CHAIRPERSONS: Senator Mary Daugherty Abrams, Representative Jonathan Steinberg

SENATORS: Anwar, Haskell, Hwang, Kasser, Kushner, Moore, Somers

REPRESENTATIVES: Arnone, Berger-Girvalo, Betts, Carpino, Cook, Dauphinais, Demicco, Elliott, Foster, Genga, Gilchrest, Green, Kavros DeGraw, Kennedy, Klarides-Ditria, Linehan, McCarty, Parker, Petit, Ryan, Tercyak, Young, Zupkus

REP. STEINBERG (136TH): And on a happy note, perhaps we should convene the joint hear – Public Hearing of the Insurance and Real Estate and Public Health Committees.

Good morning, everyone. We have really only one topic to share today. That is Telehealth; something critical to our success during the pandemic, such as it was, and for, potentially, future improvements to access and quality of healthcare in the state of Connecticut.

Before we get to that an opportunity for Chairs and Ranking Members to comment. I'll turn first to my Co-Chair, Senator Mary Daugherty Abrams, good morning.

SENATOR DAUGHERTY ABRAMS (13TH): Good morning, Representative Steinberg. I'm Senator Mary Daugherty Abrams. I represented 13th District, and I'm the Co-Chair of Public Health. I agree with your comments that this has been critical during the pandemic, and it's also shown that it could be critical for us moving forward. So it's one of the

things that we have been lucky enough to find out during this pandemic might be very valuable, even as we move out of the pandemic. So I'm excited for our hearing today. I think we'll find out a lot of good information and how we can make this work best for the people of Connecticut. Thank you.

REP. STEINBERG (136TH): Thank you. And now, we'll turn to the Co-Chairs of the Insurance and Real Estate Committee. Good morning, Senator Lesser.

SENATOR LESSER (9TH): Good morning, Mr Chairman. And I'm Senator Matt Lesser. I am the Senate Co-Chair of the Insurance and Real Estate Committee.

And it's a privilege to be able to work with our colleagues and friends over at the public health committee on this important issue, a year ago -- overnight, and we saw a transformation in the -- in the delivery of healthcare, as folks adjusted to the pandemic through the adoption of Telehealth.

Some of the initial work was done by the Federal Government and through Executive Order by Governor Lamont. But then, subsequently, the Legislature came in and made certain changes to tell how, first of all, we extended out the dates to today, which has now been extended by Executive Order to April 19 but, more significantly, we also opposed additional rules.

One, requiring payment parity that providers get paid the same amount for Telehealth visits, as in-person visits and also prohibiting restrictions on the Use of technological platforms. And so those are things that are in the law that expires actually today. But we have an opportunity as a Legislature to hear from the public about what Telehealth was -- should moving forward. There are a lot of issues to figure out and we're hoping to hear from you. And we've got a narrow time between now and April 19th to figure that out in collaboration with the public and excited for a spirited discussion today.

REP. STEINBERG (136TH): Thank you, Mr. Chairman. And now to your Co-Chair, Representative Wood.

REP. WOOD (29TH): Thank you, Mr. Chairman. Yeah. First off, the Governor's Executive Order, giving us a little bit of breathing room. We realized how important this is to hear from Members of the Public and how we can put the best Telehealth Bill forward and look forward to the discussion. Thank you.

REP. STEINBERG (136TH): Very good. And now, we'll move to Ranking Members. We can kill two birds with one stone by going next to Senator Hwang, who is ranking on both committees.

SENATOR HWANG (28TH): Thank you, Mr. Chair. And indeed, I am Senator Tony Hwang. I am the Co-Ranking Chair on the Public Health Committee, as well as the Ranking Member on the Insurance and Real Estate Committee.

I am very eager to engage in this conversation and and to echo Chairwoman Wood's comment that on the heels of the Governor's Executive Order, this is, obviously, a public health issue. And we're glad to have a collaborative partnership with the -- with the joint committees to be able to talk about this issue.

I think, another important component that I hope that we will garner from these public testimonies is the aspect of mental health, in regards to mental health -- in regards to Telehealth. So I'm very eager to engage in this conversation.

But I also wanted to to also share with the audience that there are many other Committee hearings going on today. So for those that may be not present know that they're very interested and engaged in this issue, but, nonetheless, they have other obligations and commitments in different committee. So thank

you for the opportunity to engage and I appreciate the importance of this hearing.

REP. STEINBERG (136TH): Thank you, Senator. And it is important to point out that and a number of members both these committees may also be on committees that are also having hearings today or testifying before those committees, so we'll all be in and out trying to listen, as much as we can to every speaker today.

Next up, Senator Somers. Are you there? I have no chance to look. I don't see Senator Somers. Why don't we move on to Representative Petit then?

REP. PETIT (22ND): Thank you, Mr. Chair. In accordance, every else is a critical issue for our constituents to be able to see their providers if they have still issues with COVID or issues with transportation, or otherwise, for their routine care and for their sick care as well, especially at this time when we face many mental health challenges, so I think it's critical for us to move forward. Thank you, sir.

REP. STEINBERG (136TH): Thank you. And Representative Pavalock-D’Amato. Perhaps not here as well. Again, we're all moving all over the place today. So it's -- I'm sure everybody will chime in when they are able to get back. Now I could just find a list of who's up.

We will go to a number -- one of the list -- interestingly, we have no elected officials to speak today, which will save a lot of time. First up is number one, Stan Soby, followed by Rosa Guzman. Good morning, Stan.

STAN SOBY: Good morning, Representative Steinberg, and also Senator Lesser, Senator Daugherty Abrams, Representative Wood, Senator Hwang and Representative Petit and Members of the Insurance and Real Estate and Public Health Committees.

I'm Stan Soby, Vice President for Public Policy and External Affairs of Oak Hill. Oak Hill has been providing services to people with disabilities for 127 years through community-based programs, involving education-assistive technology and advocacy through over the -- over people's life spans.

We do this in -- we have 20 distinct programs, some 150 locations in 73 Connecticut towns. We employ 1,700 professionals to successfully helped me to changing needs of close to 40,000 people with disabilities each year and we are proud to be among the 400 plus members of the Alliance of Voice of Community Nonprofits.

I'd like to thank you for the opportunity to provide testimony in support of House Bill 5596 and Senate Bill 1022 AN ACT CONCERNING TELEHEALTH. We support your efforts to codify the expansion of Telehealth services that have occurred over the past year ensuring that Connecticut continues to pay for Telehealth is same rate as in-person visits and allows services to be delivered from any setting, allows telephonic/audio-only sessions and allows the use of any HIPAA compliant platform.

We have seen during the pandemic that Telehealth has provided people a chance to talk to their providers without adding to crowds and risk and waiting room, eliminating transportation concerns and childcare issues for low-income enroll patients and reduce staff and client exposure to the coronavirus.

There have been numerous report showing that patient engagement is higher for scheduled appointments done virtually rather than physically. And I know from personal, family experience the benefit of Telehealth specifically for mental health to Senator Hwang's point.

We hope that new federal funding will be used to offset the significant costs to providers of building the Telehealth infrastructure. This is a promising results suggest continuing to use of these systems after reopening the state will continue to lead to increased service delivery, efficiency, and effectiveness.

And there's another opportunity this critical time, as we all move forward to expand into other areas where Telehealth is proven to be beneficial and efficient.

People with intellectual and developmental disabilities often over utilized emergency departments, because of their medical complexity, communication barriers and residential settings lacking the regulatory administrative leeway to do anything other than refer medical questions that cannot be resolved immediately to the nearest emergency department.

Not only is this extraordinary expensive for health systems, but it can be immensely taxing on the person. There are systems used in a number of other states ...

ALEXANDRA DOROTINSKY: Mr. Soby --

STAN SOBY: That provide teleheath --

ALEXANDRA DOROTINSKY: You've reached the three minutes if you'd like to conclude.

STAN SOBY: I would like to conclude, and I have additional information in testimony about the use of Telehealth in this way and certainly ask the committees to pass robust Telehealth legislation going forward. Thank you very much for your time this morning.

REP. STEINBERG (136TH): Thank you for your testimony. I'll start with a question. All of us

care very deeply about the needs of the disability community. And you made mention to the fact that there are-- there are proven examples of how Telehealth can be effective in helping this community gain access. When you say proven is just based upon experience and other states or what's the basis for that?

STAN SOBY: And this has been -- this has been used in other states, so that there's diversion from the emergency department. We use for folks that we support. They have their individual Community providers, but those people are not available at certain hours of the day, and the referral goes to the emergency department, as opposed to a service of appropriately licensed medical providers, who could be part of that diversionary process, give guidance and do this all telephonically with a -- with an agency nurse and meeting the needs of the individual having them have to be assessed at the emergency department in person.

REP. STEINBERG (136TH): Thank you for that. As you're probably aware, the State of Connecticut lags somewhat behind other states. We've been a little reluctant to get out in front of the beta tester on some of the technologies out there. Are you concerned at all about having appropriate safeguards, guardrails, if you will, to make sure that Telehealth is used appropriately? I'm not just talking about potential for fraud but we're really assuring quality of care.

STAN SOBY: Yes, I think there's -- if you look at populations, generally, the there's data on the quality of care, certainly other states have seen improvements when they've used this model. That information is available, I'd seen in, probably, let's say, five states immediately that have used this. New York, Missouri, South Carolina Tennessee, Indiana are some of the ones that I've picked up on. And so, there are states that have made this work and we're certainly concerned about making sure that

it's the best possible care, meets everyone's needs HIPAA-compliant, all of those things, and that can be done.

REP. STEINBERG (136TH): Thank you. Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you, Mr. Soby. So it seems that the -- one of the bigger issues for your clientele is that the use of telephonic visits. Would you -- would you say that's the biggest issue or are there any other nuts and bolts issues that your clients face in terms of trying to participate with teleheath?

STAN SOBY: Thank you for the question, Representative. I think the issue now for providers is less the technology used, but having things in place to be able to use the technology that we've all built up to.

And part of it, too, is the need, and I would certainly hope that in the legislation, there'd be the authority to the relative state agencies and guidance to work out of the different policies and procedures, directives, and those kinds of things so thinking, the Department of Developmental Services, the Department of Public Health, the Department of Social Services to be able to put the regulatory and policy mechanisms in place for this to happen, successfully.

REP. PETIT (22ND): Thank you, Mr. Soby. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you, Representative. Senator Hwang.

SENATOR HWANG (28TH): Thank you, Mr Chair. Mr. Soby, thank you and to Oak Hill for the great work that you do, in helping the IDD community.

Obviously, one of the big questions, even without Telehealth, is your reimbursement from the services you perform, on behalf of the state. Where do you see that reimbursement right now relative to your already existing Telehealth services? Are they on par with your current reimbursements for other services?

And number two, will you need some infrastructure, as well as additional training for yours -- clinicians and support services going into the new world of Telehealth?

STAN SOBY: Thank you for your question, Senator, in terms of rate reimbursement, because we are not using the Telehealth on the IDD side to that great extent, particularly around the medical are Gilead Community Services, our mental health affiliate is using.

And because the payments have been on par that's been a help. In terms of our services, we would certainly want to have this costs covered both from the technology piece, although we've we've ramped up our infrastructure.

But also in the -- for the service providers and the time that our staff use. Because all of this time will be less expensive than the cost of the emergency department. And we would certainly hope that the funding would be on a par to be able to cover those costs.

SENATOR HWANG (28TH): Thank you, again. Thank you very much for your organization's good work. And the last question, I had is from a standpoint of funding, right now, are -- your funding from the state an extension of the federal COVID funding or is it part and parcel of a standard appropriations in the state?

I guess the point of the question is, are you looking at a potential funding cliff if these

federal funds dry up down the road or are you an integral part of your budgeting right now part of the appropriations component of our budget process?

SENATOR LESSER (9TH): The -- we've certainly testified in terms of the budget going forward about the need to fully fund the cost of living services. We have been flat -- funded in our rates for now 14 years. That -- during that time consumer price index is increased 28% and which is not insignificant. And the alliance has calculated that loss of funds in the system at $481 million.

So it is significant. And hopefully, through what we have learned during the pandemic, what we have seen work, where we can see the efficiencies that the funding can be there to deliver the services that people need.

And, again, using this kind of a model in this instance diverts people from the Emergency Department when that's not the needed alternative but it's the only one available significantly, decreasing costs and other parts of the healthcare system.

SENATOR HWANG (28TH): Yeah, it's interesting, you say that you've been flat funded for the last 14 years. I believe you you didn't have any flat funding for at least the previous 12 years. And the last couple of years, we have made some efforts to to fairly reimburse your organizations.

In fact, one of the things that I remember as being a significant point of concern, one of the biggest cost factors for your organization is transportation. And I know, there was some feedback in regards to additional cost of of increasing gasoline tax or even tolls would have a devastating impact on your organization's ability to provide critical services. If we increased fees or taxes on on your transportation, would that have a

devastating impact on your ability to do business providing service?

SENATOR LESSER (9TH): Mr. Chairman, Mr. Chairman?>

REP. STEINBERG (136TH): Yes. The Chair recognize Senator Lesser for a moment. Point of order?

SENATOR LESSER (9TH): Point of -- point of information. I, obviously, we -- tolls and whatnot are important issues, but should members constricts their remarks to the content to the two Bills before us?

REP. STEINBERG (136TH): I take your point and we're going to try to be very efficient here today, but I do believe transportation issues are pertinent. Maybe not explicitly tolls, but certainly transportation access is a factor. I'll provide the Senator a little leeway on this. But thank you, Senator.

SENATOR HWANG (28TH): Well, I appreciate that, Mr. Chair, and I will end my question on that. But I want to close again by saying thinking Oak Hill's and all of our alliance and nonprofits for the great work that they do, and I appreciate the indulgence of the Chair. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you, Senator. Senator Lesser?

SENATOR LESSER (9TH): Yes, thank you, Chairman. I just have one question that we had gotten. I -- first of all, I don't see written testimony from Oak Hill on this Bill. Has that been submitted?

STAN SOBY: Yes, it has, Senator.

SENATOR LESSER (9TH): Okay, great. I'll see if we can check with our Committee Courts to make sure that that gets out. But one specific recommendation, I received about a potential changes

to our Telehealth laws were to be -- to allow asynchronous communication -- texting, for example, back and forth. Is that something that would be useful to Oak Hill clients or is that not really something that would be important to the community that you serve?

STAN SOBY: The people -- it's less useful to people with intellectual and developmental disabilities that we serve but, certainly, would be -- have potential benefit for our affiliate -- the people served by our affiliate Gilead Community Services, in terms of a different means of making contact. And I do know that that is used in other states to be able to facilitate the Telehealth process.

SENATOR LESSER (9TH): Thank you appreciate it. And I'm -- you -- I think the Chairman for the time.

REP. STEINBERG (136TH): I see no further questions for you. Thank you for your testimony today. Greatly appreciate it. A good way for us to start off.

STAN SOBY: Thank you, sir. Next up, we have Rosa Guzman in our Committee's 68 hours of hearings. This is the first time we'll have someone assisted by a translator. Welcome, Ms. Guzman, and your translator as well, Mr Cusack. Please proceed. Just make sure you're muted taken off.

ROSA GUZMAN: (translation) Okay. Okay, go ahead. Good morning, Members of the Committee. My name is Rosa Guzman. I am a Community Clinician at Capital Region Mental Health Center. I am also speaking on behalf of Southwestern Connecticut Mental Health System and Connecticut Mental Health Center in New Haven.

This service provides cultural and linguistic accessibility to the people who want people -- the

Deaf and Hard of Hearing Community, who wish to make use of our counseling services.

Telehealth is really very useful as an adjunct to our agency in that it allows us to continue providing auditory and visual access to counseling for our clients when face to face, counseling can't be provided.

Face to face counseling can only be provided or cannot be provided, not only because of COVID. But, in some cases, our clients physical disabilities may not permit them to travel to come to see culturally and linguistically appropriate services in our office.

We really depend very much on the Telehealth services to continue communication with our clients. It allows us to see our clients and their environments in a way that makes it possible for our counselors to see both the clients presentation and their living situation, which can be used in making appropriate diagnoses for the clients condition and situation.

It also assist us in appropriate provision of services. Telehealth includes the use of video phones or other media, which permits full visual communication between the client and the counselor. It's essential -- an essential tool in providing access to mental health and counseling services for the community we serve. Thank you very much for your attention.

REP. STEINBERG (136TH): Thank you for your testimony. One question for you With your experience, would you suggest that Telehealth services in the State of Connecticut are adequate for the need you describe, or is there more that we need as a state to do to be able to support Telehealth for this -- these uses?

ROSA GUZMAN: (translation) Right now, the clients seem to be fairly satisfied with the way we're providing services through Telehealth. They seem to be more -- feel more validated at being able to communicate with us through video phones or other computer meeting. So it's very important. And I think what we're providing now is sufficient. It could always be expanded, of course.

REP. STEINBERG (136TH): Thank you for that. Next up, we have Senator Abrams, followed by Representative Betts.

SENATOR DAUGHERTY ABRAMS (13TH): Welcome. It's nice to have you here today. I had a question about some criticism that i've heard in using Telehealth when it comes to counseling. And that is that people don't have the privacy that they might need to be able to engage in a counseling session in their home. So I just wondered, you know what your experience has been with that?

ROSA GUZMAN: (translation) Liz Cote wants to add an -- would like to answer your question. Elizabeth Cote, can we see her on the screen?

REP. STEINBERG (136TH): Yeah, Elizabeth will be coming up next in that.

SENATOR DAUGHERTY ABRAMS (13TH): Yes.

