

DAVID S. BENTZ
STATE REPRESENTATIVE
18th District



**HOUSE OF REPRESENTATIVES
STATE OF DELAWARE
411 LEGISLATIVE AVENUE
DOVER, DELAWARE 19901**

COMMITTEES
Health & Human Development, Chair
Energy, Vice-Chair
Appropriations
Joint Finance
Labor
Natural Resources

House Health and Human Development Committee Meeting Minutes
April 21, 2021

Chair Bentz called the virtual meeting to order at 11:00 a.m. He stated that the meeting was planned in accordance with HCR 1 and took the roll call of the committee's members. Members present included Vice Chair Minor-Brown and Reps. Chukwuocha, Johnson, Baumbach, Heffernan, Morrison, Kowalko, Lynn, Postles, Shupe, Smith, Briggs King, Hensley, and Collins. For a list of guests present please see the attendance list below.

Chair Bentz introduced **SB 73 with SA 1, AN ACT TO AMEND TITLE 24 OF THE DELAWARE CODE RELATING TO LICENSE TO PRACTICE DENTISTRY.**

Chair Bentz, the prime sponsor of the bill, explained that this bill permits an individual to practice dentistry for the Division of Public Health (DPH) under a provisional license. Delaware law provides several routes for entering practice on a provisional basis until full licensure can be obtained, but no routes currently allow hiring by DPH with the intent to practice in state supported dental clinics, assisting DPH with recruiting dentists to serve those needs.

Rep. Collins shared his recent difficulty with seeking dental care and indicated there seems to be a need for the bill.

Chair Bentz opened the floor to public comment.

Anne Farley of the Delaware Dental Society spoke in support of the bill, highlighting the Dental Society's commitment to increasing access. She explained that in Delaware, 98 percent of publicly insured kids live within 15 minutes of a Medicaid dentist, there has previously been a loan repayment program that incentivized density to move here, as well as a robust residency program.

A motion was made by Rep. Baumbach and seconded by Rep. Briggs King to release SB 73 with SA 1 from committee, the motion carried. Yes = 15 (Chair Bentz, Vice Chair Minor-Brown, Reps. Chukwuocha, Johnson, Baumbach, Heffernan, Morrison, Kowalko, Lynn, Postles, Shupe, Smith, Briggs King, Hensley, Collins); No = 0; Absent = 0. The bill was released from committee with a F=8, M=6, U=0 vote.

Chair Bentz introduced **SB 77, AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE COMMUNITY-BASED NALOXONE ACCESS PROGRAM.**

Chair Bentz, the House prime sponsor of the bill, explained that this legislation expands the Good Samaritan law by clarifying that a lay individual who administers naloxone under the community-based naloxone access program is protected from civil liability for rendering emergency care. He stated that the bill comes from the Behavioral Health Consortium and that it is a bill promoting harm reduction, attempting to ensure individuals feel comfortable administering naloxone in the case of an overdose.

Chair Bentz opened the floor to public comment.

Dave Humes of AtTack Addiction shared that as a part of a Behavioral Health Consortium subcommittee he engaged with businesses in the construction industry which employs many individuals recovering from substance abuse. He shared that when they offered to come in and do naloxone trainings the company's insurance was concerned about liability. He stated that the Department of Justice rendered an opinion that they would advise an exemption be added into the Delaware code exempting lay people from liability. Mr. Humes stated that statistics show Delaware is first in the nation in per capita prescribing of high dosage, long-acting opioids, and recently has become second in the nation in per capita overdose deaths, with the largest increase of 18 percent. He further stated that 50 percent of individuals released from incarceration die of an overdose within 3 months of release and that 75 percent of inmates released die of an overdose within 1 year of release. Mr.

Humes emphasized the importance of this legislation in removing barriers to naloxone access and saving lives.

A motion was made by Rep. Hensley and seconded by Rep. Smith to release SB 77 from committee, the motion carried. Yes = 15 (Chair Bentz, Vice Chair Minor-Brown, Reps. Chukwuocha, Johnson, Baumbach, Heffernan, Morrison, Kowalko, Lynn, Postles, Shupe, Smith, Briggs King, Hensley, Collins); No = 0; Absent = 0. The bill was released from committee with a F=8, M=6, U=0 vote.

Chair Bentz introduced **HB 160, AN ACT TO AMEND TITLES 18 AND 24 OF THE DELAWARE CODE RELATING TO PRESERVING TELEHEALTH AND ADOPTING THE INTERSTATE MEDICAL LICENSURE COMPACT.**

Chair Bentz, the prime sponsor of the bill, explained that steps taken by the Governor during the COVID-19 pandemic to remove regulations and barriers to accessing telemedicine which the General Assembly codified in June 2020 with a sunset provision of June 2021. He said that over the last year these measures have had a lot of value for patients in improving efficiency and care delivery.

Chair Bentz stated that this bill removes the requirement that a patient present in-person prior to receiving telemedicine and waives the absolute requirement that video be utilized, which is important as there are parts of the State where broadband internet is not as reliable, which often are the same areas where there are provider shortages.

