is important to acknowledge that not everyone has access to these advances. There are glaring disparities in our healthcare delivery systems, especially mental health care among disadvantaged populations. We risk taking a giant step backwards when we ignore these inequities.

How do we continue to take advantage of these lessons learned? Nevada continues to rank fifty-first in access to mental health care, according to the 2020 Mental Health America report. Ensuring payment parity for the delivery of mental health services, including audio-only, will allow Nevada to provide one more access point for mental health care.

The Nevada Psychiatric Association strongly encourages your support of S.B. 56.

MICHELLE SSCOT:
Last February, I was really sick. I live alone on the third floor of an apartment building with only stairs. My family had health challenges and could not climb the stairs. I ended up in urgent care three times in five days because I could not

breathe. My immune system was impacted by the medications I was put on, and I was stuck at home recovering for weeks. I could not go anywhere. My only lifeline was my therapist. We met via a videoconferencing program once a week, and when my internet connection was not stable, we talked on the phone. I cannot stress enough how much those calls and videoconference meetings meant to me. I spent months at home isolated from everyone and became very depressed. I was physically exhausted, and knowing those meetings were coming got me through the double whammy of the onset of Covid-19 concerns just as I was getting well enough to leave my home for short periods.

On the other side of the coin, I can also speak as an operator on Warmline, an emotional support phone service. We call and videoconference with people who are having emotional challenges or who have mental illnesses. We are unable to provide support via videoconference in rural areas due to reception or internet issues, so we rely on the telephone. Although I personally prefer videoconference meetings, I have learned how important phone therapy can be and strongly support having both options available. When videoconferencing is not available, it can mean the world to have those phone calls.

SENATOR PICKARD:
I am in complete support of increasing access to behavioral health services in Nevada. We have to get out of last place. Since we are so far behind, anything that provides more access is probably going to be a good thing.

It is my understanding that the intent of this bill is not to require all policies to provide coverage for behavioral health services, but that those policies that do provide coverage have to provide for telehealth visits to the same extent they cover in-person visits. Is that right? Or is it the intent of the bill to require every health insurance policy to cover behavioral health?

MS. FROST:
Your first statement is correct. This bill does not require insurance companies to cover behavioral health. There are federal mandates in place regarding parity, most notably the Mental Health Parity Act. The intent is that for those insurance policies that cover behavioral health, we want consumers to have the ability to access their providers' services in ways that makes sense for them regardless of the reason.

SENATOR SETTELMEYER:
You are saying that this bill will not require mental health doctors to do telehealth if they only provide in-person services. Is that correct?

MS. FROST:
That is correct. If consumers would like to receive telehealth services, they are certainly welcome to find providers who provide those kinds of services. But there is no requirement for providers to provide services via telehealth if they are not comfortable doing so. It provides choice on both sides of the coin.

SENATOR SETTELMEYER:
I appreciate anything we do to increase telehealth. As my colleague indicated, we are last in this area, and we need to do something to change that.

I am concerned, however, because telehealth and in-person services are not the same. Telehealth visits are not the same as being there in person and being able to see interactions between couples or how somebody fidgets. Providers are not able to use their full training as well through telehealth as they are in person. It is not the same thing. It is the same situation we have with the Legislature this Session. Because the building is closed to the public to maintain safety during the pandemic, we are not attaining the same quality of legislation as if we had the ability to interact with you in the traditional sense.

Can we create some type of a bonus for providers who continue to operate in a traditional fashion? They have higher expenses because they have actual brick-and-mortar buildings to clean, staff and maintain. Telehealth providers will not have those expenses.

I appreciate the concept of making these services available to more people, but we need to make sure those individuals who are providing the more traditional in-person services, which are more effective, are not forgotten.

MS. FROST:
This issue was a large part of the discussions we had on the Board about this bill. Sometimes it is preferable to visit a provider in person, and it is important to understand that. What we are seeing is that telehealth visits are being paid at a lesser rate than in-person visits, especially in some of our frontier and rural communities. The Board had a robust discussion about the needs of those communities. When you are 200 miles away from the nearest provider, should

we be paying those same providers less for telehealth service while they are still providing in-person services as well? We want to make sure we are protecting everyone. No, it is not always preferable to have services provided by videoconferencing or telephone. But sometimes it is better than nothing, especially when there are barriers to providing that service in person.