REP. STEINBERG (136TH): And that, you're the interpreter for both of them, perhaps we'll just hold off on the answering that question until it's her turn.

SENATOR DAUGHERTY ABRAMS (13TH): Yes, that's fine, we can wait and hold off. And I'll ask Liz that question. That's not a problem. Thank you --

ROSA GUZMAN: (translation) Okay, it's fine. Good, thank you.

SENATOR DAUGHERTY ABRAMS (13TH): And thank you for the work that you're doing. And I want you to know that I -- I'm a supporter of this, but I have heard that criticism, so I just wanted to see what your experience to them, so thank you so much.

REP. STEINBERG (136TH): Thank you, Senator. Representative Betts.

REP. BETTS (78TH): Good morning. And thank you, Mr. Chairman. And thank you, Mr. Soby for your testimony. I'm curious that during this time of the pandemic, have you seen a noticeable increase or need for mental health services?

And what has been the role or the success or no success of Telehealth in providing services to people who are depressed, isolated, struggling? I wonder if you could just comment on that in general?

ROSA GUZMAN: (translation) Could you repeat the question? I'm sorry. I wasn't sure you were asking me, so I missed some of it. Would you ask me again?

REP. BETTS (78TH): Certainly. Through the Chairman, COVID has become a serious problem for many people in the state, and they're suffering from conditions, such as depression, isolation, anxiety. And i'm wondering what the role of Telehealth has been, in terms of helping your clients address those issues or is Telehealth not able to address those issues?

ROSA GUZMAN: (translation) Oh, yes. It definitely is able to address those issues. It helps to reduce isolation and loneliness, depression. Many of our clients have experienced depression and isolation due to the COVID pandemic, and Telehealth is very, very helpful.

We can see their faces, we can see how they're interacting with people, they can call us anytime

whenever they need some extra help or some kind of support anytime during the day.

They can call us all during the day or during the week. I can see them and see their effects and see how they're behaving, and I can really understand how they're -- really, the full picture of how they're feeling.

And I can see, sometimes it makes the client feel very relieved to be able to talk to somebody. And many times the client isn't able to come to the Office for many issues, not necessarily COVID, but other problems as well. And they don't show up for their appointments they missed the opportunity to have a counseling session with us.

And through Telehealth, they can just stay home and they don't have to worry about whatever kinds of problems are making it difficult for them to get to our office. There's a transportation service called Veyo and we've always had a lot of problems with them. That's the service we use.

But our clients are very frustrated, they're very -- and it makes them more depressed more anxious because Veyo isn't very good at getting them where they need to be, and to tell health services reduces a lot of those feelings.

REP. BETTS (78TH): Great. Thank you very much for your answer. And thank you, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. And i'll add. Yes, we all are concerned about Veyo. And if you have examples and instance you want to share with it -- with either committee, with regard to how to improve Veyo, we're interested in that as well. We can deal with that offline.

I see no further questions. Thank you for your testimony today. We really do appreciate it. We're going to now invite in Elizabeth Cote. Mr. Cusack

will remain as interpreter. Thank you, again, Ms. Guzman. Welcome, Elizabeth.

ELIZABETH COTE: (translation) Good morning, Members of the Committee. I am here representing the Southwestern mental health system. I'm a social worker for the Deaf and Hard of Hearing Community, and I've been doing that for many years.

We would like to provide our support for the continuance and, if possible, expansion of Telehealth services. If we can also add captioning to those services that makes it easier for some of our clients to understand what's going on, people who may not sign very well, perhaps, people who became deaf later, people who don't use it for communication.

This is -- the teleheath services have been very helpful, particularly during this COVID pandemic. It's possible for us to see our clients, to see their expressions, to see their body language and to understand better how they're feeling and how they're reacting. And whether we need to recommend them to our mobile crisis team, or if possible ask them to come in for one-to-one counseling services, if they can do that.

If the teleheath services are down, the deaf and hard of hearing client -- the deaf and hard of hearing clients can come in for one to one -- one-on-one counseling sessions in person.

I would encourage strongly for the Telehealth services to be come permanent because it provides audio and visual access and communication for our clients.

And there really are no problems with HIPAA issues, because the video phone system is completely private. There are no other people involved in the call. It is only the counselor and the client. And no one else has access to that information.

It's difficult for our clients to find linguistically and culturally appropriate counseling services in the state. There really aren't very many places, only Capital Region, Southwest, Connecticut Mental Health System and Connecticut Mental Health Center have deaf and hard of hearing counselors who can work with that community.

REP. STEINBERG (136TH): Okay. Why don't we go directly to Senator Abrams who had a question earlier that, perhaps, you could answer.

SENATOR DAUGHERTY ABRAMS (13TH): Welcome, Ms. Cote, thank you for being here. My question was have you heard anything from your clients about having enough privacy in their home?

I know there's privacy between -- you know, in the connection between themselves in the counselor but, having enough privacy in their homes to really take advantage of using counseling services through Telehealth. Has that been an issue at all?

ELIZABETH COTE: (translation) In my experience in the past several years, I haven't had clients complaining about that. I believe you're referring to a situation of, perhaps, people or experiencing domestic violence in their homes in a situation like that.

That might be a concern that their domestic partner might be able to hear them making that kind of a -- of a call. But it's possible actually to use cell phones to connect to our office.

There is a system whereby you can communicate on a cell phone so they can actually get out of their own homes and communicate with us that way. They have other alternatives, rather than the video phone setup in their homes.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much. Appreciate that. Thank you for the work you're doing.

REP. STEINBERG (136TH): Thank you, Senator. One more question for you. You made mention of the use of captions. I'm not really familiar with the technical capabilities of many of the tools used for Telehealth. Is that a standard feature, or is it easily added to your knowledge?

ELIZABETH COTE: (translation) Well, captions on the video phone -- it's just like a telephone except it -- except it's visual and there are no captions on the video phone.

But sometimes some of the online tools like Microsoft teams, if the state would approve are using that, captions are available on that system, generally, most of my clients sign or they're oral and have some hearing, so I haven't had to use captions.

But if it were necessary, it would be nice if we could make that modification and allow us to use a system that will allow the addition of captions. The standard video phone does not.

But if we use a system like Microsoft teams, that does allow the addition of captions. And I don't know we have to talk to people who are responsible for approving that sort of thing to see if that can be approved.

REP. STEINBERG (136TH): Thank you for that. And, obviously, some of what we talked about today is really dictated by the federal reimbursement schedule, but I would imagine that the technology platform that is used there may be some flexibility.

So it's very helpful to us to know which platforms actually facilitate the kind of communication that

unique, so that's really very important to us.
Thank you.

I don't see any further questions. Thank you for your testimony today. Thank you, Mr. Cusack, for your assistance with these two speakers. We really do appreciate it. Next up, we have Susan Miklos, followed by number four, David Borzellino. Susan?

SUSAN MIKLOS: Good morning, honorable Members of the Public Health Insurance and Real Estate Committees. How are you? Thank you for having -- given me the opportunity to provide testimonies supporting S.B. 1022 with an amendment and HB5596. I asked you to support S.B. 1022 and H.B. 5596 regarding Telehealth.

I'm asking for a friendly amendment to S.B. 1022 to include dental hygienists, as well as dentists, with the dentists. We're both licensed professionals here in the State of Connecticut.

Telehealth and teledentistry is the use of electronic imaging and communication technology with active video to provide support in the delivery of diagnosis, consultation, treatment, patient education, transfers of patient information and triage of the patients.

During the COVID pandemic, this has become something of a need. And it's -- was instrumental prior to COVID for patient health. And, as we know, oral health is systemic with whole body health, so it's quite important, especially in these hard times.

There's a lot of different reasons for this. It's improved dental health and dental hygiene with the patients, its affordability. It reduces the cost of the patient in driving and traveling and transportation. It's very innovative with what technology is doing now, and what we should be doing moving forward.

It's a modern communication. It reduces the patient's time away from work. It actually reduces their loss of wages, but it does provide the same level of care as an office visit.

Patients appreciate the triage capability of the dental hygienists and speaking with the dentist. And it's been recognized throughout our country. We actually have, in this -- United States, we have 21 states that are already actively in this practice.

It opens up the road to access and removes a lot of barriers for both delivery and receipt of services. The current data presents that the Telehealth and teledentistry having benefits through the pandemic. And it's a novel solution in facilitating guidance at dental treatment in education. Does anybody have any questions?

REP. STEINBERG (136TH): Thank you for asking. Usually, we're the ones asking the questions here. But I have one for you.

SUSAN MIKLOS: Yes.

REP. STEINBERG (136TH): In the dental professional sphere, you make mention of its use, where for treatment and for information exchange. One of the areas that we've always been a little reluctant to get into is the aspect of diagnostics. And i'm very curious as to the limits that you see in the dental sphere, for doing anything beyond sort of routine treatment, information exchange. Are you concerned at all about it being used for any sort of diagnostic purposes?

SUSAN MIKLOS: Well, in the State of Connecticut, as you know, the dentist is the diagnostician in dentistry, that dental hygienists doesn't do any diagnostics, but we are able to do an assessment.

Having the teledentistry is very instrumental. I met a public health facility right now. And if a

child walked in here and there wasn't any kind of dentist here, I can actually have a communication and a safe, secure line where the doctor could actually visualize that abcess and be able to do the treatment or the protocol that would be appropriate for that child.

So it does help because I'll take the X-ray into the triage part of it, and then the doctor could move forward, whether it's an antibiotic that needs to be -- the doctor needs to give an antibiotic and have a conversation with that parent, so it's very helpful.

REP. STEINBERG (136TH): Thank you for that. I don't see any further questions for -- no, wait a minute. I have -- don't have my screen in the right place. I still don't see any questions for you.

Thank you for your testimony today. We really appreciate it. I'm hopeful we get to talk to all the different specialty areas before we're done today, so it's great to get some insight in the dental profession. Thank you.

SUSAN MIKLOS: Thank you. Have a great day.

REP. STEINBERG (136TH): You too. I understand next up that is actually number five, Daniel Weiner, followed by a number six, Lisa Taylor-Austin. Daniel? Which one of you is Daniel?

DANIEL WEINER: I am, sir.

REP. STEINBERG (136TH): Oh, I'm sorry. Did I skip someone? I -- my apologies, Daniel. I might have actually. I -- my apologies. I forgot Susan Miklos was next, and then you'll be after that, if you don't mind.

DANIEL WEINER: Not at all.

REP. STEINBERG (136TH): My apologies. I screwed up, and then it took me four people in -- to mess it up. Susan?

SUSAN MIKLOS: Yes, how are you?

REP. STEINBERG (136TH): Good. Oh, so you already went? Okay.

SUSAN MIKLOS: Yes.

REP. STEINBERG (136TH): There are other people there, and then I got very confused. All right, Daniel. You're up.

DANIEL WEINER: Good morning, and thank you to the Public Health Insurance and Real Estate Committees for reviewing these bills, an act concerning mental -- Telehealth. My name is Daniel Weiner, and I'm the Co-Owner of Family Resource and Development Center and Pharmacy.

REP. STEINBERG (136TH): I'm going to interrupt you, sir. Your volume is a little low. If you could jack it up just a little bit, we'd appreciate it. Go ahead.

DANIEL WEINER: Can you hear me any better?

REP. STEINBERG (136TH): Little bit.

DANIEL WEINER: Yeah, I'm trying to figure out how to raise the volume.

REP. STEINBERG (136TH): We're all learning.

DANIEL WEINER: I'm so sorry. Let me see. I'll try to shout. How's that?

REP. STEINBERG (136TH): All right. Well, that sounds good.

DANIEL WEINER: Okay, we are an outpatient private practice group that specializes in the mental health treatment of children, adolescents, young adults, and families. Specifically, we provide care to clients with both commercial insurance and Medicaid coverage.

Needless to say, the last year has placed enormous amounts of stress on the children and families in our community. It is unanimously understood that when people, especially young developing minds experienced prolonged periods of stress, they are at greater risk of developing significant mental health issues, such as anxiety and depression.

Studies are showing that between 60% and 70% of youth are experiencing noticeable levels of stress, anxiety, depression isolation, etc., over the course of this past year. In the last 365 days, treatment services in our practice have increased by 20% and, sadly, we are struggling to meet the demand.

Between March of 2019 in March of 2020, we provided, approximately, 4,500 sessions to an average of 300 clients. However, between March of 2020 to present, we provided, approximately, 5,400 sessions to over 400 active clients. At the moment, our practice, like so many others, is unable to accept more clients and we have a waitlist of, approximately, 20 to 30 children with significant mental health issues.

One major factor for this is that providers are finding it harder and harder to contract with many insurance companies. Simply put, the rates of reimbursement are unacceptable and the work required to meet the contract requirements are overwhelming.

The truth is that, if it were not for our ability to deliver mental health care via Telehealth, the severity of mental health conditions would be far worse. Telehealth has expanded access to care,

especially for lower income households and clients with limited transportation options.

Additionally, clients can access care, despite minor health issues, inclement weather childcare issues, school schedule conflicts, etc. And perhaps most important clients can access care in a far more timely manner when clinical emergencies arise.

The suggestion that Telehealth intervention is temporary, less valuable, less therapeutic and, ultimately, worthy of less financial reimbursement from insurance companies is hard for thus -- those of us who are providing care to fathom. The services that we have been providing through Telehealth platforms are professional therapeutic and, in many cases, far more effective for the clients.

For instance, when working with children and adolescents, we are finding that the ability to build rapport and help them explore their struggles is often far easier when they are able to work with us in the comfort of their own environment. Additionally, we are seeing fewer rates of missed appointments and late cancellations, which deck -- directly correlates with successful treatment outcomes.

While we are hopeful that vaccines will reduce the infection rate for citizens in the coming months, we are certain that the long-term impact that this past year will have on future mental health issues will persist and intensify. It is more important now than ever before to meet these needs in the most effective, accessible, and thorough way possible.

ALEXANDRA DOROTINSKY: Oh, you'd reached your three-minute mark if you'd like to give a conclusion.

DANIEL WEINER: It is my sincere hope that by reimbursing Telehealth services, at the same rate as in-office services, we will turn the tide and create

a greater -- an opportunity for children and families to access the care they so desperately need. We also urge the Committee to make Telehealth a standard of care that insurance companies cover for all the lives they ensure.

REP. STEINBERG (136TH): Thank you very much for your testimony, and we're very pleased that we have someone from behavioral and mental health area speak before us today.

In my opinion, there are few especially areas more appropriate for consideration to Telehealth than yours, both because of the suitability of the medium for the kind of interactions that you described, but also because of concerns about access.

We have a real shortage behavioral mental health professionals in the State of Connecticut. In fact, I invite you to consider testifying before us when we have our practitioner recruitment and retention bill hearing that we're going to have in public health and some time because we recognize how critical it is to have adequate access for all those who have needs here in the State of Connecticut.

What I find most interesting was your comment that it actually facilitates building rapport with with younger patients to think that actually we get a higher quality of care from Telehealth than we might in in-person visits, let alone the improved attendance and fewer missed appointments. I just want to give you a chance to expand a little bit further on where other areas you might see benefits of Telehealth versus in-person visits.

DANIEL WEINER: Yeah, I think, in particular, with older adolescents who are having difficulty leaving their home or having a huge challenge with kids being comfortable with transitions and the amount of changes that they've had to experience.

So if they can meet with us from the comfort of their own home environment, we're finding a greater access for them to do the work that we're trying to do. It's more -- it's a more smooth transition for them to get on the phone with us, or in a -- in a Telehealth on a Telehealth platform than dragging them into an office, so to speak, where they're particularly uncomfortable. So that's just one instance.

There are certainly cases, where it's not the most beneficial intervention, particularly with much younger children, it's difficult. However, for parents support, for family work, it can be tremendous. So we're seeing great success with it in many ways.

REP. STEINBERG (136TH): Thank you for that. Representative Betts has a question, followed by Representative Foster.

REP. BETTS (78TH): Thank you, Mr. Chairman, and thank you very much for that testimony. I have a couple of questions.

One, as you said, one of the big issues is the insurance companies are not paying a competitive rate for your services. Could you give us a range as to what your services would cost?

And the other question is, do you meet with a patient and then submit a Bill and wait for the insurance company you say, "Yes." Or do you call the insurance company first and pending their decision is when you see the patient?

DANIEL WEINER: I'll start with your second question first. No, we see that -- we see the clients first and then submit for payment after the service. So there's a number of issues that we're seeing.

One is we're often receiving denials for reasons that we're not always understanding. Two is that

there have been no adjustments to even just basic rates of reimbursement for years for many of these insurance companies. So rates that we were being reimbursed five, 10 years ago are still the same rates that we're having to accept.

But most concerning I think for us is the fact that Telehealth is not typically reimbursed, at the same rate that an office visit would be reimbursed at. It's almost a 20% decrease in normal time. So prior to the pandemic, certain companies would be paying us between $80 and $90 per service, whereas for Telehealth, they may be $60 or $61 for services.

So, at the very least we feel strongly that the rate should be the equivalent -- they should be the same as what we get reimbursed for in-office visits, but there is just a general larger issue that the rates are just seen as insufficient across the board.

REP. BETTS (78TH): And along that line -- to be along that line, what is the criteria for saying -- in general, what is the criteria for saying yes or no?

I know a lot of times doctors or surgeons will call the insurance companies, "Hey, I did this procedure. And they'll say either, "No, it wasn't necessary." Or, "It will be this way," according to some kind of manually read, not as opposed to any kind of first-hand knowledge or experience. Is kind of an arbitrary setting of the price? And do people in the mental health field have any input, in terms of the insurance companies heading rates?