Chair Bentz further shared that the bill enters Delaware into the Interstate Medical Licensure Compact (IMLC) with 29 other states, breaking down jurisdictional barriers that may prevent a Delawarean from seeing a practitioner licensed and located in another state via telemedicine. He explained that while a Delawarean can drive to another state to receive care, the telemedicine requirement is based on where the patient is located, creating limitations to accessing telemedicine.

Rep. Baumbach commented that pandemic has shown how critical access to telemedicine is and stated that he is pleased that they have the opportunity to review strengths and weaknesses of the system and strengthen these measures with this bill.

Rep. Heffernan shared that the Division of Libraries is working to set-up private rooms with computer access to enable individuals without internet access at home to have telehealth appointments at the library.

Chair Bentz opened the floor to public comment.

Susan Conaty-Buck of the Delaware Coalition of Nurse Practitioners and Delaware Nurses Association thanked the Chair and the committee for their work in expanding telemedicine access. She explained the problem of practitioners needing licenses for different states to see telemedicine patients across state lines because having additional licenses results in additional fees for practitioners. She stated the concern that if patients would like to have an appointment while they are at work across state lines, they must drive over the border for it to occur, resulting in a suboptimal care setting. Ms. Conaty-Buck stated that while the Coalition supports the bill, they would like to see the expansion of telemedicine for nurse practitioners as the IMLC does not allow nurse practitioners to be covered. She referenced a different bill before the legislature that would allow Delaware to join an Advanced Practice Registered Nurse (APRN) compact which would allow Nurse Practitioners to practice across borders. This would need to be adopted by the bordering states as well as at least 7 states nationally to go into effect.

Robert Overmiller spoke in support of the bill, explaining the benefit of telehealth in increasing access to care for him personally.

Wayne Smith spoke in support on behalf of the Delaware Healthcare Association, explaining the particular benefit to people who have difficulty accessing transportation, those with disabilities, and those with limited internet access. He also stated the importance having Delaware licensure in the IMLC, providing the State appropriate oversight to ensure the public is protected.

Christina Cammarata spoke on behalf of Neumors and spoke to the particular benefit to behavioral health. She shared that in 2019 only 3 percent of visits were done via telehealth which increased to 74 percent in 2020. She explained the increased access to care telehealth provides as patients have more flexibility in their appointments when they don't have to spend time traveling to the clinic, as well as giving providers a better understanding of home life which can assist with developing treatment. She stated that the provision allowing phone calls will enable access for individuals not previously able to utilize services due to transportation and internet barriers. Ms. Cammarata emphasized the importance and growing need for behavioral health services which telehealth can help meet.

Sue Voltz is the administrator of the telehealth program at Neumors, she explained how the COVID-19 pandemic established telehealth as a standard of care. She stated that a challenge in continuity of care is the limitations on providers treating existing patients via telehealth when a child or young adult travels to a neighboring state on vacation or at college and affirmed her support for the bill.

Carolyn Petrak of the Ability Network of Delaware spoke in support, explaining that while their members are eager for programs to return to normal operations, they appreciate having another means by which they can access services. Ms. Petrak stated that making telehealth services permeant is imperative to the workforce crisis facing the disability and behavioral health workforce. She explained that the demand for mental health and substance use disorder treatment are increasing and that it is important to offer those seeking services more options on how and where they access them, as well as ensuring that all providers have the ability to offer an array of service options and receive equitable reimbursement for providing them.

Verna Hensley of Easter Seals spoke in strong support of the bill and explained the importance of telemedicine in continuing their care for children with delays or disabilities at critical times and ensuring they do not regress. She stated that being able to access services through telemedicine increases access as some families are more comfortable receiving services virtually or provides an option in the case of the child or a sibling being sick and unable to come in-person.

Aleks Casper spoke in support for the American Lung Association of Delaware, emphasizing the importance of the bill in increasing access to care in underserved communities.

Meredith Tweedie of Christiana Care spoke in support, highlighting the fact that telehealth reduces patient no-show rates dramatically and the importance of joining the IMLC in being able to continue to offer telehealth services to patients and families in Delaware.

Nicole Freedman spoke on behalf of the American Heart Association in support, stating that telehealth can make healthcare more accessible and efficient to help address the health inequalities which have been exposed and exacerbated by the COVID-19 pandemic. They requested that the telehealth language also be included in the Medicaid statute to ensure consistency across payers, beneficiaries, and patients.

Chris Haas spoke on behalf of Delaware Insurance Commissioner Trinidad Navarro and the Department of Insurance in support of the bill, highlighting its ability to make progress in increasing access to patients. She encouraged Delawareans to seek telemedicine providers through their insurers or confirm they are in network. She explained that the Department of Insurance is investigating IMLC to better understand if there could be unintended consumer cost by potentially expanding access to care that is out of network.

After the conclusion of public comment, Vice Chair Minor-Brown inquired about the barriers to care that Ms. Conaty-Buck referenced.

Chair Bentz explained that this bill will facilitate more use of telemedicine for nurse practitioners within Delaware to Delawareans, there are problems with expanding it beyond Delaware's borders due to licensures. The interstate compact (IMLC) applies to physicians and does not extend to APRNs and nurses. Chair Bentz stated that the Interstate Nurses Compact referenced would address this issue and supplement this bill very well.