SENATOR SETTELMEYER:
I appreciate that, and I agree that it absolutely is better than nothing. It has allowed further outreach, especially in the more rural areas, and is invaluable for individuals who through their physical condition cannot make it to the office. Some individuals do not want to leave their homes, and that is understandable with what is going on. But in the same respect, do you not agree that in-person visits are better than telehealth when possible? I want to give everybody the same rate, but should we not also give a bonus to those providers who are still keeping a brick-and-mortar institution going?

MS. FROST:
For the record, I am a consumer and a parent of consumers of behavioral health services. I am probably not the right person to comment on the efficacy of in-person visits versus telehealth. I personally prefer telehealth services. I feel more comfortable receiving those services in my home than I do going across town to see my therapist. Sometimes the office can seem intimidating. Although my therapist will probably want to see me in person every now and again, I suspect I will continue utilizing telehealth services for my own mental health needs and that of my sons as well.

MS. CASE:
Our psychiatrists will be happy to chat with you further on any incentive to expanding access to mental health care and bringing psychiatric care to the patients of Nevada.

In addition to Exhibit C from Dr. Dickson, I also have a letter from Dr. Eliot Cole (Exhibit D) on this bill. Both of these individuals are practicing psychiatrists, and they talk about their experiences with telehealth, including telephone visits. While in-person visits may be beneficial for some clients, they have seen benefits to telehealth, especially for elderly patients and people with specific mental health diagnoses like post-traumatic stress disorder (PTSD) and agoraphobia. I can get you more information on that if you desire it.

SENATOR SETTELMEYER:
I appreciate that. I am not trying to argue that this is not a valuable tool. It is just a question of creating some benefit so that providers get paid slightly more for maintaining a brick-and-mortar institution. However, I support the bill, so I will not debate that any further .

Will this allow telehealth to be accepted for workers' compensation (WC) bills pursuant to NRS 616C.180 for behavioral health?

MS. CASE:
I do not think that is a question for me. I am not an insurance expert.

MS. FROST:
I do not have an answer to that question. I am happy to look into it and will reach out to you when I have more information.

SENATOR NEAL:
There is some language in sections 1 and 4 of S.B. 56 that seems to be contradictory. Section 4, subsection 3 states, "A benefit contract must not require an insured to obtain prior authorization" but goes on to say, "A benefit contract may require prior authorization." This is confusing.

MS. FROST:
This section means if payers do not require prior authorization for in-person behavioral health services, they may not require it for telehealth services. If they do require prior authorization for in-person services, they may do so for telehealth services as well.

SENATOR NEAL:
Is prior authorization currently required for in-person behavioral services?

MS. FROST:
It depends on the insurance company. Medicaid does require prior authorization, but it is not required until after a certain number of appointments.

SENATOR NEAL:
So you are trying to create parity, but it is already a patchwork based on the provider.

MS. FROST:
Based on the payer, yes.

SENATOR NEAL:
My next question is on section 6, subsection 4, which states that the cost of coverage of services to be provided in the home must not depend on the geographic location of that home. Talk to me about how that would work mechanically and logistically. I know you are trying to go across the board, but there are there regional confines to behavioral health services. We have essential healthcare providers who may focus in North Las Vegas or underserved areas only.

MS. FROST:
We wanted to achieve equity between people who live in the cities and people who live in rural settings. We are trying to make sure that regardless of where you live in the State, you are able to achieve the level of care you need.

WIL KEANE (Counsel):
Let me clarify the language in the bill. Section 6, subsection 4 was inserted to make sure that if coverage is provided in the home, it can be provided everywhere. It is intended to make sure policies are provided for everyone equally. Subsection 4 does not authorize people to provide care they would not otherwise be authorized to provide. If providers are limited as to the care they can provide, they cannot provide that care through telehealth in a manner they would not be able to provide in person.