DANIEL WEINER: I don't feel like we have any say in the rates that are established. We either accept them and we are paneled providers or we don't accept them and we're not paneled providers. It's very, very little negotiation, if any, that occurs with most insurance companies.

That said, the process of being approved for care is probably very different than in the medical world. We can treat for a number of visits before we're required to submit a treatment report that would justify the need for ongoing authorization.

REP. BETTS (78TH): Okay, thank you, Mr. Chairman. Thank you very much.

REP. STEINBERG (136TH): Thank you, Representative. Representative foster.

REP. FOSTER (57TH): Hi. Thank you so much for being with us today, and also thank you for your work. I know as you've mentioned, it's growing importance during the pandemic and it certainly shone a light on how crucial mental health care providers are in our Community and for the health and benefit of our children.

I heard you -- you've sort of touched on this a little bit from Representative Steinberg's question. But when I was canvassing and talking to folks in my district, I heard repeatedly from parents and a mental health providers alike that there were specific conditions that they hoped would never go back to having to councel in person for children because, by and large, these diseases were better managed when children didn't have to leave their home.

Or students who had a co-morbid conditions that put them at high risk for disease or were sort of managing complex medical conditions and were occasionally hospitalized and needed mental health counseling. Can you talk about some of the situations, obviously without expanding on specific patient, you know protected information that this has been a benefit for?

DANIEL WEINER: Yeah, yeah. It's a great question. I could see a number of reasons why families feel that way. I think that because we do so much family

work, we're not just always looking at the child or the adolescent, we're looking at the whole family system.

And this pandemic has leveled so much stress on families that I think just the sheer nature that families could support their child by providing therapy from home, not having to worry about transportation, being available and accessible and being able to participate.

A father can participate in his sons or daughter's family session but still be at his office and working. That often isn't the case that we can get a whole family in a session like we can and have seen through teletherapy.

I think it's also easier to convince a child who's resistance, maybe on a lot of levels, to doing therapy, to have to come into an office when they can do it from whatever room they choose is the most comfortable setting.

I have not had almost no issues with creating a sense of confidentiality, in most of my cases, so that really hasn't been an issue. So I think there's so many factors. Those are just a few as to why I think families are really hoping that we can keep doing this.

REP. FOSTER (57TH): Thank you so much. I think it's so important to sort of -- we have I think the provider and it's really important. But I just was overwhelmed by how many families were saying that they received so much additional benefit from remote care, as you mentioned, allowing more family members to to be involved. But also, I heard a story of a family who said that they had a hard time getting their child to start because of social anxiety.

DANIEL WEINER: Yeah.

REP. FOSTER (57TH): And then having that early introduction to the provider in the Telehealth setting from when you didn't have anything else that was stressful. Nothing else that was outside of their home environment that it provided a good introduction to mental health counseling that they felt like was when the pandemic ended at least now have that support from that provider that they had established, that when the child reintegrating back into the school system, they had spent all this time, investing in this relationship with a provider, that would be able to help. So I really thank you so much for your testimony today. I appreciate your help.

DANIEL WEINER: Thank you.

REP. WOOD (29TH): Representative McCarty.

REP. MCCARTY (38TH): Yes. Thank you, Madam Chair, and good morning, and thank you so much for your testimony.

As you clearly pointed out, you know, the behavioral health needs are going to continue and may even be more elevated. So I'm -- and I know we have an issue with parity and funding in many of the instances.

A one area that i'm I know we need to work out with the federal side, the Medicaid reimbursement rate. But could you just say -- let me know how has the audio only -- the audio telephone only, have you used that part of the Telehealth services in your experience?

And I think that's the work we need to do if the answer is informative, as we continue to question today because I know that's an area where the reimbursement is difficult.

DANIEL WEINER: It's certainly an issue. We have -- we would -- I would say we do -- the majority of our

work is through a HIPAA-compliant audio and video platform.

There are cases where families are just not able to do video, and we have to do audio. And there is no question is the -- to its value. But I can't speak as much to it because I think the majority of work that we do is is both audio and video.

REP. MCCARTY (38TH): Okay, and I appreciate that. And -- but stating that you do believe there may be a need for audio telephone only as well even if you are --

DANIEL WEINER: Oh, it's – yes. Yes, no question.

REP. MCCARTY (38TH): Yeah, okay.

DANIEL WEINER: Yeah, no question.

REP. MCCARTY (38TH): Okay, that's what I'm trying to determine. Okay, thank you very much. Thank you. Thank you, Madam Chair.

REP. WOOD (29TH): Thank you, Representative McCarty. Next up, we have David Borzellino, followed by Lisa Taylor-Austin. David, are you there? Okay, David --

DAVID BORZELLINO: I apologize, sorry. My mute is on.

REP. WOOD (29TH): Okay, David.

DAVID BORZELLINO: I'm sorry.

REP. WOOD (29TH): All right. You're up.

DAVID BORZELLINO: Thank you. Good morning, Senators and Representatives. I -- I'm grateful to be here today. My name is David Borzellino. I am the Director of the Medication Assisted Treatment Program at BHcare.

BHcare is a large nonprofit in Branford Ansonia, and we treat both adults and children. My particular department, we provide -- we provide medications to folks struggling with substance abuse disorders, especially opiates.

You know I -- just wanted -- you know since COVID, Telehealth has really provided an opportunity for providers and clinic and our counselors, and clients rather, excuse me, an excellent opportunity what we have noticed in our place of business and also on private practice, by the way.

We have noticed that clients are showing more. Our productivity rate is -- continues to be high. There are clients who have limited, especially in the -- with many of the clients that we provide who are on Medicare and Medicaid limited transportation issues. They show up when it snows, they show up when they're it -- when it rains, whether it does not deter people from engaging in treatment.

You know, there we have noticed that our clients are more relaxed, again, as my -- as my predecessor, Daniel said, you know there's a -- you know clients, with certain anxiety disorders are in a better place to doing this via Telehealth and video.

From a staffing perspective of -- you know as a director, I provide clinical supervision to my staff. And we are as easily accessible today by phone and by conference calling as we ever have been, so we haven't missed a beat when it comes to the supervision piece. And in some ways, I think we actually work harder together and work as a team.

You know, one of the things I am concerned -- representing a nonprofit organization is that pre-COVID, we weren't doing Telehealth. And as soon as this happened within weeks, most of us have had to spend an inordinate -- an enormous amount of money and to get -- to, again, providing these services.

And I don't think it would be a great idea if we suddenly had to stop using.

I also -- listen, I'm going to kind of go off my script a little bit here because I do agree with visual is much better than audio and, however, sometimes audio is the only way we can treat people. And I do think that's -- you know we are looking forward to some of our staff doing some in-service change -- doing some in-service on-site counseling.

So on a personal note, I know for myself when I've had medical appointments that didn't require when I just had a call my doctor, I didn't have tack -- have taken half day off of work to the --

ALEXANDRA DOROTINSKY: You have reached your three minutes.

DAVID BORZELLINO: Sit in a waiting room. So --yup.

ALEXANDRA DOROTINSKY: If you'd like to give a conclusion?

DAVID BORZELLINO: And I would just like to say that I'm -- do hope Telehealth is here to stay. And these -- I think our clients in the community are being served -- and serve -- and served well, so thank you for your time.

REP. WOOD (29TH): Having on and sharing your testimony. I just have one question.

DAVID BORZELLINO: Sure.

REP. WOOD (29TH): Can you tell us, are there any limitations to audio only? I just feel like I could kind of think of some --

DAVID BORZELLINO: Yup. Oh, yeah.

REP. WOOD (29TH): Limitation? When you with practice, can you share any with us?

DAVID BORZELLINO: Sure, let -- you know I mean even -- you know when I'm seeing clients, yes, there are certain limitations, you know? There are certainly folks who may be struggling with -- we -- you know we -- I think people in my business -- in most businesses, you know we're trained to look at people's body language and process.

So someone who is reporting that they're, for example, not using substances and you're only doing it audio, you know, you want to be able to see their face.

You know somebody was serious mental health this issue -- mental health disorders, you can see if -- you know when you assess someone with psychosis, for example. You know you can see their eye movements if they're -- if they're hearing voices and things that.

There are limitations to audio only. I do think there are for a certain group of people, maybe they're steady clients per se, it can be a benefit. And we also know, there are certain -- but we appreciate -- trust me, we know. We recognize the limitation of audio only.

REP. WOOD (29TH): Great, thank you. Representative Petit? Representative Comey?

REP. COMEY (102ND): Hello, thank you very much, Chairwoman Wood. Hello, David. Good to see you.

DAVID BORZELLINO: Hi.

REP. COMEY (102ND): I just wanted to say thank you for all the important work you're doing for the clients and for the folks that live in our communities and my town, specifically.

DAVID BORZELLINO: Thank you.

REP. COMEY (102ND): Providing them with not only the mental health care, but places to live and --

DAVID BORZELLINO: Oh, yes.

REP. COMEY (102ND): A way for them to assimilate into our community and to be active members, so thank you for your staff. I've seen you guys in action and much appreciated. And I'm glad this Telehealth --

BORZELLINO: Oh, it's great to know. Thank you.

REP. COMEY (102ND): Thank you.

DAVID BORZELLINO: I look forward to sharing that with my -- the leadership.

REP. WOOD (29TH): Thanks, Representative Comey. Representative Whit Betts.

REP. BETTS (78TH): Thank you, Madam Chair. Thank you. And thank you for your testimony. I have an interesting question to ask, in terms of your relationship with hospitals.

DAVID BORZELLINO: Yes.

REP. BETTS (78TH): And the reason why I asked them is it's not uncommon for a lot of people are having mental health issues go to the ER at a hospital.

DAVID BORZELLINO: For sure.

REP. BETTS (78TH): And hospitals are really not set up to deal with psychological problems. Have you ever or have you partnered with hospitals to say somebody comes into a ER, and use Telehealth as a way of being able to assess a person's situation?

Or it's a client of yours and you say, "We can do something." Because it seems to me, is if that might alleviate not only the overload in the ER but

it might be more efficient and helpful to the patient if you're able to do so long as it doesn't can -- you know jeopardize your privacy?

DAVID BORZELLINO: Sure. That's a great question. And I would think the -- I think the movement over the past few years have been to do -- doing a few things like that. For example, in many hospitals. One of -- they now employ recovery coaches. And those are folks who are specialized in substance abuse.

So when a client shows up in a hospital with -- going through withdrawal or needing that, the recovery coaches there to help get them to a more appropriate place in hospital bed.

I do think at like, for example, at BHcare when we do have one of our clients either going into the emergency room, our crisis team does get a call, and they do communicate with the -- with the hospital staff about that particular client. I mean we do have a -- we do have confidential -- you know, we have all our authorizations.

I do think -- it -- you know I do know that there was a more robust conversation with community partners with ER nowadays. And that has been the movement, whether in-person or Telehealth for the past few years. So we appreciate. We understand that. But, obviously --

REP. BETTS (78TH): Along --

DAVID BORZELLINO: You also know that some clients, whether they have a outpatient crisis clinician or not still need to be hospitalized.

REP. BETTS (78TH): Absolutely. Along that lines --

DAVID BORZELLINO: Yes.

REP. BETTS (78TH): My final question --

DAVID BORZELLINO: Sure.

REP. BETTS (78TH): Thank you, Madam Chair, is -- do insurance companies, are they more inclined to reimburse you if you're partnering with the hospital or that looks like they created a problem there.

DAVID BORZELLINO: [Laughing]

REP. BETTS (78TH): But I'm curious because more of a partnership link.

DAVID BORZELLINO: Yeah, I don't think they're -- I don't think there any more likely to reimburse if you're a link, but I do -- but I think in our community, I think we -- because we share clients going in from -- like in the Ansonia clinic to -- may end up in Griffin Hospital. The folks in the Branford Catchment area end up at Yale, even Middlesex hospital.

I don't think they're more likely to reimburse because of the partnership. I think you have more data to support an outpatient level of care, if necessary. I think that's best way I can answer that question. I hope I answered that correctly or within reason.

REP. BETTS (78TH): Yes, you did. Thank you very much.

DAVID BORZELLINO: Okay, thank you.

REP. BETTS (78TH): And thank you, Madam Chair.

REP. WOOD (29TH): Thank you, Representative. Representative Petit, are you there now?

REP. PETIT (22ND): I am. Got kicked off, and signed back on Thank you, Madam Chair.

REP. WOOD (29TH): Ok go.

REP. PETIT (22ND): Mr. Borzellino, two quick ones up. You said that your no show rate per se was way down. I'm assuming you meaning because of Telehealth. That's exactly --

DAVID BORZELLINO: Correct.

REP. PETIT (22ND): What I hear from CMHA that they're present --

DAVID BORZELLINO: Right.

REP. PETIT (22ND): People making business was very high. That's what you meant, correct?

DAVID BORZELLINO: Yes. Yes, yes.

REP. PETIT (22ND): And secondly, more qualitative. You've been in the field for a long time.

DAVID BORZELLINO: Yes. [Laughing]

REP. PETIT (22ND): [Laughing]. Do you -- do you think that -- have you noticed any qualitative difference in terms of your ability to evaluate people in the -- in the larger group of those with substance abuse, be it alcohol opioids versus people with depression, anxiety, or other issues? Have you noticed much of a qualitative difference in terms of the quality of your visits and ability to manage those patients?

DAVID BORZELLINO: Again, I think, if you take a look at the real severe ends of that spectrum, for example, folk -- clients with, as I said before, with significant mental health issues or psychosis and all and clients who are actively using substances I think they're a little bit harder to assess, at times.

But when you take the the group that's more in the middle, I do think, yeah, they're getting good

quality care. And, as we all know and, Dr. Petit, I -- you know you being in the -- with your background, you also know a lot of the quality also depends on the client a -- the counselor-client relationship.

You know not all counselors and not all doctors are great and have a great bedside manner. But, for the most part, I think the quality is still there. And I think -- and I do see that there's more receptivity for clients.

I think about my old agency that I used to work at -- I used to work at New Britain gen -- Farrell Treatment Center in New Britain. I used to run this outpatient in residential.

Our cloak -- folks who had to walk during the snow when we didn't close. And it -- and it rained because Veyo didn't pick people up who live less than whatever the criteria is, they're still coming in. And say, we're experiencing the same thing here. And so -- here. And I do see clients are just much more responsive.

REP. PETIT (22ND): Thank you for that and --

DAVID BORZELLINO: Thank you.

REP. PETIT (22ND): David, for all the work you do for these folks. So thank you, Madam Chair.

DAVID BORZELLINO: Thank you.

REP. WOOD (29TH): So and thank you for coming and sharing your testimony.

DAVID BORZELLINO: Thank you very much for having me. And I wish you all the best during this season of public hearings. Take care.

REP. WOOD (29TH): You too. Next up, we have Ben Shaiken, followed by Rebekah Doweyko. Ben, are you there?

BEN SHAIKEN: I am. Good morning, Madam Chair and Members of the Committee. My name is Ben Shaiken. I am a Manager of Advocacy and Public Policy at the Connecticut Community Nonprofit Alliance.

The Alliance is a statewide association of Community nonprofits, which provide a central services in every city in town in Connecticut, serving more than half a million people in need and employing 117,000 people across the state.

I'm here today to testify in support of making Telehealth services in Connecticut fair and equitable and permanent, in support of the two Bills that are before you today. I wanted to touch on a few things some of our members have testified already today, but just highlight a few areas to to bring up this morning.

One is that, as several folks have mentioned already in Connecticut because we were the last state in the country to authorize Telehealth behavioral health services in our Medicaid program. Authorization came the day before the Governor's Executive Orders and declaration of emergency last year.

Most community providers, set up a Telehealth system, basically, overnight. Their outpatient clinics closed due to COVID, and they spend hundreds of thousands of dollars getting their -- getting their staff technologically equipped, getting software, getting secure connections, getting oftentimes hardware to their clients. And all of this was a -- was a -- was an expense that didn't come with the -- with the reimbursement.

And so to go back, if you will, today is -- that they had the Governor not extended his Executive Order, where many of the flexibilities regarding

Telehealth would have -- would have expired. To go back to a system that existed before the pandemic would be really detrimental both to the the community providers and to the clients that they serve.

I also want to urge the Committee, as you're considering, the Committee is as
you're considering the draft of your Bill to make sure that you continue to the directive that has been in place since the state of emergency was declared, to continue to pay for Telehealth that -- at the same rate as in-person visit and to allow services to be delivered from any setting.

The payment for services should be based on the treatment that's provided not the location from where the service is provided. And Telehealth -- especially as we think about the fact that providers, as we get out of this pandemic, finally, are are going to be continuing to deliver it, for some clients, but will also be offering in-person visits, and in most cases, right now, still have started to do that again and are offering in-person services.

They now have double costs, right? They're paying for the Telehealth infrastructure and they're paying for their outpatient clinics to be open in person. As we move into, you know, the full reopening of our society and finally getting through this, that's going to continue.

You'll have clients that are -- that still prefer Telehealth visit, so you don't have clients who want to come in and person and you're going to need, as a provider, to maintain both of those locations. So from that regard, we think, it's really important for the services to continue to be reimbursed at the same rate.

ALEXANDRA DOROTINSKY: You've reached your three minutes, if you like, to give a conclusion?

BEN SHAIKEN: Sure, thank you. I will just mention there's been some talk about audio-only Telehealth today. We also support it, continuing it's been something that, that was done by through this emergency order. We are seeing some providers reporting up to 40% of their -- of their utilization being through audio-only.

So just to conclude we urge the Committee to pass a robust Telehealth legislation that guarantees people of Connecticut will have -- will continue to have access to Telehealth services using the device of their choosing and that providers continue to be paid at the same rate as in-person services in the future. Thank you.