Rep. Postles clarified that the nurse practitioners can still treat patients within Delaware, which Chair Bentz confirmed.

Chair Bentz explained that nurse practitioners will see the same intrastate expansions that physicians have, the bill is just unable to address practicing interstate for APRNs as the compact is only for physicians. To break down the jurisdiction barrier that the IMLC does for physicians, an additional compact specific to APRNs would be needed.

Rep. Baumbach confirmed that this bill does not cause any backward movement for nurse practitioners, just not quite as much progress forward as physicians, which Chair Bentz confirmed.

A motion was made by Rep. Smith and seconded by Vice Chair Minor-Brown to release HB 160 from committee, the motion carried. Yes = 15 (Chair Bentz, Vice Chair Minor-Brown, Reps. Chukwuocha, Johnson, Baumbach, Heffernan, Morrison, Kowalko, Lynn, Postles, Shupe, Smith, Briggs King, Hensley, Collins); No = 0; Absent = 0. The bill was released from committee with a F=9, M=5, U=0 vote.

Chair Bentz adjourned the meeting at 11:52 a.m.

Respectfully submitted,
Chelsea Chatterton

Speaker List:

- Anne Farley (Delaware Dental Society)
- Dave Humes (AtTack Addiction)
- Susan Conaty-Buck (Delaware Coalition of Nurse Practitioners and Delaware Nurses Association)
- Robert Overmiller
- Wayne Smith (Delaware Healthcare Association)
- Christiana Cammarata (Neumors)
- Sue Voltz (Neumors)
- Carolyn Petrak (Ability Network of Delaware)
- Verna Hensley (Easter Seals)
- Aleks Casper (American Lung Association of Delaware)
- Meredith Tweedie (Christiana Care)
- Nicole Freedman (American Heart Association)
- Chris Haas (Delaware Department of Insurance)



April 21, 2021

Chair Bentz, Vice-Chair Minor-Brown and Members of the House Health and Human Development Committee:

Thank you for the opportunity to provide comments on House Bill 160, the Telehealth Access Preservation and Modernization Act of 2021 sponsored by yourself and Senator McBride. The American Lung Association supports this bill.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 37 million Americans living with lung diseases including asthma, lung cancer and COPD, including over 112,000 Delaware residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association believes that everyone should have affordable, accessible and adequate healthcare coverage. Throughout the COVID-19 pandemic, telehealth has emerged as vital way for patients to safely access care. In August of 2020, the Lung Association and its partners agreed to [principles on telehealth](#). House Bill 160 aligns with these principles as it expands telehealth services and makes the flexibilities permitted during the COVID19 pandemic permanent practice in Delaware.

Telehealth has been an important delivery method for improving access to care in underserved communities and in particular rural areas, those with physician shortages and areas with limited access to primary care services. The COVID-19 pandemic has placed a spotlight on the role of telehealth allowing many high-risk patients to continue to receive timely and safe care and treatment while maintaining their safety. While many of the flexibilities in telehealth policy have been time-limited, the American Lung Association strongly believes that all patients should have continued safe access to appropriate telehealth services after the COVID-19 pandemic to help reduce gaps in care.

House Bill 160 allows for permanency in a number of strong telehealth policy measures including improving access through easing technology barriers by permitting audio-only communication which is critical for rural and low-income populations which might lack broadband internet access. The bill also makes permanent the ability for providers to establish relationships via telehealth, rather than telehealth being limited to patients and providers with existing relationships. This can help address shortages of specialist providers in a geographically convenient area.

The American Lung Associations believes the definition of originating site is too vague, as it allows payors and providers to determine what is appropriate. While, both providers and payors have an interest in the definition of originating site, during the Public Health Emergency, many patients have appreciated the flexibility of originating site to include their homes. The Lung Association and our partners believe originating site requirements should be eliminated to provide patients flexibility to access care when they need it. We encourage you to amend the bill to allow for additional flexibility around the originating site requirements.

The American Lung Association believes that telehealth is a critical piece of access to care for many patients and will continue to ensure that patients have timely and safe health care services and treatments. We applaud the legislature for addressing these needs during the midst of the pandemic and appreciate the willingness to allow these flexibilities to remain permanent beyond the pandemic. We would encourage a favorable vote from the House Health & Human Development Committee of House Bill 160 and encourage swift passage by the Delaware General Assembly.

Sincerely,

A handwritten signature in cursive script that reads "Aleks Casper".

Aleks Casper
Director of Advocacy
American Lung Association



Principles for Telehealth Policy

Background

Telehealth has long been an important care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. However, the COVID-19 pandemic has highlighted the role of telehealth in helping patients continue to receive timely and safe health care services and treatments from their providers. Telehealth -- including telemedicine and telemental health -- helps reduce gaps in access to services and care, including access to primary care and specialized providers when in-person visits are not a safe or feasible option.