I completely agree with Ms. Frost on section 4, subsection 3. The goal of subsection 3 is to make sure prior authorization is not imposed on telehealth or standard telephone use unless it is universally imposed. If the policy already requires prior authorization before getting this kind of service, you have to get the prior authorization if you are going to get it through telehealth or standard telephone.

Earlier, there was a question about WC coverage. That is covered in section 9 of S.B. 56, which extends this same coverage to policies of insurance that provide for WC.

SENATOR NEAL:
Section 8, subsection 2 of the bill talks about the State Plan for Medicaid and concerns the nonfederal share of expenses. How is such payment broken down now by geographic location?

MS. FROST:
I am not a Medicaid expert and cannot answer that question. I would be happy to research that and get back to you.

DUANE YOUNG (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
Medicaid does not set its rates differently based on geographic location. In fact, NRS 422 already demands pay parity from traditional telehealth and in-person services.

SENATOR LANGE:
Would children be included in this bill? In many instances, it is more beneficial for children to go to a therapist or a counselor in person for some of the reasons Senator Settelmeyer mentioned. Is this bill intended to cover only adults, or would it also include children?

MS. FROST:
This bill would include children, yes. Those decisions would be left up to the provider and the parent to decide the best and most effective way to provide services to the child.

SENATOR LANGE:
I know people who have used telehealth, and it has been beneficial to them. This is a great opportunity.

SENATOR SCHEIBLE:
I have questions about the dynamics you are working with and the information that led to this policy decision. Could you distill this for me? For example, in many cases consumers utilize telehealth because the alternative is to forego treatment entirely. The choice is not between telehealth and in-person treatment; it is between telehealth and nothing. Is that the situation we are running into most often?

MS. FROST:
Yes, that is the choice, especially during lockdown. Covid-19 did not do a whole lot to improve the mental health status of many residents of Nevada. Since the lockdown has been lifted, many have chosen telehealth because of their own fears. Consumers may also have vulnerable relatives living with them, and they do not feel comfortable leaving their homes. Some providers are now seeing consumers in person again, but that does not mean all consumers are willing or able to see providers in person.

SENATOR SCHEIBLE:
That leads to my second question. To the best of our ability, this bill strives to remove cost as a factor, because it will no longer be more expensive to be seen via telehealth than to go to the doctor's office. Is that right?

MS. FROST:
That is correct. This bill is about ensuring that providers are neither incentivized nor disincentivized to utilize telehealth when it is in the best interest of the consumer. It also does not mandate that the consumer has to use telehealth or that the provider can only use telehealth.

SENATOR SCHEIBLE:
I want to put a finer point on this. If we want to encourage people to go see their providers in person when possible, where possible, this policy would help to do that by removing a financial incentive to switch to telehealth. It would no longer be cheaper to be treated by phone or video than to go to the office.

MS. FROST:
That is correct.

SENATOR HARDY:
I do not know if I have questions that can be answered, but I will put them out. In the long run, the role of telehealth may be more an augmentation of in-person visits.

There is also a large difference between telehealth and standard telephone visits. If I cut off the videoconferencing camera, you cannot see me and do not see anything else I am doing. Being able to see the person when you are doing telehealth makes a difference. Some aspects of a visual meeting are hard to replace with anything else. When we videoconference, we take advantage of

seeing someone eye to eye. When you are dealing with couples therapy, you are interested in how they both look as opposed to standard telephone.

When you are looking at PTSD, how does WC fit into this? Section 7 talks about licensing and certification; how do we handle that?

A brick-and-mortar practice requires a different investment from a telehealth practice. I think the intent of the bill is to extend telehealth. The telephone is not as effective as telehealth because it lacks visual contact. Even telehealth is not that effective because, from a doctor's standpoint, it is hard to do away with the impression of touch.

In short, I do not think these three methods—telehealth, telephone and in-person visits—are equal.

MS. FROST:
We are not trying in any way to suggest that telehealth is equal to in-person visits. We know that some mental health modalities cannot be accomplished via telehealth and should not be tried. The same can be said for physical health. Though I can see my provider via telehealth, we are missing some of the pieces, such as the ability to touch. I have not been able to figure out a way to get a blood draw through telehealth, though I would be happy to try. Your provider may decide he or she needs to see you in person.