REP. WOOD (29TH): And thank you for your testimony. You brought up a point on Telehealth infrastructure, which I don't think we really have -- go too much into up until now. Can you just share with us some of the costs?

BEN SHAIKEN: Yeah, sure. So, you know, when when providers were able to -- it's a great question. When providers moved to the system sort of overnight, as did many businesses. You know they had staff who started working from home and needed technology, so this could be just buying laptops or iPads.

It's also software licenses so to purchase the kind of video phone systems that were brought up earlier today or the HIPAA-compliant software packages, many providers spent hundreds of thousands of dollars on software licenses. It can -- it -- also, it can dovetail into needing to make modifications to your electronic health record system to be able to access it remotely, and those changes are expensive.

And then on a -- you know, on the side of working with clients to try to ensure that clients still have access to services, not everyone has an iPad or

a laptop at their house that they're able to easily sort of login to their behavioral health session, and so many providers worked hard to sort of provide that technology to their clients, so they were able to continue to access those services.

So all of those things where you know pretty significant costs that happened in the -- in the spring. There's a question I think from Representative Betts earlier, although I may be mistaken about, how that was reimbursed.

And I will say not -- certainly not directly from any -- from any state funding. Some providers were able to access some federal funding through PPP loans or through some direct funding from the Centers for Medicare Medicaid Services.

But, you know, by and large, those costs were born on the backs of community providers, and it's one of the reasons that the rate parity issue is so important.

I think the insurance industry will say that part of the benefit of Telehealth is being able to more efficiently, or for lower cost provide services. And, certainly, before the Medicaid system switched over, there were commercial insurance plans, offering Telehealth to Connecticut residents at a lower rate.

But we strongly feel that both in the Medicaid system and in the commercial insurance system, the rate parity between Telehealth and in-person visits still needs to continue, because the cost of delivering the services is definitely still there.

REP. WOOD (29TH): Great. Thank you for sharing that with us. Representative Whit Betts.

REP. BETTS (78TH): Thank you, Madam Chair. Good morning, Ben. I have a question that people frequently brought up today, and that is the

difference in price between the Telehealth service and in-person service. Could you inform the committees to how big a disparity?

And tell us, do you get paid -- not you -- but to people who use tell -- Telehealth services, do they get paid somewhere in the area of $75 to $90 an hour versus if you're in-patient, in-person is that, say, $150? I mean what -- how big a disparity is there?

BEN SHAIKEN: So we heard earlier from someone. I can't speak directly, Representative, and I'll explain why that the the difference pre-pandemic had been about 20%. I will say the Governor's Executive Orders that the Legislature codified in the summer and that have been extended to April mandate rate parity.

And so, for the last year providers have been paid at the same rate for Telehealth services, as they would have been paid to deliver those services in person. In the Medicaid system, the rates started fresh the first day of the pandemic.

And so the -- those rates haven't -- don't have any differences. In the commercial world I think it varies by by provider type and by provider, you know agreement with insurance company, and it varies by company as well, so I don't have exact rates.

You know, I will say that there's -- I think there are beginning to be and there's a portion of Senate Bill 1022 that that deals with out of state providers.

And I would say The Alliance has some concern that we don't design a Telehealth system that incentivizes folks to have connect -- not to have connections with local providers, as we think about this post pandemic world that we don't have a rate -- you know, a rate design structure that only allows tell health providers who don't have brick and

mortar locations in Connecticut to have a margin in the commercial insurance world here.

I think it's important to have that option to be able to go see a local provider, even if you're receiving your services telephonically, if something you know if something happens where you need to come in, in person. So I hope that answers your question. Thank you.

REP. BETTS (78TH): Actually, it reminds me of a politician. They didn't answer the question because I'm looking for $1 range. And I hear all these generalities, and is 20% lower and higher.

I think what the Committee is looking for is the current approximation dollar wise it's being paid for Telehealth versus in-patient. And I know it varies by region and qualifications, but could you give us some kind of, you know, financial difference.

Because, obviously, the -- when you're talking 20%, the insurance companies, saying 20%. We don't know what that 20% is. So, can you give us a sense as to what these services cost for treatment?

BEN SHAIKEN: So I don't have the exact numbers in front of me. I'm happy to follow up with with more detail.

I think that the challenge to answering the question in a -- in sort of broad generalities is is that in the commercial insurance world, there is significant variance depending on the service type and provider type.

And so, whether, you know, the difference between seeing a psychologist or a -- or a licensed clinical social worker, there's different reimbursement rates, depending on insurance company. And so I'm happy to follow up with some information about what the -- what the -- some of the existing rates are.

The other piece that makes it I think difficult to give a -- an assessment of today is, obviously, we're in the middle of this pandemic were more services than normal are being delivered telephonically.

And because the state was very late to adopting a Telehealth system overall, it means that there's no really time period pre-COVID that I could go back to a point and say this is the sort of "normal times" for Telehealth delivery services.

So the Telehealth phenomena in Connecticut is very much, you know, born out of COVID. And so, any information on a -- on a, you know, sort of broad system wide scale that we have would be very COVID-specific rather than to say, "This is what we could reasonably expect to happen, you know, in six months, once we have gotten back to a relative, you know sort of normalcy in our day-to-day lives."

So I'm happy to follow up with some examples of what units of service cost and our build out in both the Medicaid system and behavioral health system.

REP. BETTS (78TH): Thank you. That would be helpful. Because I know within the industry, there has to be a range of prices. Because if somebody call up to say, "I want to see doctor so and so," what do you charge per hour or things of that nature.

There's got to be something they give us some kind of guidance in terms of what the current payment system is, whether you're a psychiatry psychologist cancer, whatever.

So the Committee could -- or the Committees could have a better understanding of the parity or the need to get accretive parity. So I thank you very much. And I thank you, Madam Chair.

Rep. Wood: Thank you, Representative. Next up is Representative Nuccio.

REP. NUCCIO (53RD): Good morning, Madam Chair. Thank you very much. Good morning, Sir. How are you?

BEN SHAIKEN: Well, how are you?

REP. NUCCIO (53RD): Good. So I have a couple of questions, I guess so let's go back and forth. So you had mentioned again that the setup costs for Telehealth. And I think that's something that we need to consider.

Where I struggle with this Bill in -- and I've talked to a couple other people before this. I don't struggle with the expansion of Telehealth services. I think there are some arenas that Telehealth services can open up doors. I think, mental health, especially is an enormous place for us to look at the availability of Telehealth options.

Although my daughter who's going for her doctorate disagrees with me in some sense. She says that it's good with a place but there's a lot of cues you get as a psychologist in person that you can't get over a computer. So I think, again, it's good for some things not for everything.

Where I struggle, though, is one item I'm always looking at and -- in this role here on insurance is the cost of health care. In parity, in Telehealth, across the board to me I think is dangerous because I truly just don't believe you get the same services that you do when you go into a doctor's office.

Like if you are on a high deductible plan and it costs what my PCP costs, which $164.16 for an office visit -- going in having my blood pressure taken, my glands palpitated, all of the things that happen in

a physical visit, none of that happens when you're in a Telehealth call.

And, to be honest with you my family itself has experienced plenty of times when we've had been on a Telehealth call $164.16, and then the doctor says, we have to come into the office. That's another $164.16.

So it does not help from the actual cost of a healthcare perspective. So I think we need to kind of look at the structures that we're building here, and then, how we can price that from a parity perspective to make sure that doctors, who are building these infrastructures, to be able to handle certain calls in a Telehealth option can be reimbursed fairly for that.

Because there is disparity. Prior to the pandemic, Telehealth calls were reimbursed at a much significant -- insignificant less rate than they were for a regular office visit. But I just don't think that we've seen enough data that justifies me going online for a Telehealth visit for $164.16 cents to what I'm getting in the office.

So I guess that I kind of struggle with that there. I think I, personally, would like to see a team of legislators, or whatever, however, we can manage to do it, to sit down and talk about these different structures and how we can adequately reimburse the providers. But i'm just not 100% there yet, that I think this should be a one for one for everything across the board.

So that very long winded stupid soliloquy from a politician here, I guess, my question to you is, is there a way for you to be able to define for us what the cost structure looks like that providers have to put in place for Telehealth call? And how can we be assured, in any sense, that a provider wouldn't somehow be incented to them go to mainly a Telehealth platform, while minimizing their physical

space and cutting their own costs with a higher profit margin in this case?

BEN SHAIKEN: Thanks. That's help -- that's a -- that's a that's a great question. So just first off so just a about my organization at The Alliance. We're primarily representing community providers, community nonprofit providers of behavioral health services in that -- within that group providers that are sort of, primarily, contracting with the State of Connecticut to deliver services to Connecticut's most vulnerable.

And so many of those clients are people, who are participating in Connecticut's Medicaid program were uninsured.

But we also have, you know, obviously, behavioral health providers. We'll see anyone who comes through their doors, and so they also accept commercial insurance, plans different from other providers, from from clinicians and private practice, etc.

I would say, on the whole community providers in Connecticut are seeing sort of disproportionately high numbers of Medicaid patients. And that arrangement that they have I think with the state is how I would answer your question around this sort of guarantee for a -- for providers to continue to deliver the same high quality of services, whether it's in-person or telephonically that they -- that their missions are hard to -- in their agreements with state agencies, like the Department of Mental Health and Addiction Services or Department of Children and Families are to serve that population and to meet them wherever their needs are.

And so, in the past they've been constrained by only being allowed to see patients in outpatient setting within the four walls of their licensed clinic. And they have I think experienced, by and large, that

tele -- behavioral health services have opened a ton of doors for them, in terms of client engagement.

But they've also experienced I think is -- as Mr. Barzellino said a few minutes ago that it doesn't work great for everyone. And so I think as we think about how this -- how this service expands into the future, it's a question of how do you have both operating at the same time available to people who might want to come in person and others who might want their their services to be delivered, you know, over a device?

And then also sort of a hybrid model, where there are people who may need to start services in person, but then may be able to continue, or maybe come in, once a month and then have, you know, have visits the other three weeks telephonically, all sorts of things like that.

And, frankly, then, how do you manage a workforce who is seeing clients, both in person and telephonically when COVID restrictions, in terms of who can be in the office, you know, completely go away?

So I think there's a way as the Legislature looks to craft this Bill to make sure that on both the Department of Public Health and then in the Medicaid world, the Department of Social Services, and also the sort of -- the departments that specialize, in particular, populations like Jamison DCF ensure that the continuation of Telehealth services to those -- to the populations that they're responsible for are being done in the most -- you know, in the most -- in a way that most benefits the client.

The other side of that coin is, of course, that by incentivizing, by lowering rates for Telehealth visits, while it certainly incentivizes providers to bring people in in-person, it also makes it more difficult for providers to participate in the system

if you -- if you don't allow for them to continue to be reimbursed for services.

By and large, the greatest cost, even with all of those infrastructure needs is the cost of paying a clinician. And so as soon as were lowering those --

MALE: Hey, doctor. Right, how are you?

BEN SHAIKEN: Reimbursement rates, it becomes -- it becomes very challenging for providers to deliver the service, especially for community providers when they're already experiencing really significantly low rates of state -- of state funding for their services.

REP. NUCCIO (53RD): So that's actually a great point, first of all. And thank you, you know, for what your organization does. Like I said, I think the greatest opportunity we have in Telehealth is definitely with availability of mental health services across the board.

You brought up a very good point as we continue to expand Medicaid because we have such a need in this -- the state for that, especially right now, there's disparity and reimbursement on Medicaid calls, compared to a regular insured call.

And I know that there's a lot of -- there's a lot of issues and even trying to get mental health providers to the table to be a network for insurance because of the whole out-of-network pay, compared to in-network pay.

So there's a lot of work I think that we have to do regarding -- having availability of mental health providers and the depth of bench to make sure that we've got enough people in network. And I also think there's a lot to do to look at the Medicaid reimbursement rates because as providers get reduced Medicare Medicaid reimbursement rates, their costs don't go down, so it just gets shifted to another

populace that is insured and, again, we're getting right back into the circle of how do we reduce health care costs and we're not really -- we're not really -- we're chasing our tail on that.

So thank you for what you -- what you brought to the table here. I appreciate what your organization does, in regard to mental health availability. And I would encourage you to please stay in touch with both of these Committees and Boards to bring ideas and suggestions forward.

Because I think we -- we're going to have to work beyond the language that we have in these two bills to come up come up with something that is really for the betterment of the people and not the 00 not the pieces of legislation as they stand. So thank you very much for your -- for your time in your -- in your back and forth, I appreciate it.

BEN SHAIKEN: Thank you.

REP. WOOD (29TH): Representive Meskers.

REP. MESKERS (150TH): Thank you, Madam Chair. And thank you for your testimony. I got in at the end of the testimony. Unfortunately, I've been locked in multiple meetings.

But I think when we talk about parity and Telehealth, it becomes a lot of the issues that Representive Nuccio mentioned, which is that we have to figure out the efficacy, the cost structure, both for the insurance companies and, obviously, for the providers of service.

And what the fair level, is it at parity, or is the ratio, and the effectiveness of the treatment in Telehealth versus in-person, so there's a lot of moving parts. So just to say blanket parity without understanding both sides and the cost structures for for the providers, and whether this increases their efficiency, whether it -- you know, there is a ratio

of 80%, 90%, 75%. There's all those sorts of things.

I think, mandating parity in reimbursement it doesn't set factor in the cost and efficacy issues and the measurement and qualities. And so, I'm more inclined to think that we have to have that fair sit down conversation between the providers, the insurers and figure out how that gets worked out in an equitable manner.

So I have that same question about, you know, we said -- tell about it. And I know what you're -- you know if, in summary, you -- is there a response to that, or you think I'm off base or I'm missing something?

BEN SHAIKEN: I think -- thank you for the question, Representative. You know I think the issue of mandating rate parity in perpetuity is definitely something I know has been been brought up with some -- with some -- with some controversy in in the Legislature in both in the -- in your special session in the summer, with the Bill that expired today or expires today and in then in this Bill.

I will just say, you know, as you are all aware, you know, the the act of sort of governing some of the services by Executive Order is challenging and it makes the -- it makes the service delivery for folks challenging. I can't tell you how many questions I received over the last week or two saying, "Hey, is Telehealth going away on March 15th? What's going on?"

And I had to sort of, say, "Well, the Executive Order, and this is the expiration date." So I would just encourage that the Legislature not pull the plug on rate parity immediately. If this is a conversation that needs to continue to happen, it ought to. But I would encourage the Legislature to look, perhaps, to the Bill that's in the Human Services Committee around the Medicaid program,

which House Bill 6472 has its drafted now would ensure ensure rate parity for the next in audio-only services for the next two years, which gives you some time to figure things out.

I appreciate that that around the country, the delivery of all healthcare services telephonically through commercial insurance plans has been something that the insurance industry has pioneered, and that -- and that there are cost-savings associated or there were pre-COVID cost-savings associated with delivering those services telephonically some services.

I would also just mentioned, though, that, at least for community providers, you know, the recovery of their costs is is not something that's happening in many cases, especially for behavioral health services through any reimbursement rate that -- whether it's the Medicaid program or commercial rates, no one is sort of turning a profit, if you will, on a -- on a unit of service. It's part of the reason that we find challenges, finding private providers to accept commercial insurance and Medicaid rates in Connecticut.

And so, I would just encourage the Legislature to -- as you consider this Bill, which, you know, now has this deadline of April 20th, as the Governor has extended these provisions by Executive Order, to extend this this rate parity discussion until you've had enough time, as the Legislature to can -- you know fully consider whether it needs to move forward into the future.

And it doesn't, if it's something that has, you know, has decided that needs to sunset that it's sunsets over an appropriate period of time, rather than sort of just going away overnight or upon passage of a Telehealth Bill.

REP. MESKERS (150TH): Thank you very much. You've answered your -- the question adequately. Lot to chew on, I appreciate it.

REP. WOOD (29TH): Senator Abrams.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Madam Chairwoman. My question is about how Telehealth helps to address healthcare equity? And also, I think, as we think about parity, it's important to remember that it's not always about the health care provider, but about the person who's receiving the services.

And if I can get my services without having to worry about transportation or daycare and I can take care of my chronic illnesses in a way that I don't normally because I don't have the time or the ability to make those appointments and get to those appointments, the long-term cost benefit there is for people who are -- you know when we have people in our state, who were taking good care of their health, their mental health, and their physical health. I wondered if you could speak to that a little bit.

BEN SHAIKEN: Sure, yeah. We -- we've done some initial research, particularly around access to healthcare services during this pandemic for children. And we have found I think what was reported by folks who spoke before me that telebehavioral health has been one of the sort of shining stars of the pandemic in terms of, you know, something that providers were -- frankly, they had no idea what to expect, right?

That when when things, a year ago switched over to remote services, folks really didn't know what was going to happen, how they would continue to maintain their relationships with clients, how folks with challenging behavioral health issues would be able to be served? And they were, by and large, I think, very pleasantly surprised like I said -- and it

doesn't work for everyone and there definitely have been people who have struggled.

But on the whole providers have reported, you know, really significant lessening of sort of barriers to treatment. They've reported a way way lower no show rates for services. They've reported better engagement, I think, with some of the folks adolescence, especially over Telehealth services and, you know, continued treatment outcomes that the outcomes of providers measures, they go through their treatment, haven't really suffered.

So it eliminates a lot of the barriers that exists, like child care. If you have a child who needs behavioral health services, but you also have other children, getting your sort of whole family together to go to those appointments is now -- is now something that you don't have to worry about, if you struggle with transportation, not just the Veyo system in the Medicaid world, but anything getting to your appointment is now eliminated.