In response to the public health emergency, federal and state agencies provided new, and in some cases time-limited, flexibilities to increase access to telehealth. Our organizations believe telehealth can and

should be used to increase patient access to care and stand ready to work with Congress, the Administration, and state governments, to ensure that all patients can continue to safely access appropriate telehealth services during and after the COVID-19 public health emergency.

Principles

Our 35 patient and consumer advocacy organizations believe that affordable, accessible, and adequate health insurance is key to improving the health and wellbeing of all people living in the United States. As such, we believe that legislation or regulations concerning telehealth should meet the following principles:

1. **Improving Access through Equitable Coverage:** Telehealth services should be covered by all health plans including, but not limited to, Medicare, Medicaid, the ACA Marketplace, and other federal and state regulated commercial health plans. Telehealth has become an essential tool to access care during the current COVID-19 pandemic and can help improve access to care over the long term. We support policies that expand coverage of essential telehealth services for all plans and payers.
2. **Improving Access through Easing Technology Barriers:** Telehealth services should be equitably available through easily usable technologies that are accessible to people with disabilities, with limited English proficiency, and limited technology. The option of audio-only communication is especially important for rural and low-income populations, as many of these patients lack internet access.
3. **Preserving and Promoting Patient Choice:** A patient should have the opportunity and flexibility to choose whether they will access care in-person or via telehealth technologies.
 - I. Patient Cost-Sharing Obligations: We support policies that limit patients' out-of-pocket costs for telehealth services to be no more than their in-person equivalent. When telehealth is an appropriate option, payers should not incentivize patients to seek out one setting over another for their health care; the decision to seek care in-person or virtually should be left to patients and their providers and be made on a case-by-case basis. Limiting patients' cost-sharing requirements for telehealth care to the rate for corresponding in-person services will ensure the patients are neither incentivized nor disincentivized from using the right care setting for them. We also support additional patient protections from excessive cost-sharing that may emerge as telehealth grows.
 - II. Provider Payment: We support policies that enable providers to offer virtual services, where appropriate, to their patients. As described above, the payer should not promote one care modality over another; the decision about receiving a service telehealth or in-person should be a case-by-case decision between a patient and his/her provider. Payers should reimburse providers at a sustainable rate that allows them to continue offering this option to their patients.
 - III. Utilization Management: Utilization management tools should not be used by health plan payers to push providers or patients towards a particular care setting or to determine or limit visit frequency for telehealth appointments.
 - IV. Network Adequacy: Telehealth should supplement, not supplant, provider networks. Plans must maintain in-person networks to existing or stronger network adequacy requirements. Plans must also ensure that patient referrals to other providers, including specialists, are

valid when made by a telehealth provider or through a telehealth visit. Plans should also list telehealth capabilities in provider directories.

4. **Removing Geographic Restrictions:** Geographic restrictions place a burden on and can limit both patients and providers when evaluating treatment options for optimal care.

- I. Originating Sites: Originating site requirements should be permanently eliminated to ensure that patients are not required to travel to specific locations to access telehealth services unless special equipment is necessary for an examination by a remote provider. Before the COVID-19 pandemic, Medicare rules largely limited use of a patient's home as the originating site to those living in rural areas or with a specific condition. The drastic spike in telehealth usage during the public health emergency has shown the futility of geographic restrictions and that, in many cases, it is appropriate and safe for patients to receive care from their homes.
- II. Inter-state Access: Allowing providers to practice across state lines through telehealth services will increase access to care and improve care coordination for patients, particularly in underserved areas. We support policies that promote the provider-patient relationship and care coordination, acknowledging that an established, in-person relationship between provider and patient may be essential for proper diagnosis and treatment. Telehealth can play an important role in follow-up care and should not be restricted by the provider's licensing state. Therefore, we support policies that would ensure patient access to necessary providers that are in good standing in their home state, even if that provider is out of state.
- III. Remote Monitoring: Remote monitoring is essential for patients with chronic conditions. Allowing providers to access patient information in real time could help reduce emergency room admissions and improve health outcomes. We support policies that remove barriers to remote monitoring through compliant technologies in order to promote the health and safety of patients.

5. **Protecting Patients and Provider Legal Rights:** Health plans should clearly define what telehealth services are covered; providers must use technology compliant with patient privacy, disability access, and civil rights law. This information should be transparent and easy to understand for consumers.

6. **Increasing the Evidence Base for Telehealth:** As telehealth becomes more common, data must be collected and more research must be conducted on the usage and outcomes of telehealth, with special attention to promoting health equity in order to determine how telehealth technologies should be designed and implemented so that all populations have equal access to their potential benefits. To this end, demographic data must be collected, including race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socio-economic status, insurance coverage and geographic location. Data must be collected in accordance with patient privacy laws and with opt-out procedures.