At the same time, we want to give mental health providers latitude to work with their individual patients, and for patients to have a voice in how their treatment is provided. We have seen some incredible things happen during the pandemic. I do not think any of us ever anticipated providing mobile crisis services through telehealth, and yet there we were. We know it is not optimal, but we also know we need to give consumers choices for how they receive services.

Unfortunately, we also need to prepare for a future where this type of situation may happen again, whether it is a pandemic, a natural disaster or some other problem. This bill is preparation for the future and what it may hold. We do not want to create barriers where they do not need to be.

SENATOR HARDY:
Doctors and therapists are already using telehealth. We have been talking to people on the phone for decades. This just allows them to be paid for it, which is great for everybody. It incentivizes providers to do more with telehealth, which perhaps incentivizes them to do less of the in-person visits. It is a conundrum. We need to strike a balance to see what works best for the consumer.

As a physician, sometimes I say, "No, I need to see you in person." If they say, "I don't want to," I say, "Well, I need to." So with telehealth, sometimes you are going to get into this quandary. The therapist knows that sometimes the best thing is to see the person in real life.

In general, I think this bill is great. I love the concept of getting more out of telehealth. I love the fact that we can get paid for doing something we have always done. But a standard telephone call falls far short of the real thing.

CHAIR SPEARMAN:
The U.S. Department of Veterans' Affairs (VA) has been using telehealth for some time. I will read to you from their webpage at <https://telehealth.va.gov/>:

> The U.S. Department of Veterans Affairs is leading the way in telehealth innovation to make sure Veterans can access care when and where they need it. VA Telehealth Services is transforming how Veterans access high-quality VA care. From your home, the clinic, or the hospital, VA telehealth technologies make it easier for you to connect with your VA care team.

During the pandemic, the VA hospital near me was closed; no one was going in, and everything moved online. I would like to think I got the same quality of care during that time. Is it possible to check with some people who are already doing it, and perhaps, like the VA, doing it right? That may help make this bill better, I do not know. If there is a way to do that, I would encourage you to do so.

Is S.B. 56 replacing or augmenting current policy?

MS. FROST:
In my opinion, this bill is an augmentation of mental health services.

CHAIR SPEARMAN:
In combat situations, telehealth is probably the only way the troops can get treatment. I saw it used when I was at the Pentagon before a lot of people were even talking about it. I would recommend you check with the VA, see what backstops they use to make sure it is ethical and the patient does not suffer. If it is an augmentation, that means the original way is always available.

SENATOR SETTELMEYER:
My daughters have both used telehealth during this pandemic. It increases availability, since some traditional businesses were shut down. I am supportive of the bill.

I need to ask a further question, though. Will this also cover mental therapy via text? I have found six businesses that provide this service. How does that work? How is that billed out? I cannot imagine that a person could text back and forth with a therapist for an hour. Will this bill also cover that?

MS. FROST:
That was not the intent, but I am willing to work on that issue if it is desired.

When the Board talked about telehealth, we were thinking of it as a matter of videoconferencing or using the telephone when videoconferencing was not available or feasible. We recognize that videoconferencing would be better than telephone only, but circumstances do not always allow it.

I did a tour of the rural regions in February and March 2020. Driving through many of those areas and talking to people who live there told me a lot about the issues they face with unstable internet. We do not have the infrastructure in place to allow everyone to use videoconferencing. We all know we need it; it is a budgetary issue primarily, but logistics are a factor as well. We just wanted to make sure people had the ability to access services, including those who live 200 miles from the nearest provider. None of us are saying everyone should use telehealth every time. We are saying we want them to have the ability to access those services regardless of whether they are rural or urban. If there are legitimate reasons they cannot access some sort of videoconferencing platform, they have the ability to access service via phone.

MR. KEANE:
As you can see in the bill, the various provisions being amended are provisions already in NRS authorizing telehealth for services in general that are provided by an insurer. The term "telehealth" may be misleading. Telehealth requires both audio and visual elements. Under existing law, you have to provide behavioral health services or any other services through telehealth, but only if it is both audio and visual. The nuance this bill provides for, among other things, is to allow behavioral health services to be provided by standard telephone—in other words, audio only. Under current law, you cannot do that; you must have both audio and visual. This bill says that for behavioral health only, you can provide services through audio only. That is what the bill means to do. I would not read this bill as allowing for texting without audio.