And, frankly, it gives clients choice. The world where behavioral health clinics were -- have -- are closed because of COVID is over. It hasn't existed since last summer. Clinics have opened back up to in-person services and figured out a way to do it safely. So now clients have a have a choice and we're seeing people who, for whatever reason, are choosing their services telephonically.

I know just personally when I had doctors needs over the last year, unless they're absolutely necessary for me to go in-person due to COVID, I've enjoyed them telephonically. But -- and we're seeing the same thing with behavioral health patients. We expect many of those folks will come back in-service -- in-person services once the vaccine is more widely distributed.

But, you know, I think, we also expect the Telehealth is here to stay because it gives folks

the choice to to sort of have their -- to receive counseling services in the comfort of their own homes or without having to sort of deal with getting to -- getting to the clinic. So that piece of client choice, I think, has allowed more people to access services and, therefore, I think, has really helped the the sort of equity question, in terms of who's able to get to services a lot.

SENATOR DAUGHERTY ABRAMS (13TH): And mine -- just one more question if you wouldn't mind. Is my assumption correct in that reimbursements, whether they're by private insurance or through our Medicaid program, reimbursements for visits, things like that, they are it's not where you set up your office is not a consideration.

So if you're in a area that has higher commercial real estate prices or you have a larger office or things like that, those aren't part of the consideration to what your payment is -- is really -- am I correct in assuming that or not?

BEN SHAIKEN: I -- yes, the -- as other speakers have sort of said before you, there's not a heck of a lot of negotiation, I think, that happens around the rate that you're reimbursed for services, whether it's by the state, through the Medicaid program or through commercial insurers. There's variants to the rates.

In the Medicaid world, they're supposed to be cost based. But there's that -- we have a lot of data that that shows that Medicaid rates, especially in behavioral health really do not cover the cost of care. And so, I think there are definitely some advantages to to being able to have a smaller footprint if you're in a place where commercial spaces very expensive.

I will say from from folks that we represent, they're generally organizations that do have an existing brick and mortar facility and do have the

option for clients to come in, in person and we're not seeing anybody have plans to reduce that in-person footprint just because Telehealth services are available. It's really caused them to be able to serve more people and serve them better, rather than being able to produce what their -- what their -- what their sort of brick and mortar services are not available.

SENATOR DAUGHERTY ABRAMS (13TH): So what I mean -- I think my point more is that what we're ultimately paying for is someone's knowledge and education and experience and rather than the building or or what their -- what they have within that building. So it's no different in Telehealth. You know what we're paying someone for is their -- is what they can provide the healthcare provider. And so that's why I think the the parity is important.

BEN SHAIKEN: Make sense. I agree.

REP. WOOD (29TH): Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. I just
wanted to follow up on something that I heard Mr. Shaiken say a minute ago. Through you -- you had said that parity was a -- I said parity that Telehealth was here to stay. And I think by that -- from that I took it to mean that it had proven to be popular with both patients and providers.

But if on April 9th before -- on or before April 19th, we don't extends the parity provisions of the Telehealth law, do you believe that Telehealth will be here to stay? And I -- and the reason I'm asking is because I recall last summer, when a previous Executive Order seemed likely to expire, I've heard, at least, anecdotally, that some major physician hospital networks were limiting Telehealth appointments because the reimbursement question.

SENATOR LESSER (9TH): So I think -- I guess the question is how dug in our providers in providing the service on -- given the uncertainty about future payments?

BEN SHAIKEN: Yeah, it's a great question, Senator. Thank you. I think the answer is, is that we're really not sure because like I said earlier this is a system that was -- that was sort of born of COVID. There's no -- what was it like before COVID really to go back to.

Before the the authorization of Medicaid Telehealth and before COVID, there were commercial insurance plans that we're reimbursing for Telehealth services. For behavioral health services at a -- at a lower rate, I think the participation among Connecticut's community providers was limited.

And the reason for that is is that, you know, both the rates were low enough that it wasn't -- there wasn't much of an incentive to participate, unless you really have to scale as a network to make it work.

And then secondly, because the Medicaid population wasn't included a big portion of your clientele -- of your client base as a community provider wasn't eligible for the service. So I don't know what would happen in -- and I think frankly a lot of it would likely be rate dependent.

If on April 20th, the rate parity provision expired, I will say that that rate parity provision also exists by Executive Order in the Medicaid program, as to a number of other flexibilities we've talked about today. So, while the Medicaid programs authorization and Telehealth services is not conditional on legislation or on the pandemic, most of the flexibility pieces that have been added are.

And so, you know, think there's a -- there's a significant concern about both commercial insurance

and the Medicaid program beginning to pay lower rates for services, because, you know, providers costs are only just beginning to be sort of met, in terms of the the ability to stand up those services overnight.

So, again, I think, you know, if there is this conversation of ending the -- this period of rate parity at some point in the very near future, I would encourage the Legislature to extend it, you know, the -- at least a year or two, so that we can have a much fuller, you know, sort of process and study of what the true cost of delivering the service is remotely versus in person. And that -- and, frankly, a study that exists outside of COVID restrictions that can truly sort of measure what folks are interested in receiving outside of -- outside of COVID.

You know I will also just sort of say that there -- there's a question about about equity between the Medicaid program and what people who have commercial insurance are able to receive. And I would just also really encourage the Legislature to to make sure that Connecticut's Medicaid program, it continues to offer its members the same sort of breadth of services that commercial insurance plans are offering, both in terms of what services are available and then for the rates that are -- that are paid to providers to ensure that both the Medicaid program and commercial insurance rates are adequately paying for the cost of services.

SENATOR LESSER (9TH): Thank you.

REP. WOOD (29TH): Representive Foster.

REP. FOSTER (57TH): Thank you, Chairman Wood. I have a question. Ben, I'm not sure if you're the right person to answer this today, or if you can weigh in. But I imagine that the idea of parity varies by provider type and just thinking about the, you know, concept of the Members of our Committee,

if I think of like Dr. Anwar and Dr. Petit. Imagine a pulmonology, endocrinology, what can be done via telemedicine would vary tremendously.

So our providers do -- like are providers asking for reimbursement for things via telemedicine that can't be done via telemedicine? Because my guess is not so much. I'm trying to -- I'm trying to wrap my head around this whole idea of parity, I -- if there are things that are being tried to be done remotely that shouldn't, that can't be.

And if then we're getting double billed because then they -- then they get referred to an in-person appointment. Can you sort of address -- can you talk about how that might be addressed to now? And if that's something we need to work out further in these conversations?

BEN SHAIKEN: Thanks. So I -- I'm not the right person to answer a question about pulmonology or otherwise. But I will say it's interesting -- your question is interesting because it's something that came up in 2019 as we, and others, were working with the Department of Social Services to think about designing a state plan amendment for telebehavioral health services in the Medicaid program.

And there was a lot of back and forth about what do we need to require a patient relationship to originate in person, do we need to, you know, who gets the services? What conditions are eligible for them? How can we determine if someone should or shouldn't be allowed to bill for tell -- and what we ended up landing on, I think, as you know, as a group of people who designed the Medicaid plan, people who are billing it, people who receive services is that's the decision that is up to the patient and the provider.

If you as a patient want to receive in-person, services and feel like you are getting what you need out of in-person services, you ought to be able to,

obviously, outside of the public safety issues created with my COVID, you need to be able to to access those services in person.

If you think you -- you know, a phone call is something that can handle it or a video chat or whatever for either an acute need or something that's ongoing, that's a decision that just like most other health care services you're deciding what you need with your healthcare provider. And that either the Medicaid program or an insurance company really ought not to dictate that you do or do not need a particular medical service in the nature that you do or do not need it.

And so, that's something that I think calls into question this this thought of do we -- do we need -- you know, doing need rate parity? I think we need to create a system that doesn't incentivize one way or another that allows the full breadth of services to be available to the people who received them in Connecticut. And that means the availability of both in person and Telehealth.

And if we -- if we sort of get rid of rate parity, I think the situation that will be created, at least in the short term, is the availability of Telehealth services going down in folks who have found them to be very useful, as they've received behavioral health services not being able to access them with as much as much as they are right now, and with the providers that are offering them right now.

REP. FOSTER (57TH): I appreciate your suggestion for an extension and study because I think that that's something that I have often thought about when I think about the type of care that my family engages with, I think about pediatric care.

And I remember having this moment at the beginning of the pandemic thinking, oh, I wonder if that -- or antibiotics are going to be prescribed to children at higher rates during this pandemic to avoid in-

person visits? And if we're going to have some sort of like unintended consequences that down the road, because people are preferentially choosing to not expose their child in a pediatric care setting to potentially COVID.

And I remember thinking about that thought process, as we were preparing for this public hearing today that I doubt that that same people choosing remote and maybe doing something, that wouldn't have been the same process in an in-patient setting will happen post-COVID, but it is something to to sort of evaluate, so I appreciate that suggestion. And I appreciate you being here. It was good to see you.

BEN SHAIKEN: Thanks. You too.

REP. WOOD (29TH): And thanks so much for your time today.

BEN SHAIKEN: Thank you.

REP. WOOD (29TH): Next up, we have James Hoko, followed by Shawniel Chamanlal. James, are you there?

JAMES HOKO: Okay, hello. I am here. Am I on?

REP. WOOD (29TH): I -- yup. They can hear you.

JAMES HOKO: Okay. So I want to thank the Committee this morning. My name is Jim Hoko. I'm a Madison Connecticut resident. I'm also a doctoral level ECB-certified Behavior Analyst Certification Board. I'm licensed to provide behavior analytic services in Connecticut, Massachusetts, Rhode Island, and New York. I'm also the Executive Director of a national organization called Behavior Analysts Leadership Council, supported by over 600 Connecticut members, organizational leaders, practitioners, and business owners.

So in this last capacity that I address the Committee, and express strong support for both Bills related to health -- Telehealth. Behavior analysts not only provide essential behavioral programming to individuals but also parent training to support that program. Both of these are critical for children who are significantly challenged with social, emotional, and behavioral issues. Having spent the last three decades as a behavioral analyst, serving a large number of children and families in Connecticut, I can tell you a few things.

First, I've never experienced the situation that was so potentially disruptive to children's mental and behavioral health. And for children who were so affected by these issues, such as children, with significant autism, this continuity of service is essential.

Second, that the ability to provide medically necessary behavioral health services was both invaluable and informative. It was invaluable in a much needed treatment and support was able to be maintained and even enhanced during a time when endemic was challenging us all. The availability of Telehealth provided therapeutic consistency required for children with behavioral and cognitive challenges in the continued collaborative support for families, which was critical.

It was informative in that it showed us that not only behavioral Telehealth services are possible, but also that the modality enhanced the accessibility of services to families, who would not otherwise be able to receive them to dissociate not -- socio economic and other limitations, such as lack of transportation or restricted time due to working multiple jobs, who are in case, of a single parent working single job, and language translation issues which were actually more easily arranged via the video meeting platforms.

BLC and many behavioral analyst practitioners and business owners across Connecticut ever reported a great deal of success over these recent months during the pandemic, and strongly support the continued use of this technology through Telehealth provided central behavioral health services to patients clients and families.

This is a good Bill. Both these Bills are good. They do good things for some very special children and very deserving families. Once again, I would like to express my strong support for S.B. 1022 AN ACT CONCERNING TELEHEALTH, and urge for passage of this much-needed legislation.

REP. WOOD (29TH): Thank you. We have questions around Representative Parker.

REP. PARKER (101ST): Thank you, Madam Chair, and thanks, Jim, for being here with us. Just wondering if you have any comments about this conversation that has been ongoing about the payment parity in terms of the in-person versus tele services in the context of your specific behavioral work. Have you seen that there are services that can't be done via Telehealth and, therefore, need to be done in person? And just if you have any comments on the work that you and the folks in your community provide? Is it actually similarly resource-dependent when it's done virtually, as opposed to in-person? Thanks.

JAMES HOKO: Thank you for the question. Both my personal opinion, what I've heard are pretty similar in that I think we were surprised by what we could do via Telehealth. I personally done some assessments and done some other sessions and witnessed sessions. And sometimes, the response and the effect of the treatment is very surprising.

I know, in the beginning, not having been familiar with this, there was lots of questions of whether or not that could be done. And I guess I've come to

the conclusion that what is true of most things. That there are some situations in which Telehealth is very appropriate and is effective. And there are other situations in which it is less effective.

The support that I'm talking about is the support for the ability to choose that option if it is clinically appropriate and not choose it if it is not clinically appropriate. In terms of rate parity, I think the essential issue in the field that behavior analysts working is whether or not there are provide -- you are able to access a provider. There is a large shortage of behavior analytic services across the country and, including in Connecticut, so there's is -- there's room for a lot more services.

If the rates are not equitable via Telehealth or with Medicaid, for example, then you may not be able to provide -- you may not be able to secure those providers for those services. What I hear resoundingly from people is the accessibility of services is much improved via Telehealth, as well as the relationships between the parents and the providers.

REP. PARKER (101ST): Can I do one quick follow up. In terms of the accessibility, is that -- one of the communities that we are being newly accessible to, is that about a socioeconomic challenge that families face? Is it about physical ability? Or who really being -- .

JAMES HOKO: I think -- I think a lot of is -- a lot of it is socioeconomic and there are other factors, so i'm probably not the best one to talk about specifics, because our organization represents a lot of people. I know that there are other people slated to talk. They're probably better people to answer in specifics.

REP. PARKER (101ST): Thanks so much. And thank you, Madam Chair.

REP. WOOD (29TH): Senator Abrams.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Madam, Chair. I just wanted to point on, I think that you, along with many of our other speakers, have talked about the fact that, you know, in in-person visit could be preferable time. And I just want to make sure that we're continuing in this conversation to say there's often times where Telehealth could be the preferred way.

JAMES HOKO: Oh, absolutely. That's -- that is why I'm talking today.

SENATOR DAUGHERTY ABRAMS (13TH): That is not -- yeah because I think that's what you were trying to say too. So I think it's important that we keep remembering that, yes, there are times when an in-person visit is absolutely the way to go and the most effective way to get your healthcare, but there are also times when Telehealth can be the most effective way to get your health care, so I think we have to keep in mind that it goes both ways.

JAMES HOKO: Right. And I think that my comments were to the fact that I think there are a lot of people that were pleasantly surprised at how much that latter group is true is that we can provide --

SENATOR DAUGHERTY ABRAMS (13TH): Yeah.

JAMES HOKO: Those services via Telehealth.

SENATOR DAUGHERTY ABRAMS (13TH): I agree. And I think, particularly, in the behavioral health area, I think people have been surprised to see how many people are more willing to engage in getting those services on through this method than they would have been or has been previously in going to in-person visits. And I think that's a really great thing, so thank you.

REP. WOOD (29TH): Thanks for your testimony, Jim. Next up, we have Stephen Wanczyk-Karp, followed by Kyle Zebley.

STEPHEN WANCYZK-KARP: Good morning. My name is Stephen Wancyzk-Karp. I'm Executive Director for National Association of Social Workers Connecticut chapter. We thank these two -- the two committees for putting this Bill together. I want to talk very briefly about access to care and some of the other benefits that are in this Bill.

In terms of access to care, first of all for students who are working at home remotely, Telehealth has really been the only way to identify them and work with them and deal with any issues that they're facing both for school social work for them for social workers in health care clinic. Telehealth also helps residential long-term care facilities that otherwise would not have behavioral health care.

It helps those who are homebound and literally just cannot get to a physicians or mental health providers offices. It helps those who transportation limitations. And we know that, particularly in the law of our lower income residential, transportation and in many parts of rural, parts of the state, transportation is a major obstacle to getting here.

It helps those who are, in particular, again, low-income individuals who are in multiple jobs, do not have the ability to take time off from work, like some of us, or in professional positions may be able to do, whereas they may be able to get away for a while, during a lunch break. So those are areas that we're looking at.

Family obligations is another area, where -- for parents with young children, where it's just difficult to get to an in-person session. It also -- we believe is improving health equity. And for

some clients when they choose to have family members or caregivers in the session with them, it really does help the provider to get a better picture of what's going on in the home versus having someone just in the office.

Now, these are all things i've heard from my members. Social workers provide the majority of mental health care in the State of Connecticut. All of these benefits are things that we've heard. We've also heard, though, is our members are very much in support of and concerned about losing the opportunity for audio-only.

There are clearly individuals who do not have adequate access or access at all to intubate -- Internet-faced -- a base services. There are individuals who have disruption of services. I've talked to members who said, you know, their Internet went out. The Internet went out, so I was able to call them back on the phone and complete a session.

Disruption of services is a big issue. And for many of our members, they're very concerned about not being able to do something after April 20th. And we're hearing increasingly from members saying, "Do I take a new client on for Telehealth?" The clients are feeling anxious about, "Am I going to be able to continue my Telehealth sessions?" The providers are beginning to feel anxious, "What's going to happen with Telehealth" is the lack of clarity is I think a significant problem.

I would have to say in terms of rate parity is our opinion that rate should be based on treatment not location. So if you're providing psychotherapy in your office or you're providing psychotherapy like Telehealth that rate shouldn't change simply because you're doing it through Telehealth.

ALEXANDRA DOROTINSKY: Mr. Wancyzk-Karpa, A you've reached your three minutes. If you'd like to give a conclusion.

STEPHEN WANCYZK-KARP: Sure, if many providers -- if you're going to have lower rates, you are going to lose providers. So just in conclusion, I would say that we need a full health care system. Telehealth is not a panacea but it clearly is a major piece of our health delivering and it, clearly, increase accessibility.