Alpha-1 Foundation

ALS Association

American Cancer Society Cancer Action Network

American Diabetes Association

American Heart Association

American Kidney Fund

American Lung Association
Arthritis Foundation
Cancer Support Community
Chronic Disease Coalition
Crohn's & Colitis Foundation
COPD Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Juvenile Diabetes Research Foundation
Leukemia & Lymphoma Society
Lutheran Services in America
Mended Hearts & Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
United Way Worldwide
WomenHeart: The National Coalition for Women with Heart Disease



Verna Hensley
Testimony re: HB 160
Easterseals Delaware & Maryland's Eastern Shore

Good morning. My name is Verna Hensley and I am the Vice President of Public Affairs at Easterseals Delaware & Maryland's Shore. We are the largest provider of Early Intervention Services in the state. Because of telehealth, Easterseals therapists have been able to maintain life-changing therapies to children at the most critical developmental time of their life – age's birth to 3. In the past year, Easterseals served 885 children, and being able to deliver services via telehealth meant that children with delays or disabilities had access to much needed intervention.

I wish there were time to share with you the countless success stories that teletherapy has allowed to happen. Here's one: When Easterseals services were shut down last year due to COVID, Stacey and Chris were so grateful to have the therapists serving their daughter, Blaire Marie, pivot to teletherapy via zoom.

Her mom, Stacey, says: "By having services during COVID, Chris and I knew our daughter wouldn't regress in meeting her goals. At the end of March, Blaire Marie was feeding herself, she rolled over in April and began to prop-sit in May, all thanks to Easterseals therapy services! Blaire Marie picked up with in-person services beginning in September and she has continued to soar ever since."



The role of therapists has always been to coach our families to support their child's development so that they can teach and practice new skills during their time together at home or in the community. At a time when many parents and children are spending *even more* time together at home, we had an opportunity. Through teletherapy, we had and need to continue to have the opportunity to prevent regression and to help parents continue to be empowered as a part of their child's success.

Since reopening, Easterseals is once again offering therapy at home and in daycares for children who respond best in that environment. However, we also can continue to offer teletherapy to families who still want to receive therapies virtually. And, we can switch to teletherapy when the family has been advised to quarantine.

Easterseals enthusiastically supports HB 160 and the permanent authorization of telehealth.

Thank you.



April 21, 2021

TO: The Honorable David Bentz, Chair
The Honorable Melissa Minor Brown, Vice-Chair
Members of the House Health and Human Development Committee
411 Legislative Avenue
Dover, DE 19901

FROM: Jocelyn I. Collins, Delaware, Maryland, & Washington, D.C. Government
Relations Director
American Cancer Society Cancer Action Network
555 11th St. NW, Suite 300
Washington, DC 20004
jocelyn.collins@cancer.org
(301) 254-0072 (cell)

SUBJECT: HB 160 AN ACT TO AMEND TITLES 18 AND 24 OF THE DELAWARE CODE
RELATING TO PRESERVING TELEHEALTH AND ADOPTING THE INTERSTATE
MEDICAL LICENSURE COMPACT

POSITION: SUPPORT

Dear Chair Bentz, Vice-Chair Minor Brown and Members of the House Health and Human Development Committee,

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. We support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. On behalf of our constituents, many of whom have been personally affected by cancer, we thank you for the opportunity to provide public comments on HB 160. ACS CAN stands in strong support of this legislation.

Research shows that while overall cancer mortality rates in the U.S. are dropping, populations that have been marginalized are bearing a disproportionate burden of preventable death and disease. And despite notable advances in cancer prevention, screening, and treatment, not all individuals benefit equitably from this important progress.

Telehealth provides cancer patients and survivors with a convenient means of accessing both cancer care and primary care. Thanks to technology, many face-to-face encounters with patients and their health care providers can be supplemented by or, in some cases, substituted with telehealth visits that enable providers to deliver clinical services from a distance using options like video conferencing and remote monitoring. Telehealth -- including telemedicine and telemental health -- helps reduce gaps in access to services and care, including access to primary care and specialized providers when in-person visits are not a safe or feasible option. This is an particularly important option for individuals in rural areas of the country and those who are immunocompromised.

COVID-19 has further highlighted the important role of telehealth in helping patients continue to receive timely and safe health care services and treatments from their providers. While many of the flexibilities in telehealth policy have been time-limited, ACS CAN strongly believes that all patients should have continued safe access to appropriate telehealth services after the COVID-19 pandemic to help reduce gaps in care.

HB 160 allows for permanency in a number of strong telehealth policy measures, including, improving access through easing technology barriers by permitting audio-only communication which is critical for rural and low-income populations which might lack broadband internet access.

ACS CAN applauds the Delaware General Assembly for addressing these needs during the midst of the pandemic. We ask for a “favorable report” from the House Health & Human Development Committee and encourage swift passage of HB 160.

I can be contacted at jocelyn.collins@cancer.org or **301-254-0072** with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Jocelyn I. Collins". The ink is dark and the signature is fluid.

Jocelyn I. Collins

Telehealth for People Living with and Beyond Cancer



Thanks to technology, many face-to-face encounters with patients and their health care providers can be supplemented by or, in some cases, substituted with telehealth visits that enable providers to deliver clinical services from a distance using options like video conferencing and remote monitoring. Telehealth provides cancer patients and survivors with a convenient means of accessing both cancer care and primary care – a particularly important option for individuals in rural areas of the country and the immunocompromised. For example:

Cancer Screening

When family history and/or results of a genetic test require a conversation with a genetic counselor before and/or after the test, video chat with a genetic counselor can be a viable option.