A question came up earlier with regard to other states. Many states have expanded telehealth services temporarily, not through legislation but through executive order. As far as making a more permanent change such as S.B. 56 is contemplating, New Hampshire, Colorado and New York have similar legislation right now.

STEVEN COHEN (Disability Self-Advocate):
I support S.B. 56 and agree with the testimony of Ms. Frost and Ms. Case.

JACQUELINE HARRIS (Licensed Marriage and Family Therapist, Licensed Alcohol and Drug Counselor):
I am in support of this bill. I am in private practice and am also a member of the Clark Regional Behavioral Health Policy Board and the Clark County Children's Mental Health Consortium.

Last March, due to the Covid-19 pandemic, my colleagues and I switched entirely from an in-person practice to telehealth within a number of days. I was completely telehealth for ten weeks and am currently a hybrid of in-person and telehealth based on client need and preference.

As a private provider of behavioral health, I support this bill for several reasons. First, the bill would allow for ongoing flexibility of service delivery. This would allow seamless provision of any service in telehealth as needed or requested by the client. I also support this bill for continuity of care. It allows clients to stay with their same providers versus switching to a new provider. Under some insurance policies, if clients want telehealth, they must end services with their

in-person provider, switch to the telehealth option, then continue with their in-person provider if they want that. I also support S.B. 56 due to enhanced access to care. It allows people who have transportation, childcare or healthcare issues to access services. Telephonic access is important for clients who may not have the access or the technological skills to use videoconferencing. Also, in the event videoconferencing technology fails, telephone access allows treatment to go forward.

ROBIN REEDY (Executive Director, National Alliance on Mental Illness Nevada):
The National Alliance on Mental Illness (NAMI) Nevada is in enthusiastic support of S.B. 56. This bill is an augmentation of existing law that adds a tool to the toolbox. It gives the decision of treatment to the doctor and the patient. Telehealth and telephone do have unique costs that are different from those of a brick-and-mortar business, and I am not sure whether they are less or more expensive. I would also like to address the fact that there are geographic differences in services across Nevada. Fee for services and managed care organization are different in Las Vegas versus Fernley.

I would also like to remind everyone that parity is still a problem. While it is still a federal law, there are a lot of exemptions to that law. Government providers do not have to follow the parity law. Parity is different unless you know how to complain about it. We enforce parity in Nevada by complaining to the Commissioner of Insurance. We do not proactively have insurance companies show that they are providing parity for behavioral health conditions. There are a lot more barriers to treatment for those who live with mental health conditions.

NANCY BOWEN (CEO, Nevada Primary Care Association):
We represent the State's eight community health centers, also known as federally qualified health centers. These centers were created to serve underserved populations and geographies. The majority of our patients have low incomes and are racial or ethnic minorities. A fifth of our patients come from rural Nevada counties.

As we rapidly expanded direct-to-patient telehealth services in response to the pandemic, we learned that not every patient has access to the devices and internet services that enable telehealth. This tracks with the U.S. Census, which estimates that 15 percent of Nevada households do not have broadband access. In 30 percent of zip codes, that number is 25 percent or greater. We know that many residents lack access to video telehealth, and those are the same

residents disproportionately left behind by the traditional healthcare delivery system and most affected by the current pandemic. Allowing audio only benefits to expire with the public health emergency would only reinstate access disparity that has long existed. We cannot afford to go backwards.

We believe that S.B. 56 is an excellent beginning to the discussion of adding audio-only telehealth to the current definition of telehealth in NRS. The Committee should approve this bill. We also believe this bill does not go far enough to expand primary care services allowed to audio-only telehealth. We urge the Committee to look for additional opportunities to expand these services.

JOAN HALL (Nevada Rural Hospital Partners):
We are in support of this bill, as it increases flexibility for those individuals experiencing behavioral health crises. Adding telephonic means a great benefit to seniors and lower-income residents in rural areas who do not have access to smart phones or tablet computers, and for those who have limited bandwidth. This bill expands access to behavioral health services to Nevadans who have difficulty with distance or transportation, as well as a lack of providers for behavioral health services in the rural areas. Providers will still often be housed in brick-and-mortar facilities and have the same costs: schedulers, billing, electronic health records, licensing fees and malpractice issues. Providing them adequate reimbursement is important to ensure they provide this service to us.