So we really are looking at, we need in-person care, we need Telehealth care. That's really going to be best practices going forward. And one quick comment it's just that we are about to face a tsunami of mental health needs out of this pandemic. I'm more concerned about post-pandemic mental health and I actually am about current pandemic mental health. And without Telehealth services, we're not going to have the ability to deliver those services to the number of people need it. Thank you.

REP. WOOD (29TH): Thank you, Stephen. Any questions from the Committee? Great, thank you for your testimony. Next up, we have Kyle Zebley, followed by Tom Kassan. Is Kyle there?

ALEXIS AUMAN: Hi. My name is Alexis Auman. I'm speaking in lieu of Kyle Zebley today.

REP. WOOD (29TH): Okay, you're on.

ALEXIS AUMAN: Thank you. Chairpersons and Members of the Committees. My name is Alexis Auman. And I am the Chief of Staff at the American Telemedicine Association. The ATA in the 400 organizations who represent our membership is the only org -- national organization completely dedicated to advancing Telehealth, representing teleheath providers, delivery systems and payers, as well as partner organizations and alliances.

The ATA thanks the Committee for its efforts to craft sensible forward-thinking telepolicy in

Connecticut. We are pleased to see Senate Bill 1020 make its way through the legislative process.

The ATA supports language and the proposed legislation which will allow licensed practitioners located in other states to render Telehealth services to Connecticut patients.

Patients should be able to receive virtual care from their provider of choice, regardless of that providers' physical location, so long as the practitioners are utilizing the appropriate technology to uphold the established initiative care and during good standing with their home states regulatory boards.

The ATA also applauds you and your colleagues for proposing legislation that would require public and private health insurance plans cover Telehealth services to the same extent as services provided in-person.

While the ATA appreciates legislation attempt to allow for the use of audio-only phone calls and the practice of Telehealth under certain circumstances, the ATA would like to emphasize is commitment to technology neutral language in mandating that only in-person providers or practitioners enrolled in Connecticut medical assistance program may use audio-only technologies.

The Legislature creates unnecessary roadblocks for residents seeking care, especially those who do not have access to high-speed Internet connections necessary to operate audio visual technology or who would prefer to pay for their health care services without cash.

Providing texting in the delivery of Telehealth services could have adverse effects on certain behavioral health therapist that effect utilize this Telehealth technology. Thank you for your time today and for your interest in improving access to

Telehealth services in Connecticut. We look forward to working with you in this endeavor.

REP. WOOD (29TH): Thank you any questions from the Committee? Okay, thank you very much for your testimony. Next up we have Brian Lynch followed by Jennifer Brett. Is Brian Lynch available? Do we have Jennifer Brett?

JENNIFER BRETT: Hello, my name is Jennifer Brett. And I am a licensed acupuncturist.

Dear Co-Chairs Lesser and Wood, Vice Chairs Anwar and Comey, Ranking Members Whang and Pavalock D'Amato and Members of the Committee, thank you for the opportunity to speak today.

I'm testifying to request that raised Bill S.B. 1020 be modified to include licensed acupuncturists in the definition of Telehealth providers. While many think of acupuncturist is providing acupuncture and other hands-on modalities for pain only, those practicing traditional Chinese medicine, provide a wide range of services that can be communicated to patients and monitored in a Telehealth setting.

These services, include self acupressure, therapeutic exercises, TCM-specific diet and nutritional counseling herbs and lifestyle recommendations.

During June and July 2020, the UB Clinics Acupuncture Clinic provided established patients case assessment herbal care management and home cell treatments via Telehealth, as requested by patients.

These services terminated when the UB Clinics reopened in late July 2020. While there was not a large number of requests for services, those patients who had been started on herbal and lifestyle modifications did require follow up on a regular basis. The UB Clinics provided HIPAA-compliant video assessments and home treatments,

offering guidance to those patients for treatments usual -- utilizing the acupressure tai chi and qi gong exercises, diet lifestyle and herbs until such time as the clinic reopen.

Specifically, our experience in teaching in the teaching clinic noted that Telehealth visits are an environment that provides a comfortable, safe environment for history taking and tongue diagnosis. The Telehealth option allows the acupuncturist to conduct a history and examination with modifications, due to the nature of Telehealth visits. Moreover, Telehealth visits provide a means for regular follow up to recognize any clinical signs and symptoms that warrant a referral to other health professionals.

During the Telehealth visits, we focused on case management. Discussions included collaborations with the patient to develop short, medium, and long-term treatment plans, assessing patient outcomes and modifying plans consistent with changes in the patient's condition. For those situations in which individual acupuncture patients cannot safely go to the acupuncture clinic allowing for Telehealth visits for those require an ongoing management of diet, lifestyle and herbal therapies was an important option.

We used a variety of codes for both telephone and online visits during this time. My understanding of the qualifications of acupuncturists and the needs of their patients is that Telehealth would be a great benefit to a relatively small number of patients. But those that need such help and advice, particularly for diet and herbal therapies such access to the provider can be critical to ongoing care.

Very specifically when patients, we had on herbal therapies or diet modifications were given new medications by their other providers, we needed to be in consultation with that patient to make sure

that there were no contraindications to the diet supplements or herbal therapies.

ALEXANDRA DOROTINSKY: You've reached your three natures three minutes if you'd like to give conclusion.

JENNIFER BRETT: Thank you.

SENATOR LESSER (9TH): Thank you. Are there questions from Members of the Committee? I just have one real quick -- can you -- you can bill for nutrition counseling? Is that -- is that accurate?

JENNIFER BRETT: There are dietary -- dietary counseling is part of what acupuncturists do. It's very variable depending on the insurance provider, whether or not they reimburse for such counseling.

SENATOR LESSER (9TH): And does Medicaid?

JENNIFER BRETT: Medicaid does not cover that at this time.

SENATOR LESSER (9TH): Thank you very much. Questions for Members of the Committee? If not, thank you very much. Next up, I believe, we have time Tom Kassan.

TOM KASSAN: Good afternoon. Good afternoon, everyone, Chairperson Steinberg, Abrams, Lesser, Wood, and Members of both Committee. My name is Tom Kassan. I am physical therapist. I'm a Public Policy Chair of the American Physical Therapy Association, the Connecticut chapter. Thanks for the opportunity to testify this morning in support of S.B. 1022 AN ACT CONCERNING TELEHEALTH.

There is absolutely no question for everyone, we spoke to this morning of the pandemic has shown the value of Telehealth. And this Bill takes some common sense steps to ensure that value is maximized beyond the end of the current pandemic.

The last year has pushed all healthcare providers, PTs, included, to adapt their practices as needed, to provide high quality of care to their patients, while keeping patient safety as a top concern. While physical therapy can't always be delivered through digital or electronic communications, Telehealth has become a very helpful tool in the physical therapist toolkit to deliver care when certain barriers present themselves.

While PTs has typically been considered hands on. I've personally seen how PTs can still provide high quality of care and valuable care to their patients through these platforms and have many patients that can attest to this.

We, as an organization, have worked for years to demonstrate this value, and the COVID-19 pandemic has certainly served as a catalyst to speed the acceptance of that change.

Thanks to the Executive Orders removing barriers to care. Telehealth was critical to PTs providing high quality care to patients during the pandemic in a safe manner. Without this action, many patients across CT would have been unable to receive the health care they required in a timely manner, which not only negatively impacts, the quality of lives of those patients but also cost the system more as a whole as conditions become more chronic.

Simply put, this Bill it's allow providers to continue to deliver care when appropriate to their patients in Connecticut without the artificial barriers that have been constructed over time. Payment policy has been the greatest barrier to providers treating patients through Telehealth but others exist as well, such as physical distance from their provider of choice eliminator -- eliminating barriers of high quality. Accessible healthcare is a must, while we progress access to medicine in the 21st century.

We, as an organization, have signed the joint testimony from all providers supporting Telehealth submitted by a wide range of providers which details the benefits and challenges of Telehealth with much more specificity. Out of respect for your guys' time, I will not reiterate those here, but simply associate our position with those marks as well. Thank you again for the opportunity to testify today and I look forward to working with you on this and other issues as the process moves forward.

SENATOR LESSER (9TH): Thank you for your testimony. Are there other questions or comments from Members of the Committee? Seeing none, thank you very much.

TOM KASSAN: Okay, thank you guys for your time.

SENATOR LESSER (9TH): Next up, we have Susan Schaffman with the Connecticut Ortopaedic Society.

SUSAN SCHAFFMAN: Hi, everyone. Thanks for your time this morning. I'm Susan Schaffman. I'm the Executive Director from the Connecticut Orthopaedic Society. And i'm here today to provide some testimony. You do have the written testimony from Dr. Michael Aronow, our President of the Society.

So I'm just going to cover two points because we do agree with a lot of the previous testimony from other providers. And as physicians, Telehealth was a lifeline for our patients -- for the patients, especially during the stay-at-home orders. So we would ask that this be continued and we would also ask that the
audio component of Telehealth also be included.

We do -- we did find that some patients in the orthopedic community had some difficulty with the video portion. Sometimes the elderly or the ones that had some mobile issues, so that would be very helpful to them to continue to be able to have that telephone option or audio option.

And then the last component of the Bill that we'd like to address is the requirement that a physician who's providing the Telehealth services determine the coverage if that patient has that coverage.

And we would just request that, perhaps, that responsibility go back to the healthcare insurer who does have the information as far as their clients go, whether or not they have the health care coverage what that entails, so we would just ask it perhaps the Committee's -- both Committees consider that.

In conclusion, we think that this S.B. 1022 is a critical component in maintaining health care services for all in Connecticut, and we appreciate your consideration. Thank you.

SENATOR LESSER (9TH): Thank you, and can you give us an example of a type of orthopedic service that will be provided via Telehealth.

SUSAN SCHAFFMAN: Sure. So during the the critical stay-at-home period, there were people that were injured, perhaps, not seriously, and so there was that opportunity to, you know, by camera be able to determine what that might be, or if that person might need to go to have an MRI or X-ray of that injury.

And then also many of the physicians use it as an opportunity to provide further information on the diagnostics that might have already been done on that patient, but that they didn't -- you know they didn't have the opportunity to meet in person, because they -- the offices are closed, so they're able to provide that diagnosis, based on the X-rays or MRIs that the patient had received.

SENATOR LESSER (9TH): Okay, thank you. Other questions or comments from Members of the Committee? Seeing none, thank you for your testimonies.

SUSAN SCHAFFMAN: Thanks so much. Thank you.

SENATOR LESSER (9TH): I have been told that Dr. Brian Lynch has joined us. He's up earlier.

DR. DR. BRIAN LYNCH: I am here.

SENATOR LESSER (9TH): And Dr. Lynch, good to see you.

DR. BRIAN LYNCH: Good to see you again. Thank you for giving me the time and opportunity to address your Committees. I'd like to point out that you do have my written testimony, so I won't read it verbatim but kind of hit some highlights within it.

I'm Dr. Brian Lynch. I'm a practicing optometrist in Branford Connecticut, resident of North Branford, and I serve as the Legislative Chairman for the Connecticut Optometric Association.

As you know that the pandemic has changed all of our lives. And one of the things that certainly has done in my -- in my vocation is it is -- it's changed how we care for our patients, how they wish to be cared for.

And Telehealth has facilitated those patients who don't want to come into my office for an in-person, evaluation and it is enabled me to address their concerns remotely.

Certainly, we can't do everything we do on a normal day-to-day basis via Telehealth, but it does help us get through some of the tests that we need to report today. We treat patients, for a number of eye diseases, as well as co-manage with primary care providers in patients, diabetes, or other systemic diseases. Monitoring ocular effects of patients, medications and managing their post-operative care after cataract surgery among our responsibilities.

Access to Telehealth technology has enabled our profession to deliver some of our care in a way, in which some of our patients wish to receive it. The audio-only component has been helpful, as well as our involvement in Telehealth since back in 2015, and this is officially was fast. So I encourage your support of this. I encourage your inclusion of optometry in it, as we go forward. And I thank you for your your opportunity to address you today.

SENATOR LESSER (9TH): Thank you, doctor. Other questions from Members of the Committee? Yes, Representative Comey.

REP. COMEY (102ND): Thank you, Chairman Lesser. Hello, Brian. Good to see you. I’m fine.

DR. BRIAN LYNCH: Hey, Robin. How are you? Good to see you.

REP. COMEY (102ND): I know I haven't been down here. Is there's -- are there -- are there helpful programs or things like that, that you are using, you're able to use whether it's specific tools that you use and in your -- in your practice that are -- use telemed -- you know for telemedicine watch?

DR. BRIAN LYNCH: Sure. As you're familiar, I should point out the Robin represents my office district, so no conflict of interest here. But I think Robin will attest to the fact that we're a varily --- very community-based practice that very friendly and accessible to all of our patients.

So I've certainly used a lot of Facetiming with patients. I've used Zoom meetings with patients. Teladoc is available to us. Granted, as you know, having been in my office, it's difficult to do a lot of what we do because so much of what we do is hands on and requires the sophisticated equipment that we have to diagnose and treat patients' problems.

But oftentimes and yesterday was one of them. I had one patient contact me with a large stye in her lid. And she goes, "Brian, what am I going to do about this?" And at my morning 7 A.M. coffee, you know, I'm looking at a stye. My wife is there, "Really, Brian?" I go, "Well, yeah. You know, this is what we do."

It has been helpful to patients sometimes to just triage the problems that don't necessarily need to come into the office. But then again for our patients, a little bit more anxious about coming into the office, it's allowed us to address via technology some of their problems without making them come in.

REP. COMEY (102ND): Yes, I appreciate that. I have heard a couple of instances where we're folks have been able to do a video visit and you've been able to -- or --

DR. BRIAN LYNCH: Yep.

REP. COMEY (102ND): Practitioner, has been able to see -- to see their eye and be able to identify that it's a stye or something --

DR. BRIAN LYNCH: Yep.

REP. COMEY (102ND): That's a little bit less serious than needing the whole -- the whole workup. So thank you very much for your testimony and always being an advocate for your association.

DR. BRIAN LYNCH: Thank you so much.

SENATOR LESSER (9TH): Thank you Representative Comey. Other questions or comments from Members of the Committee? Seeing none, thank you, Dr. Lynch, for your testimony.

DR. BRIAN LYNCH: Thank you. Have a great day, everyone.

SENATOR LESSER (9TH): You too. Next up, we have Keith Zeitlin, followed by Gretchen Raffa.

DR. KEITH ZEITLIN: Unmute. Hello. Hi there. Hey.

SENATOR LESSER (9TH): Hello.

DR. KEITH ZEITLIN: Hey, sorry. I am -- hi. I'm Keith Zeitlin. I'm a naturopathic physician. And I was just Telehealthing one of my patients and just had to stop the visit for a second. So thank you so much, everyone, for taking testimonies today on this issue.

This has been a complete boon. Telemedicine has been such a -- in some cases, lifesaver for my patients over the course of this experience. The transition -- excuse me, the transition forward that's going to be challenging is that so many of them have gotten used to not having to leave work, being able to actually on not arranged for childcare, as so many of the kids have been at home, but even moving forward as the kids go back to school convincing them that they need to come back into the office, if it isn't some sort of a situation where I have, so we have to do physical exam or they have a musculoskeletal issue, that's going to be a challenge.

We have already reached out to our patients to ask are you willing to come back in? Because we'd love to have them in. And many of them are saying, "No, you know, it's so much easier for me not to." So I can't emphasize how advantageous it has been for the safety of my patients, my staff through this whole experience. But moving forward it's going to be really interesting how to convince people that this isn't just the new normal.

Okay. On -- in some of the previous testimony, there were some questions about on reimbursement parity. I'm not sure that we're able to actually

share the numbers, or if that's breach of contract with the insurance companies actually discuss like what we will be paid.

Or if you can -- if anyone could give me any input on that, but I know how much we would actually be reimbursed for telemedicine service versus what we would in-person, if that's information that I can share and that you need to know. Again, thank you very much for our listening to our testimony. And if there's any way to continue this moving forward in some framework, I think it's going to be a great advantage to the population.

SENATOR LESSER (9TH): Thank you for your testimony. Other questions or comments from Members of the Committee? If not, thank you. Next up, we have Gretchen Raffa.

GRETCHEN RAFFA: Good morning, Senator Lesser, Senator Abrams, Representative Steinberg, Representative Wood, and Honorable Members of the Public Health Insurance and Real Estate Committees. My name is Gretchen Raffa, Senior Director of Public Policy Advocacy and Organizing with Planned Parenthood of Southern New England, testifying in support a raised Senate Bill 1022 and House Bill 5596, AN ACT CONCERNING TELEHEALTH.

As a state's largest provider of family planning and sexual and reproductive health care to nearly 62,000 patients last year at 14 health centers across our state, planned parenthood believes all people should have access to quality, affordable health care, regardless of who you are, where you live, your income or if you have health insurance. At planned parenthood, we know people sexual and reproductive healthcare can't wait, especially during a public health crisis.

PPSNE virtual Telehealth visits over the last year has provided uninterrupted access to care for some birth control visits, sexually transmitted

infection, testing a treatment, gender-affirming hormone therapy, primary care, HIV prevention medication, and treatment for a range of chronic and acute conditions and connects patients to the health care providers they know and trust.

Since March of 2020, PPSNE conducted more than 18,500 Telehealth visits through the end of February 2021, reaching patients who might otherwise have struggled to take time off or arrange transportation or childcare to come in person to a health center.

In 2020, about 21% of Telehealth visits were by patients new to PPSNE. Our Telehealth services, expand access to high quality and affordable sexual and reproductive health care, especially for those who often face systemic barriers to healthcare and who are disproportionately impacted by COVID-19. We're very thankful for the state and federal government's immediate action steps taken to make Telehealth more accessible during the public health crisis, which has insured more people have access to health care.