Cancer Diagnosis

Telehealth can provide greater access to clinicians and researchers who specialize in cancer subtypes which can improve the diagnostic process and treatment planning.

Cancer Treatment

Clinicians can offer remote care, such as care planning with shared decision-making, second opinions on treatment plans, chemotherapy supervision, and symptom management via telehealth when appropriate.

Clinical Trials

Telehealth can positively impact clinical trials through new technologies and devices and virtual visits, which can improve the collection of data in clinical trials and make it easier for patients to enroll, and improve diversity in trial subjects.

Survivorship

Survivorship plans to address the late and long-term side effects of cancer treatment while monitoring for a possible recurrence and taking specific steps to prevent recurrence can be developed by survivorship experts remotely as needed.

Improving Health Equity

Telehealth can increase access to quality cancer care among underserved populations (e.g. residents of rural communities, individuals with limited income, patients with low health literacy, and people of color).

Telehealth Experiences

ACS CAN, through the [Survivor Views](#) program, asked a cohort of cancer patients and survivors about their experience with and interest in telehealth (pre COVID-19). Of those who used telehealth a majority of respondents found it *Very Useful* (84%) or *Somewhat Useful* (11%), primarily because they were able to speak to their provider sooner, the telehealth visit took less time than going into the provider's office, and/or they found the telehealth visit more convenient than having to leave their home.

A particular benefit of telehealth emerged during the coronavirus pandemic - cancer patients vulnerable to COVID-19 could video chat with their providers from the safety of their home without risking additional exposure to the virus. ACS CAN again surveyed its Survivor Views cohort to ask about the use of telehealth when in-person visits were disrupted by the pandemic. More than half (54%) of respondents reported having a medical appointment that could not be conducted in-person since the beginning of the COVID-19 pandemic. When this happened, nearly half (49%) of respondents reported rescheduling the appointment to occur via video. The pandemic has demonstrated the importance of adaptable policies around telehealth that allow patients to reap the optimal benefits of telehealth.

Limitations

Telehealth visits are not always appropriate; procedures and certain services like physical examinations require in-person care. In addition, users must have sufficient health literacy and affordable access to technology (e.g. smartphone, access to broadband) to use telehealth effectively. Not all patients are able to voice their needs in a video chat but can in-person. Likewise, providers may be better able to recognize patients' concerns in-person than through a video chat or telephone call. Many people simply prefer to talk to their providers in-person.

As more providers offer telehealth options and as more third-party payers expand their coverage of telehealth services, more patients are expected to utilize telehealth options. However, limitations, such as state licensing laws, geographic-, location-, and technology-based restrictions can create barriers that can limit the appropriate use of telehealth.

ACS CAN Position

ACS CAN supports the use of telehealth services that meet the following set of principles:

Patients' and survivors' use of telehealth must always be voluntary.

- ACS CAN finds significant merit for telehealth for cancer patients and survivors who choose to use it but would not support legislation and third-party efforts to require the use of telehealth in lieu of in-person visits, efforts to limit face-to-face interactions, and efforts to steer patients into telehealth against their will.
- ACS CAN believes that patients must always have the option to see providers in-person after a telehealth visit and must not be limited to only telehealth services.

Telehealth cannot replace all face-to-face visits.

- ACS CAN believes that, with rare exceptions when remote visits are the only option, telehealth must supplement but not replace traditional in-person care.

Requirements for face-to-face visits before a telehealth encounter may not always be warranted for certain telehealth visits.

- ACS CAN would be particularly supportive of removing face-to-face requirements in instances where a patient uses telehealth services in order to obtain a second opinion from experts who are not readily accessible.
- ACS CAN does not believe that a requirement for at least one face-to-face visit is necessary when the telehealth visit does not result in a prescription. ACS CAN believes that telehealth initial visits that lead to a prescription for non-schedule drugs can be acceptable under two conditions: 1) that there is a synchronous telehealth interaction between the patient and prescriber and, 2) that the health care provider conducts an appropriate clinical evaluation for the individual patient according to the patient's symptoms and diagnosis.

Telehealth should not be used for purposes of determining network adequacy.

- ACS CAN does not support state or federal policies that would include the availability of telehealth services to be counted towards a health plan's network adequacy determination.

Patients' privacy must be protected.

- ACS CAN would oppose any weakening of privacy protections and may support strengthening protections if technological advances warrant.

Third-party payers should cover telehealth visits.

- ACS CAN supports parity for telehealth visits with in-person visits.

ACS CAN recognizes the need for third-party payers to protect themselves against fraudulent billing.

- ACS CAN recognizes that third-party payers must institute reasonable practices (such as monitoring provider payments for telehealth services and ascertaining that providers do not bill more than what would be expected) to protect themselves against fraudulent billing.

Governments should foster patients' and survivors' voluntary use of telehealth.

- ACS CAN encourages federal and state governments to continue to make it easier for patients to take advantage of appropriate telehealth services.

Broadband technology should be expanded to make access to telehealth viable.