Senator Hardy's points are valid. Not being able to see people is very difficult. Not being able to see the visual cues we get from assessing patients in person is a disadvantage. But in the arena of behavioral health and in these times, this is better than not having access to these services at all.

We hope you will vote to pass this bill.

ADRIENNE MICHELSON:
I am in support of this bill primarily because this issue impacts communities in the rural counties and nonurbanized areas. I live in Las Vegas and recently had to use telehealth to find out that I had cancer. This telehealth appointment led to emergency surgery. I needed that telehealth appointment because I was unable to physically visit my physician. I had nephrotic syndrome; it caused my ankles to puff up and made it hard and challenging for me to move and access health care, even within minutes of my own house. In my case, access to

telehealth services was incredibly important and consequential for my health. It is no different for people who do not have access within a couple miles to quality and well-known mental and physical health care. They should have the opportunity to access quality health care even if it is by a telehealth appointment.

BARRY GOLD (AARP Nevada):
We support S.B. 56. We have certainly seen the value of telehealth during the pandemic. It has improved access to medical care and treatment. When people have been told to stay at home as much as possible, telehealth can be the only option available for medical appointments and services. By adding the use of standard telephone, S.B. 56 makes an important addition to the availability of services, which will help many Nevada families. Many low-income Nevadans lack access to videoconferencing, and they rely just on standard telephones to communicate. Many older Nevadans still rely on the old trusty telephone that plugs into the wall; they do not have cell phones with video capabilities. These groups should be able to have access to telehealth services using the equipment they currently have and can afford even if it is not optimal.

Transportation is also a huge barrier for many older Nevadans, lower-income citizens and people in the rural counties. Telehealth can bring routine and specialty health services to their homes when trips out are challenging or even dangerous. In addition, there are 350,000 family caregivers in Nevada who provide unpaid care to friends or loved ones, many of whom could benefit from broader access to telehealth. Family caregivers need help if they are to continue doing what they do, and telehealth is one way to provide this needed support.

On behalf of our 345,000 members across the State, AARP supports S.B. 56. It will improve access to health care by increasing the availability of telehealth to Nevada families who must rely only on standard telephones.

TOM CLARK (Nevada Association of Health Plans):
We are in opposition to S.B. 56. We appreciate the Legislature creating legislation in 2013 and 2015 that afforded the ability for innovation within healthcare services. As we continue to face the Covid-19 pandemic, making sure individuals and families can access care when needed is a priority for all of us. Telehealth options allow you to do so safely, securely and conveniently from your own home.

We have concerns about provisions regarding the use of audio only in behavioral health. With audio only, a telephone, the clinician is unable to appropriately assess the patient in ways that two-way live video provides, such as body language, surrounding environment and facial expressions.

The Nevada Association of Health Plans is in line with the Association of Behavioral Health and Wellness in its suggestion to seek input from the appropriate regulatory agencies and to conduct research as to whether behavioral health services provided via audio only are an effective long-term strategy to provide safe, quality, evidence-based and clinically appropriate care. It is currently unclear whether audio only is an appropriate way of providing service for all behavioral health treatments.

We also recommend that insurers continue to have the flexibility to negotiate prices to keep healthcare coverage affordable for all consumers. The payment parity provision is contradictory to telehealth's cost effectiveness. If telehealth can help reduce the cost of using the healthcare system and produce provider visits, it is contradictory to mandate that those services be paid the same.

Finally, we appreciate the flexibility in site location for a patient to access care. However, we do have a concern and a question with the "geographic location" language found in section 1, subsection 4 of the bill. Is that intended to extend beyond State lines? If so, we recommend language clarifying the provider is permitted or licensed to practice in the state in which the person is accessing care.

We have spoken with Ms. Frost and look forward to continuing to work with her.

MARCUS CONKLIN (Teladoc Health):
We are opposed to S.B. 56. We have submitted written testimony and a suggested amendment (Exhibit E).