We know that increasing access to health -- to Telehealth does not address all in equities and healthcare access and coverage and will not replace in-person visits totally. We thank this Committee for prioritizing the continuation of insurance coverage for Telehealth services and recognizing the importance of payment carrier -- payment period parity for Telehealth for providers to be reimbursed at the same rate as in-person visits for delivering in equivalent care.

We also think the Committee for recognizing the importance of audio-only Telehealth option to allow patients to use their telephone for visits, if video option is not accessible for a person due the barriers, including lack of technology or Internet access, which you've heard of plenty about.

I've shared in my written testimony some suggestions for substitute language, and, specifically, the in network, out of network distinction. We would hope that that would be removed, all together, both in the definition of Telehealth provider and audio-only coverage, as we believe that Telehealth services should be available and covered, regardless of the choice of provider.

All people need and deserve equal access to comprehensive health care, including sexual and reproductive healthcare. Telehealth has been one option to ensure continued access to care a PPSNE for thousands of patients, through this public health crisis. Care through Telehealth is an important option --

ALEXANDRA DOROTINSKY: Ms. Raffa, you've reached your three minutes, if you like, to give a conclusion.

GRETCHEN RAFFA: Yep. We strongly support S.B. 1022 with the suggested amendments and we urge the passage before the current Executive Order expires on April 20th. Thank you for your time and consideration.

SENATOR LESSER (9TH): Thank you for your testimony. If the order isn't expired -- isn't extended or if the Legislature does not act prior to April 19th when it expires, do you anticipate that that would cause a disruption?

And also, if you knew in your answer you want to mention, I'd asked a couple of folks previously about the possible addition of asynchronous communication so that would be texting or other forms of that, that would be useful as well.

GRETCHEN RAFFA: Yes, I think we would definitely see people losing access to the timestamp for them that's essential reproductive health care services that they need. Telehealth really transformed our

ability to be able to ensure that people have continued access to preventative health care, so absolutely that would make disruption of care.

And specifically when we think of a lot of the patients that we see at our health centers for people that are juggling childcare issues or transportation, this has become an option for people that, oftentimes, might face barriers to coming for an in-person visit.

SENATOR LESSER (9TH): Thanks. Now, questions or comments from Members of the Committee. I see, I think, Representative Gilchrest has her hand up.

REP. GILCHREST (18TH): Thank you, Mr. Chair. Hi, Gretchen. So good to see you. I know you mentioned that, you know, Telehealth won't solve all the problems and that there will still be a need for in-person. I'm just wondering, could you speak a little more about how you do believe equity will be enhanced by using Telehealth?

GRETCHEN RAFFA: Yes, absolutely. I think, making preventative health care more accessible to people specifically people, that, again i'm going to lift up the fact that transportation is oftentimes an issue. And thinking about the people that we serve at planned parenthood primarily identify the majority of our patients are people of color and identifies people of color that fall under 150% of the federal poverty level. So when we're thinking about the people that access care at planned parenthood health centers across the state, this is absolutely an equity issue.

REP. GILCHREST (18TH): Great. Thank you so much, and thank you for all you do.

GRETCHEN RAFFA: Thank you, Representative.

REP. GILCHREST (18TH): Thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you, Representative. Senator Somers.

SENATOR SOMERS (18TH): Yes, good morning. Hi Gretchen. How are you?

GRETCHEN RAFFA: Good morning, Senator. How are you?

SENATOR SOMERS (18TH): I had a question for you on the audio portion. I think this is something that's really important. I know I've talked to a lot of clinicians where their patients don't have the access to tech -- to technology, where their phone can actually see another person or, you know, they don't have a computer. And I've heard many clinicians, you know, stress the fact that they need to be able to also be compensated for an audio visit, if that person doesn't have the technology.

And I was wondering if you could speak to that? Do you run into that also at your facility for what you're doing because of the populations that you're serving also? And is that something that you see is a true need. I know that the reimbursement on some of the audio visits for clinicians, you know, in the hospital are like $12 for the -- for the visit. So many of them are saying, "I can't even do it if that's the reimbursement." And I wanted to know if you could speak to that.

And then also how does that -- how does the Telehealth payment work for you guys when you are on a sliding scale for income? How does that work? Can you explain that at all for payment -- for services?

GRETCHEN RAFFA: Yes, from my understanding from our clinical folks -- and I can get back to the Committee with specific numbers -- that we are actually doing a limited amount of audio only because a lot of the folks that we are seeing use

their smartphones or do have access to smartphones and video capability.

But it is -- we have delivered audio-only Telehealth visits, so we think it is very important that continues in any policy and, again, the same determination of people are charged exactly the same way if they're on the sliding fee scale. We assess their payment or their -- the cost of their services based on that sliding fee scale so self-pay would work the same way.

SENATOR SOMERS (18TH): And if Telehealth services are not continued, you know, after April 19th, I think it is now, I see that is a big area of concern, especially in -- you know the populations that you serve it and the kind of business that you're in, would you agree with that, that this is something that -- especially now, because we're still struggling to get vaccines and we're still in the pandemic time that, that would be really detrimental to people's health in your particular case, if we did not have an ability to extend it.

GRETCHEN RAFFA: Absolutely. Absolutely. And I think, again, I can't emphasize enough for many of the folks that come to planned parenthood for health services, these are time-sensitive health services. They're essential preventative health care that is time-sensitive and, again, needs to be available and accessible to all people.

We actually closed two of our centers permanently due to the impact of the pandemic. And, you know, thinking about that area of the state, and specifically the Northeast corner, making sure people have access to Telehealth services, especially with transportation barriers, I think, is really important to the patients that, again, we see in our health centers across the state.

SENATOR SOMERS (18TH): I was just going to bring that up. I remember speaking to you probably almost

-- maybe a little just about a year ago about -- maybe it was a little bit less than that about the fact that you had to close to centers because what was going on. And and representing people in the in the Northeast corner, there is no transportation it's very difficult and now they have very limited access.

So I want to thank you for what you've been able to do during the pandemic to continue the services that you provide to women and others, and, you know, I'm very supportive of moving this forward so i'm interested to see what your recommendations are. Thank you.

GRETCHEN RAFFA: Thank you, Senator. Appreciate it.

SENATOR LESSER (9TH): Thank you, Senator. Other questions or comments. Seeing none, thank you for your testimonies this morning.

GRETCHEN RAFFA: Senator.

SENATOR LESSER (9TH): Next up, Kathy Flaherty, followed by Dr. Ghumman.

KATHY FLAHERTY: Good morning, Senator Lesser and Members of both the Insurance and Public Health Committees. My name is Kathy Flaherty. I am the Executive Director of Connecticut Legal Rights Project.

We represent low-income, people who are eligible for mental health services from the Department of Mental Health and Addiction Services. And I'm speaking in support of the Telehealth Bills, not only in my role as Executive Director of CLRP, but also in my role as a patient trying to access healthcare during the pandemic.

I was actually drafting my testimony when the announcement came out about the Governor's latest Executive Order because I was really concerned that

you waited this long to hold the hearing when the Bill that passed over the summer extent -- expired today. And a lot of us testified over the summer that we thought you should make coverage of Telehealth permanent.

So to see it expire today if it were not for his Executive Order last night, there would be people who would not be getting visits covered, but, hopefully, you will be able to pass these Bills and get them to the Governor's desk so that he can sign them before April 20th.

It has allowed access for our clients to services that they otherwise might not have been able to access during the pandemic. I know, for me it has allowed me access two visits that I otherwise would not have felt comfortable going in person.

I'm not old enough to get the vaccine yet. I still get nervous every time I go to the doctor and I do have to go for more health care because I'm one of the people, dealing with long COVID. And I have had audio only.

You know I had a therapist who said, "Do you want to do this over video or do you just want to talk?" And I said, can I just talk, because I was already exhausted -- was in meetings way back when. So being able to have audio only was a huge help. So I would just encourage you to to move these Bills along, and thanks for giving me the opportunity to testify today.

SENATOR LESSER (9TH): Thank you, Kathy. Other comments or questions from Members of the Committee? Seeing none, thank you. Next up, we have a Dr. Ghumman, followed by Brendan Peppard.

DR. KHURAM GHUMMAN: Thank you. Respected Senators, Representatives, distinguished Members of the Insurance or Real Estate Committees and the Public Health Committee, on behalf of physicians and

physicians-in-training of the Connecticut State Medical Society, I want to thank you for the opportunity to provide this testimony to you on two bills, Senate Bill 1022, and House Bill 5596 for related to the Telehealth. And I'm here to support both the Bills, with some minor suggested modifications.

The COVID-19 pandemic has exploded the use of Telehealth, faced with lockdowns and public health concerns. Physician offices in Connecticut quickly and efficiently turned to Telehealth to be able to care for our patients during this crisis.

As we begin to look beyond the crisis, the use of Telehealth becomes and remains an increasingly important part of medical care of moving forward. That pandemic has highlighted existing racial, economic, geographic disparities that can hinder access to medical care.

Telehealth has the potential to improve access to care for marginalized groups, faced with challenges of limited resources and limited access to care. Telehealth can save money and time for those who do not have access to reliable transportation and childcare responsibilities and cannot take time off from work.

However, coverage alone is not sufficient for facilitating and expansion of Telehealth. As many insurers have historically covered select services but have reimbursed physicians at a significantly reduced rate, compared to rates for the same services provided in-person.

The reduced rates are not sustainable and do not cover the overhead costs of the technology nor the physician times. Physicians must have the flexibility to decide whether to use their patients via Telehealth or in-person, without unnecessary pricing incentives.

I see me in my practice newborn and OPS. I should have the clinical judgment to see that six-month-old child, where I do need to look inside their ear to see and decided they need an antibiotic treatment. Worst is an adult hypertensive who could certainly be seen remotely via Telehealth visit. They have had a chance to get their blood work done ahead of time, so we have to have the flexibility in making the right choices for our patients.

But at the same time, we would be remiss if we did not discuss the potential pitfall in Telehealth, the expansion of the for-profit corporate health Telehealth companies. Corporate Telehealth companies often market themselves to Connecticut residents patients as a quick and inexpensive way to get medical treatment, without going to your primary care doctor. The result is fragmented medical care, which is not beneficial for patients or physicians.

When medical care is provided outside of the medical home, important medical information does not make its way into patient's medical records. This could potentially present a dangerous medical situation for patients who may, for example, be prescribed antibiotics via Telehealth provider outside of their medical home that reacts with their existing medication.

CSMS urges this legislator to take an important step forward in improving the access and value of medical care provided to Connecticut patients by adapting comprehensive Telehealth legislation that ensures coverage in parity in --

ALEXANDRA DOROTINSKY: Dr. Ghumman, you've reached your three minutes, if you'd like to make a conclusion.

DR. KHURAM GHUMMAN: Reimbursement. Yes. So, CM -- CMS would be happy to work with members of both Insurance Real Estate Committee and the Public Health Committee in amending these Bills. And I

want to thank you for your time, and I'm happy to answer any questions. Thank you.

SENATOR LESSER (9TH): Thank you doctor. Thank you for your testimony. Dr. Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you, doctor, for your testimony. There was some testimony earlier on that I don't know if you're able to hear. And there was some confusion over when people could Bill for the same diagnosis, if someone has seen for hypertension, whether it's in the office or by Telehealth can they be seen for that same diagnosis within a week or that, that pretty much break most of the rules of most of the insurance providers can do. You know the answer to that?

DR. KHURAM GHUMMAN: So thank you, Representative, for this question. So great question and i'm happy to answer. So as of today, my understanding is that you cannot bill for the same ICD-10 diagnosis code within a seven-day period.

For example, if I see somebody, you know, for an ankle sprain. And the -- you know the child, the adult couldn't come into the office. And I offered them the service via Telehealth. But now the nature of the injury, the nature of the visit or the worsening of the symptoms potentially warrants a in-person visit, I'm unable to submit the second bill for the same service -- for the same medical condition within seven days.

And I also want to underscore another point here. That goes back to the continuity of care and the primary care relationship. If I know my patient from the pre-injury visit, I'm able to offer the right treatment via Telehealth and then bring them back if needed to close the loop on that treatment.

So to answer your question, my understanding is that I'm unable to bill for the same visit within seven

days. And I will add the continuity of the primary care piece with this, where we can bring them back in to address and close the loop.

REP. PETIT (22ND): Thank you. And this is -- this is a broader question since you've been working with this for over a year now and it goes to the issue of how far the Legislature should micromanage? By that, I mean if we pass legislation that allows for Telehealth audio, visual, etc., has your experience with the insurance company has been such that they have been reasonably fair in terms of micromanaging, setting up the rules that allow you to do these office visits from your point of view? Have you run into any bumps in terms of the nuances of implementing Telehealth in it in a busy practice?

DR. KHURAM GHUMMAN: So, again, thank you for this important question. So, yes. So there had been a lot of hurdles, a lot of hoops that we have to jump, and, you know, challenges in terms of the -- there are certain pieces I think if we could adapt and change the insurance coverage, the -- when we can leave that to the insurance companies, not us having to find their coverage.

Because it's very challenging in -- in remote environment to -- A, have their insurance cards and their insurance card like, you know, what's, you know, the Telehealth services covered or not.

So I think we do see these challenges come up in providing the right care for our patients, so I will encourage us to maybe consider leaving that confirmation part -- confirmation to the insurance companies, rather than the physician offices.

REP. PETIT (22ND): So to be clear, you would prefer that the patients contact their carrier to see that they're covered in -- for the service before starting a service with you?

DR. KHURAM GHUMMAN: Right. And, secondly, you know, there's certain -- you know there's certain visits which are the insurance companies all ready had their own third-party, like you know the corporate entity, providing those services, where there is no medical records, they do not have the big picture of this patient's medical history, their allergies and whatnot.

And then what we are proposing is to keep the continuity and the context of care for this patient involve a primary care -- that existing relationship with their primary care physician and provide that service, rather than shipping out to a third party, which may or may not be Connecticut-based company in the first place.

So what we are trying to suggest is we focus on the continuity of care and the context in their community, their family, their other pieces that are already a part of the care provided by the primary care physicians that the existing relationship.

REP. PETIT (22ND): And one more, if I may, Mr. Chair. Doctor, has this been helpful in terms of call groups in terms of -- when when you're covered for half a dozen other physicians at night and there's a sick call -- the ability to do Telehealth, especially with video has -- is that allowed you to give more timely care and decrease the potential for office visits or emergency room visits? Have you seen that in your own practice?

DR. KHURAM GHUMMAN: Absolutely, Representative Petit. It's been a very, very valuable tool. And they just -- you know just to share certain examples, like -- and there are different patients on your panel. It's not a one-size-fits-all.

It is a very valuable tools to have available to physicians. And I practice primary care, so I can speak for primary care. It's a valuable tool in primary care. It's not a one-size-fits-all. It

cannot be used for every different single kind of visit.

But having this availability for certain different visits for elderly patients where their family member, their daughter wanted to connect, their son wanted to connect for this visit, so they can review their medications remotely. They have the capability. It may have been challenging for them to come into the office visit with their family member.

A hypertension follow up is different than an ankle sprain that requires clinical assessment. A knee pain, which requires, you know -- you can certainly rule out with their certain clinical exam skills, where you could avoid that expensive MRI that would have been ordered with a -- with Telehealth visit. So I think the -- having access to it and use it when it's the -- clinically needed for the right patient care is what we're looking for.

REP. PETIT (22ND): Thank you, Ghumman. Thank you, Senator Lesser. Thank you.

SENATOR LESSER (9TH): Thank you to you both. Are there other questions or comments from Members of the Committee? Whatnot, I appreciate your detailed and thoughtful testimony and look forward to working with you in utilization if this legislation moves forward. Thank you.

DR. KHURAM GHUMMAN: Thank you, Senator.

SENATOR LESSER (9TH): Next up, we have Brendan Peppard, followed by Leigh Nathan.

BRENDAN PEPPARD: Yes, and Members of the Committee, thank you for the opportunity to speak today on the issue of Telehealth. I am Brendan Peppard, Regional Director for America's Health Insurance Plans.

Health insurance providers are supportive of the appropriate use of Telehealth to provide access and reduce costs to necessary medical services for our members. During the COVID pandemic Telehealth, has emerged as a tool, that improves access to care by removing traditional barriers to the use of healthcare, such as distance, mobility, and time constraints. There has been a significant increase in utilization since the pandemic and shutdowns. In order to move forward, there are a number of things that can cement the positive changes we have seen regarding the use of Telehealth.

First, during the crisis, many states lifted restrictions on practicing across state lines. This has been a positive, allowing to let clinicians to deliver virtual care to patients outside the states where they're licensed, which increases options for patients.

Next, inconsistent state regulations restrictions or mandates relating to the types of technologies or specialties or originating sites may limit health insurance providers' ability to design benefits that best meet consumers needs moving to broad acceptance of the various technologies and types of providers who can offer health -- Telehealth services is also a positive thing.

However, there are some things we have concerns with. We believe that health insurance providers should have flexibility in the design of benefits. We are particularly concerned with requiring equivalent Telehealth and the in-person payment rates. This eliminates the cost saving potential of Telehealth and can create inadvertent disincentives.

It is important to point out that payment parity is not the same thing as coverage. This approach made sense during the pandemic and plans did agree to do this. Telehealth visits do not always require the same level intensity, however, or the same amount of time or the same equipment as in-person visits and

thus should not be required to be reimbursed equally.

We have heard the providers cannot provide Telehealth unless equivalent payment is offered. Providers are not required to offer Telehealth. There are providers who are willing to negotiate and offer these services and our members continue to have Telehealth as an option.