- ACS CAN encourages federal and state governments to do more to bring broadband technology to rural areas. (e.g. help to fund broadband expansions and to support the placement of the necessary equipment). In expanding broadband technology, federal and state governments must remember that affordability is an important component of access in all geographical locations.

Advancing Health Equity in Cancer Care Through Telehealth



Research shows that while overall cancer mortality rates in the U.S. are dropping, populations that have been marginalized are bearing a disproportionate burden of preventable death and disease. And despite notable advances in cancer prevention, screening, and treatment, not all individuals benefit equitably from this important progress.

For example, we know that:

- Hispanic, Latinx, American Indian, and Alaskan Native adults are least likely to have a usual place to go for medical care;
- Individuals living in the South and Midwest are less likely to have been screened for colorectal cancer than those in the Northeast and Mid-Atlantic;
- Low-income cancer patients who live in non-Medicaid expansion states are 3.5 times more likely to be uninsured, and thus less likely to receive early stage diagnosis of lung, breast and, colorectal cancers; and
- Individuals from low-income households are less likely to be included in clinical trials.

Health Equity in Cancer Care

Everyone should have a fair and just opportunity to prevent, find, treat, and survive cancer.

Telehealth can help to reduce these disparities and improve health outcomes for all individuals, regardless of race, ethnicity, gender, age, sexual orientation, socioeconomic status, or zip code by providing cancer patients with a means of accessing both cancer care and primary care. Advancements in telehealth have allowed for many face-to-face encounters with patients and their health care providers to be supplemented by or, in some cases, substituted with visits that enable providers to deliver clinical services from a distance using options like video conferencing and remote monitoring.



The use of appropriate telehealth services for cancer patients in under-resourced communities can advance health equity through:



Mitigating transportation barriers faced by rural communities or individuals who lack reliable transportation to medical care



Extending the reach of navigation services so that more patients get access to resources that help eliminate other barriers to care

Increasing access to specialty care that may not be available near an individual's home



Alleviating barriers related to taking off from work or finding childcare to attend medical appointments



ACS CAN Position

ACS CAN supports the use of telehealth services that meet the following set of principles:

Patients' and survivors' use of telehealth must always be voluntary.

- ACS CAN finds significant merit for telehealth for cancer patients and survivors who choose to use it but would not support legislation and third-party efforts to require the use of telehealth in lieu of in-person visits, efforts to limit face-to-face interactions, and efforts to steer patients into telehealth against their will.
- ACS CAN believes that patients must always have the option to see providers in-person after a telehealth visit and must not be limited to only telehealth services.

Telehealth cannot replace all face-to-face visits.

- ACS CAN believes that, with rare exceptions when remote visits are the only option, telehealth must supplement but not replace traditional in-person care.

Requirements for face-to-face visits before a telehealth encounter may not always be warranted for certain telehealth visits.

- ACS CAN would be particularly supportive of removing face-to-face requirements in instances where a patient uses telehealth services in order to obtain a second opinion from experts who are not readily accessible.
- ACS CAN does not believe that a requirement for at least one face-to-face visit is necessary when the telehealth visit does not result in a prescription. ACS CAN believes that telehealth initial visits that lead to a prescription for non-schedule drugs can be acceptable under two conditions: 1) that there is a synchronous telehealth interaction between the patient and prescriber and, 2) that the health care provider conducts an appropriate clinical evaluation for the individual patient according to the patient's symptoms and diagnosis.

Telehealth should not be used for purposes of determining network adequacy.

- ACS CAN does not support state or federal policies that would include the availability of telehealth services to be counted towards a health plan's network adequacy determination.

Patients' privacy must be protected.

- ACS CAN would oppose any weakening of privacy protections and may support strengthening protections if technological advances warrant.

Third-party payers should cover telehealth visits.

- ACS CAN supports parity for telehealth visits with in-person visits.

ACS CAN recognizes the need for third-party payers to protect themselves against fraudulent billing.

- ACS CAN recognizes that third-party payers must institute reasonable practices (such as monitoring provider payments for telehealth services and ascertaining that providers do not bill more than what would be expected) to protect themselves against fraudulent billing.

Governments should foster patients' and survivors' voluntary use of telehealth.

- ACS CAN encourages federal and state governments to continue to make it easier for patients to take advantage of appropriate telehealth services.

Broadband technology should be expanded to make access to telehealth viable.

- ACS CAN encourages federal and state governments to do more to bring broadband technology to rural areas. (e.g. help to fund broadband expansions and to support the placement of the necessary equipment). In expanding broadband technology, federal and state governments must remember that affordability is an important component of access in all geographical locations.



Principles for Telehealth Policy

Background

Telehealth has long been an important care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. However, the COVID-19 pandemic has highlighted the role of telehealth in helping patients continue to receive timely and safe health care services and treatments from their providers. Telehealth -- including telemedicine and telemental health -- helps reduce gaps in access to services and care, including access to primary care and specialized providers when in-person visits are not a safe or feasible option.

In response to the public health emergency, federal and state agencies provided new, and in some cases time-limited, flexibilities to increase access to telehealth. Our organizations believe telehealth can and

should be used to increase patient access to care and stand ready to work with Congress, the Administration, and state governments, to ensure that all patients can continue to safely access appropriate telehealth services during and after the COVID-19 public health emergency.