We are supportive of what this bill is trying to accomplish in terms of being able to treat mental health patients using more traditional telephone methodologies. However, in an effort to find payment parity for brick-and-mortar doctors, the bill seems to sweep in organizations that provide telehealth services exclusively. We have talked with Ms. Frost about our concerns, and Exhibit E provides some suggested language to allow brick-and-mortar doctors to have payment parity

when they choose to treat patients via telehealth, but also to allow the market to determine rates on telehealth services as it pertains to those that exclusively provide telehealth. We are not wedded necessarily to the exact language in Exhibit E. We are willing to work with the bill's sponsor and the Committee to find language that works for Nevada and allows both services to go forward in a way that is healthy for the marketplace and conducive to patients and doctors.

CLAUDIA TUCKER (Teladoc Health):
The physician shortage is real. The shortage of mental health providers is even more critical. Virtual care is still valid health care. Just as technology has changed the way we bank, shop, travel and interact with others, technology has changed the way we deliver and receive health care. Senate Bill 56 has some good policy points: it does not require prior authorization for in-person visits, it is technology-neutral, it removes any geographic restrictions, and it does not require a reason why the patient has chosen telehealth over an in-person visit.

However, in addition to increased access to quality health care, telehealth also brings savings to both patient and payer. Because this bill requires that a telehealth visit be reimbursed at the same rate as an in-person visit, these savings will be removed and will create an artificial financial arrangement that does not exist today. Should a provider be reimbursed for behavioral health services offered through telehealth? Absolutely. If a provider can offer those services at a lower rate, should they be forced to remove the savings? No.

My point is not that brick-and-mortar practices should not be reimbursed at the full amount. They have overhead expenses that telehealth companies do not. Companies like Teladoc can provide quality health care and savings, and we currently do that in Nevada. In 2020, we were able to save patients and payers over $24 million in healthcare costs. This savings would be removed if this provision stays in the bill.

We support the work the Legislature is doing to help increase access to mental health services. The ability to use a telephone to expand the reach of mental health services to those who need it is critical. We ask that you also give one more tool to your residents by removing the reimbursement parity language in this bill and allow the savings telehealth brings to remain available to the residents of Nevada.

CHAIR SPEARMAN:
Do we have someone here who can address the fiscal note for this bill?

MR. YOUNG:
This bill has an approximate fiscal note of $32 million from the General Fund and $500,000 in county match funds. Per *Code of Federal Regulations* (CFR) section 410.78, telehealth services require audio and video equipment with interaction telecommunications. This was waived during the public health emergency. However, the Civil Rights Division within the U.S. Department of Justice has authority over the CFR and would have to take federal action in order to remove this provision requiring audiovisual within the telehealth component outside of the public health emergency. That is the demonstrated fiscal impact of the bill. If that federal regulation is not waived after the public emergency ends, the State would be responsible for both the State share and the federal share of any of these services provided through a platform that is not compliant with the Health Insurance Portability and Accountability Act.

The bill also has other implications in regard to cost-based reimbursed providers. The cost of methodology is built on their infrastructure. Those who are providing mostly in-person services would have a higher cost methodology, while those providing telephonic services would have a lower cost built into their methodology. This would tie the Division's hands to appropriately assess costs for cost-based reimbursed providers.

JOANNE MALAY (Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
We are neutral on S.B. 56. We stand ready and able to provide behavioral health services via videoconference or telephone.

CHAIR SPEARMAN:
I will close the hearing on S.B. 56 and ask Mr. Melgarejo to work with both sides to find acceptable language on this bill.

CHAIR SPEARMAN:
Is there any public comment? Hearing none, we are adjourned at 9:41 a.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
S.B. 56	B	1	Char Frost / American Psychiatric Association	"Support for Permanent Expansion of Telehealth Regulations after Covid-19"
S.B. 56	C	1	Lesley R. Dickson / Nevada Psychiatric Association	Support Letter
S.B. 56	D	1	B. Eliot Cole	Support Letter
S.B. 56	E	1	Claudia Tucker / Teladoc Health	Written Testimony and Proposed Amendment