Principles

Our 35 patient and consumer advocacy organizations believe that affordable, accessible, and adequate health insurance is key to improving the health and wellbeing of all people living in the United States. As such, we believe that legislation or regulations concerning telehealth should meet the following principles:

1. **Improving Access through Equitable Coverage:** Telehealth services should be covered by all health plans including, but not limited to, Medicare, Medicaid, the ACA Marketplace, and other federal and state regulated commercial health plans. Telehealth has become an essential tool to access care during the current COVID-19 pandemic and can help improve access to care over the long term. We support policies that expand coverage of essential telehealth services for all plans and payers.
2. **Improving Access through Easing Technology Barriers:** Telehealth services should be equitably available through easily usable technologies that are accessible to people with disabilities, with limited English proficiency, and limited technology. The option of audio-only communication is especially important for rural and low-income populations, as many of these patients lack internet access.
3. **Preserving and Promoting Patient Choice:** A patient should have the opportunity and flexibility to choose whether they will access care in-person or via telehealth technologies.
 - I. Patient Cost-Sharing Obligations: We support policies that limit patients' out-of-pocket costs for telehealth services to be no more than their in-person equivalent. When telehealth is an appropriate option, payers should not incentivize patients to seek out one setting over another for their health care; the decision to seek care in-person or virtually should be left to patients and their providers and be made on a case-by-case basis. Limiting patients' cost-sharing requirements for telehealth care to the rate for corresponding in-person services will ensure the patients are neither incentivized nor disincentivized from using the right care setting for them. We also support additional patient protections from excessive cost-sharing that may emerge as telehealth grows.
 - II. Provider Payment: We support policies that enable providers to offer virtual services, where appropriate, to their patients. As described above, the payer should not promote one care modality over another; the decision about receiving a service telehealth or in-person should be a case-by-case decision between a patient and his/her provider. Payers should reimburse providers at a sustainable rate that allows them to continue offering this option to their patients.
 - III. Utilization Management: Utilization management tools should not be used by health plan payers to push providers or patients towards a particular care setting or to determine or limit visit frequency for telehealth appointments.
 - IV. Network Adequacy: Telehealth should supplement, not supplant, provider networks. Plans must maintain in-person networks to existing or stronger network adequacy requirements. Plans must also ensure that patient referrals to other providers, including specialists, are

valid when made by a telehealth provider or through a telehealth visit. Plans should also list telehealth capabilities in provider directories.

4. **Removing Geographic Restrictions:** Geographic restrictions place a burden on and can limit both patients and providers when evaluating treatment options for optimal care.

- I. Originating Sites: Originating site requirements should be permanently eliminated to ensure that patients are not required to travel to specific locations to access telehealth services unless special equipment is necessary for an examination by a remote provider. Before the COVID-19 pandemic, Medicare rules largely limited use of a patient's home as the originating site to those living in rural areas or with a specific condition. The drastic spike in telehealth usage during the public health emergency has shown the futility of geographic restrictions and that, in many cases, it is appropriate and safe for patients to receive care from their homes.
- II. Inter-state Access: Allowing providers to practice across state lines through telehealth services will increase access to care and improve care coordination for patients, particularly in underserved areas. We support policies that promote the provider-patient relationship and care coordination, acknowledging that an established, in-person relationship between provider and patient may be essential for proper diagnosis and treatment. Telehealth can play an important role in follow-up care and should not be restricted by the provider's licensing state. Therefore, we support policies that would ensure patient access to necessary providers that are in good standing in their home state, even if that provider is out of state.
- III. Remote Monitoring: Remote monitoring is essential for patients with chronic conditions. Allowing providers to access patient information in real time could help reduce emergency room admissions and improve health outcomes. We support policies that remove barriers to remote monitoring through compliant technologies in order to promote the health and safety of patients.

5. **Protecting Patients and Provider Legal Rights:** Health plans should clearly define what telehealth services are covered; providers must use technology compliant with patient privacy, disability access, and civil rights law. This information should be transparent and easy to understand for consumers.

6. **Increasing the Evidence Base for Telehealth:** As telehealth becomes more common, data must be collected and more research must be conducted on the usage and outcomes of telehealth, with special attention to promoting health equity in order to determine how telehealth technologies should be designed and implemented so that all populations have equal access to their potential benefits. To this end, demographic data must be collected, including race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socio-economic status, insurance coverage and geographic location. Data must be collected in accordance with patient privacy laws and with opt-out procedures.

Alpha-1 Foundation

ALS Association

American Cancer Society Cancer Action Network

American Diabetes Association

American Heart Association

American Kidney Fund

American Lung Association
Arthritis Foundation
Cancer Support Community
Chronic Disease Coalition
Crohn's & Colitis Foundation
COPD Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Juvenile Diabetes Research Foundation
Leukemia & Lymphoma Society
Lutheran Services in America
Mended Hearts & Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
United Way Worldwide
WomenHeart: The National Coalition for Women with Heart Disease