We also underscore the Telehealth should not become a replacement for needed in-person visits. We do not want to create inappropriate incentives to substitute a Telehealth visit for a necessary in-person visit.

A recent NGA report includes the perspective that there are efficiencies in Telehealth, making it a lower cost service and the requiring payment parity misses an opportunity to lower costs. Our recommendation is to allow flexibility and negotiating appropriate payment rates for Telehealth services. The savings from such such negotiations can and do benefit the consumer.

The explosion of Telehealth under COVID has provided opportunities and raised new questions. Ultimately --

ALEXANDRA DOROTINSKY: Mr. Peppard, you've reached your three minutes, if you like, to give a conclusion.

BRENDAN PEPPARD: We believe the growth is good. Health insurance providers have been promoting Telehealth use for a long time, and we believe that much of what we have seen regarding the increase in utilization is positive. Thank you, again, for the opportunity to speak today, and I am prepared to answer any questions that Committee has.

SENATOR LESSER (9TH): Thank you, Mr. Peppard. And appreciate your testimony. Understands your concerns

that legislating payment parity would prohibit or limit the ability of the industry to utilize Telehealth as a cost containment device. But in Connecticut, we are seeing our current system at Telehealth set to expire on April 19th of this year.

So I think one of the questions that these two Committees are wrestling with and probably the Legislature as a whole is the issue of potential disruption. You mentioned that payment parity is not necessary for providers to provide the service, that may be true.

I'm not sure. I think the that's one of the questions before us. And so, you know, do you have any thoughts about how we should think about potential disruption to the healthcare system at a -- at a particularly volative time?

BRENDAN PEPPARD: Thank you, Senator. That is a fair and reasonable question, I appreciate your asking it. We are not out of the pandemic yet. And so, for this Committee to consider a period of time, and we heard this discussion earlier.

During which payment parity continues is not unreasonable. However, making it into the statutes as a permanent requirement would be a concern. Because at some point, we will have a return to normalcy. We certainly hope. I -- if not, I will be quite unhappy, and i'm sure the rest of us will be as well. But that considering it within the terms of the pandemic is one thing, considering payment parity for permanent future, I don't think makes sense.

SENATOR LESSER (9TH): Represemtive Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you, Mr. Peppard. I think your statement on the necessity at times for in-person visits versus Telehealth visits is right on and what we've heard from several providers to date.

I know it's been difficult during the pandemic, given the limitations are everyone's faces. Has the industry been able to gather any data yet that would suggest that the ability to do Telehealth, say, with elderly patients who might not, otherwise, get door or people with sick visits that it has diminished the need for urgent care or emergency room visits, which can really run up visits, has that been a sort of a blessing in disguise of this, or is it too early to look at any of that data?

BRENDAN PEPPARD: I have not seen any data, and that is another very good question. I think, as we said, Telehealth is a very useful tool. It should not be a replacement for necessary in-person care. But for people who are not able to otherwise access care, it should be available. As for the question -- the direct question, I'm sorry. I just can't answer it. I don't believe we have data about replacement of maybe inappropriate ER utilization or other -- or other visits.

REP. PETIT (22ND): And in terms of the payment parity issue, it's a big question. I don't know if you can answer it simply. Providing the service they are seeing someone for follow up and for hypertension or diabetes in your office versus Telehealth is the payment that most companies render just consider the cognitive and procedural issues that occurred during that visit, or does it also have some form multiplier like the federal rates in terms of your structure, in terms of your cost of maintaining your office, your staff, etc., or the private insurance was mostly aimed at, specifically, the cognitive and procedures that go on in-person?

BRENDAN PEPPARD: So I don't know the detailed answer to that. All I can say is that certainly that there would be a consideration for the type of service at the -- in that -- in that -- in setting that rate in that negotiation for that rate.

The teleservice -- the Telehealth payment rate generally would not take into consideration the bricks and mortar overhead, for obvious reasons that the reason, those are built into the rates for in-person visits is because you're sending somebody to an office.

And there, as we said, very good reasons to have people in the office, so we do not want to see this substitute for those services. I'd -- so I don't -- I don't have it, again, specific information to your specific questions, so I'm sorry about that.

REP. PETIT (22ND): Is it possible for your organization to send some information to the Committee in terms of what is the typical percentage of fee thats related to brick and mortars versus those that are related to the other portions of the service rendered?

BRENDAN PEPPARD: I will see what information we have. I don't know if it is collect -- I don't know if it's collected in that way, but i'll see what we have.

REP. PETIT (22ND): All right. Appreciate it. Thank you. Thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you Representative. Can you -- I know Representative Farrar has a question. I'm going to hand it over to her in just a second.

I guess one concern I'd heard from industry was that expanded use of Telehealth would expands a healthcare utilization. I don't know if that's a bad thing or not, but that was a concern that they -- that I'd heard expressed in terms of net healthcare spent.

Over the last year, have we seen at net -- generally speaking, have we seen an increase or a decrease in healthcare utilization as Telehealth is used?

BRENDAN PEPPARD: So I don't have the most up to date information on that. I know that last year during COVID, there was a decrease in utilization. And -- but that's not it -- obviously, not a typical year.

And so, I think that's a question that should be looked at. I think there's been a discussion earlier about examining the whole healthcare system and how Telehealth fits into it, particularly within increase utilization of Telehealth.

But at the moment I don't know whether there's just been -- I know we've seen a more return to normal use of in-person services. I don't know that it is back at its pre-COVID levels. But we certainly saw a significant increase in the use of Telehealth.

SENATOR LESSER (9TH): Thank you. Representative Farrar.

REP. FARRAR (20TH): Thank you, Chairman. I must express, thank you for being here. Just a quick follow up, I think I heard to you -- and apologies if you mentioned this at the start of your testimony. I had to come in from another meeting. I kind of heard two pieces to the conversation that were happening.

One saying the organization cannot support the permanent, you know, continuation of Telehealth and the way that it's been used during COVID. And then, at the same time, I heard you say that Telehealth should be an option for patients. So can you kind of give me a sense of what you mean by that and what your organization is suggesting it looks like moving forward? I'm trying to reconcile those two pieces.

BRENDAN PEPPARD: Certainly, if I had said that, that would be confusing, but that is not what I said. I said, we are supportive of the use of

Telehealth. We are not supportive of the continuation of the payment parity provision.

We believe payment parity should not be part of this, which we believe that reimbursement question should be left to negotiation between the payers and providers and that rebounds as a benefit to consumers.

REP. FARRAR (20TH): So your your challenge is in regards to who is deciding where -- like the payment looks like at the end of the day, and whose responsibility that is?

BRENDAN PEPPARD: We believe it should be left to a negotiation. Correct.

REP. FARRAR (20TH): Okay, thank you for clarifying.

BRENDAN PEPPARD: Certainly.

SENATOR LESSER (9TH): Thank you, Representative. Other questions or comments from Members of Committee? Seeing none, thank you for your testimony.

BRENDAD PEPPARD: Thank you.

SENATOR LESSER (9TH): Next up, we have Leigh Nathan. And I believe the next person we have in -- is Solandy Forte after that, but there may be other people who are signed up before Solandy, who appear between now and then. Leigh, you're up.

LEIGH NATHAN: Okay, hi. Good morning, everyone. My name is Leigh Nathan. I'm a physician. I'm a resident of the town of Madison, and I have been practicing psychiatry in publicly-funded mental health clinics in Connecticut since 2014.

I currently practice at BHcare in Branford, and I'm also a Consultant for supportive housing works on matters pertaining to homelessness and mental health

in Fairfield County. I'm here to explain why I believe you should support Senate Bill 1022 and House Bill 5596.

A lot of these have been covered by previous people, but I just want to point out, in my experience Telehealth has really sped up the rhythm of recovery for a lot of my clients. I do medication management, but we also incorporate other elements of recovery into the visits and it just seems like a lot of people are getting better, faster than we did before COVID and before we were able to use Telehealth. I think this is because we're just able to have a more regular rhythm of scheduling appointments and transportation barriers aren't as much of a problem.

It's really made it possible for me to treat people who work, especially people who don't have a lot of assets, who work and who may not be able to leave work regularly in order to receive care. This includes people for whom I prescribe Suboxone, medication-assisted treatment for opioid use disorder.

I'm convinced that there are people who I would not be able to treat if they had to leave work regularly in order to have the visits that we do so, I do think that it save lives in that regard. I get a lot more accurate information about medications because people can check the meds and that they go grab from their kitchen counter, what have you, during our visits, and so I found that to be incredibly helpful.

For people who are experiencing domestic violence situations, this has been a significant addition to the menu of services that we -- that we offer people in this situation. It can vary from day to day about what's the best place to hold a visit.

Is the office the best place to hold a visit, or sometimes it's home? You know know things can

fluctuate wildly, so we need to be able to offer that flexibility to people in domestic violence situations, I believe.

Another thing that's come up for me, as I provided telephonic-based care, audio-only-based care is the striking realization that we should have been doing this a long time ago. I've been able to do a lot over the phone. I believe that delivering some care is better than delivering no care, and I've been able to do a lot over the phone.

I do think that video-based care is superior to telephonic based care, but it's not always available. A lot of my patients just don't have the tech skills to purchase or acquire or utilize a video-based device. They don't have either the funds or the knowledge of how to acquire Internet or cellular data services.

And so, many people need really hands on personal technical assistance in order to migrate from from phone-based care to video-based care. So I do think we need a robust plan to help the residents of Connecticut migrate from phone-based care to video-based care.

I also want to point out that you know how we practice healthcare is fluid. We're always able to adapt to new situations, including Telehealth from a --

ALEXANDRA DOROTINSKY: Ms. Nathan, you've reached your three minutes, if you like to give a conclusion.

LEIGH NATHAN: Sure, thank you. And so we can adapt to two changes as time goes on. But in the meantime, my agency operates a bricks and mortar facility, they pay me for my time and my clinical decision making and time don't change, based on where the patient is located, and I think my organization needs to be reimbursed at the same rate

for the services that I provide, so I support both these bills, in light of this, and thank you for your time today.

SENATOR LESSER (9TH): Thank you, doctor, for your -- for your testimony. You mentioned the use -- that you use Telehealth for survivors of domestic violence. Obviously, one of the necessary components for the expansion we've seen in the last year is the waving the PEPA. Are there specific privacy concerns or patient safety concerns that we should be considering as we look for a more permanent Telehealth situation?

LEIGH NATHAN: Absolutely, the consideration and all of this is flexibility and choice and options. Every person situation is different. Some people may have access to privacy in their homes, to have a Telehealth visit and some people might not. That would vary from person to person.

And so, we really try to make the most of the options available to us to optimize privacy and, you know, to be able to carry out the visit as as necessary, but sometimes we just got to make do with what we've got, but privacy is definitely an issue.

SENATOR LESSER (9TH): But you wouldn't -- you wouldn't be recommending any additional language in the state statute for us, or at the -- any of the statutes dealing with Telehealth for us to ensure the safety or privacy of people -- domestic violence situations.

LEIGH NATHAN: I wouldn't require privacy in order for a service to be delivered.

SENATOR LESSER (9TH): Okay, thanks.

LEIGH NATHAN: Thanks.

SENATOR LESSER (9TH): Representative Parker.

REP. PARKER (101ST): Thank you so much for being with us, Dr. Nathan. It's nice to see you here, and thanks for your testimony. I just wanted to see if you could share a little bit further on what you started getting into about the -- you know, providing telephonic care. I'm curious to you, and I'm asking on the spot here.

So just do you have a sense of how many of your patients do not have access or would struggle with the video and would require the coverage for only the telephonic piece of it? So I'm curious if you could speak about that, just a sense of the proportions within your patient community.

Then also you talked about you know strategies to help transition folks, noting that you know, oftentimes, the video would actually be better if we could get there. Any sense of what that might be? What's worked? What you've seen happen in your practice in this last year?

LEIGH NATHAN: Thank you, Representive Parker. You are reminding me of something that I've been wanting to do for a long time, which is to count the number of people in this situation. It's significant.

Significant enough, where i've embarked on this with the supportive housing works in Fairfield County to try to get a pilot going up in that region. It's a -- it seems like daily, if not more frequently than daily occurrence, where, you know, I will interact with someone who -- it's clear that the telephonic-based -- they're just not comfortable or are able to get on to a video-based modality of care.

I get emails regularly from clinicians who meet with people in therapy who say, "We're trying, it would be great, we just can't." You know, like there's just -- it's very, very, very common. I don't have a specific number, but I don't even want to put out number but it's very common.

REP. PARKER (101ST): Sure. And is -- .

LEIGH NATHAN: And it affects many members of the healthcare team, as well as the patient.

REP. PARKER (101ST): Any sense of if there's a -- priority is not the word, but the sort of most common occurrence. Is it a result of age, is a result of access because of socioeconomic status, is a result of folks just not feeling comfortable, for, you know, privacy or whatever other reasons? You have a sense of which of those is the biggest challenge?

LEIGH NATHAN: It's hard to -- I would say the biggest challenge would probably be age, combined with socioeconomic status. There are people for whom video-based care exceeds their comfort zone and these may be younger people, especially people with the history of trauma.

And I do think socialeconomic factors play a part in that as well, but they prefer the privacy really that telephonic-based care offers, and we've been able to make some great strides and really amazing strides actually now I think about it in that -- in helping some of those particular patients. But, by and large, I think it comes down to kind of telecom literacy and social -- funds available for these devices in the service.

REP. PARKER (101ST): Sure, and some that have that the literacy is developed just by engaging in, I'm sure, getting more people in that. That's one of the strategies?

LEIGH NATHAN: Strategy would be, yes, coaching. If people can learn then, teaching them if they can't, then just going ahead and downloading Zoom or whatever on their -- on their device. You know the needs to kind of very there as well.

REP. PARKER (101ST): Thanks for all your time, Dr. Nathan. Thanks. And thanks for working -- doing -- for being here. Thanks, Mr. Chair.

SENATOR LESSER (9TH): Hey, thank you, Representative. Are there other comments, questions, Members of the Committee? If not, thank you. Next up actually we have Mark Schaefer. And then following Mark Schaeffer, Solandy Forte. Good afternoon, Mr. Schaefer. please proceed.

MARK SCHAEFER: Good afternoon. I'm trying to find the testimony that I have right in front of me just moments ago. Good afternoon, Members of the Public Health and Insurance Real Estate Committee. It's a pleasure to be here to testify in favor of Senate Bill 1022 and Health Bill 5596 concerning Telehealth. CHA supports these bills.

S.B. 1022 recognizes a Telehealth uses technology to connect patients to a wide variety of vital healthcare services enables access to primary care physicians, specialists, and a variety of other providers. As you've just heard, it further recognize that patient care will be improved by retaining and refining the significant expansion and health coverage and flexibilities that were introduced in response to the pandemic.

We'd like to raise concerns however about Sub-Division 13 of Sub-Section A of HB 5596, which appears to make a provider status as a Telehealth provider contingent on their enrollment and a private and health insurance network or the Connecticut Medical Assistance Program or CMAP network.

As written, a provider would not be a Telehealth provider when providing health services to a patient with uninsured or patient for whom the rendering provider is out of network. In either case, a provider may be participating in a private health insurance network but not the network available to

the insured individual, and those would not appear to meet the proposed definition of Telehealth provider.

This provision would disadvantage those who are uninsured and limit freedom of choice among those who are insured. It is also in conflict with Sub - Paragraph A of Sub-Division 1, which appears to contemplate that some patients may, in fact, not have coverage for Telehealth services to the lack of insurance benefit limitations or network status but I like to pay out of pocket.

We strongly support the provisions in this Bill that provide coverage for the full range of Telehealth modalities and preserve access to audio-only Telehealth services, especially for those who remain on the far side of the digital divide, such as many older adults and individuals, who are low income in communities of color.

We commend the inclusion of provisions that ensure reimbursement parity and flexibility, with respect to where the patient and provider are located at the time of service. We ask that you make a change to Sub-Section C that would allow a practitioner to use telemedicine, to conduct the necessary patient examine communication to satisfy the requirements for provide -- prescribing a schedule to drug.

And we do not support Sub-Section K as written, which pertains to the provision of tells services to a patient located in Connecticut but licensed in the jurisdiction out of Connecticut. It is critically important that patients have a locally licensed provider of care, who is able to coordinate and ensure continuity of care for the entirety of patients care needs, including in-person care as the need arises.

We recommend that this legislation be amended to permit healthcare providers to deliver Telehealth services, consistent with the scope of practice of

their license to a patient located in Connecticut, if the rendering provider is engaged with employed by or contracted with a Connecticut-based healthcare provider or their affiliate. We strogly support --

ALEXANDRA DOROTINSKY: Mr. Schaefer, you've reached your three minutes, if you'd like to give a conclusion.

MARK SCHAEFER: Sure. We strongly support provision that required individual and group insurance policies to provide health coverage for the full range of health care services that would otherwise be covered in-person, and we support House Bill 5596 call for a study by the Department of Public Health to examine the benefits and implications of Telehealth service expansion. Thank you. Thank you so much for your time today.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much, Mr. Schaefer. Appreciate you being here. You know the input from your association is so important in helping us get this Bill right, so I greatly appreciate that and I'm going to assume that you also put in written testimony.

MARK SCHAEFER: I did which elaborate -- which covers a little bit more thoroughly some of the areas where we thought some tweaking of the language might be considered.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much. I think that is important that we consider those things, so thank you for being here. I don't see any hands raised, so I'm going to thank you for your time today and i'm sure we'll be in touch, if we look at the written testimony if we have any questions.

MARK SCHAEFER: Much appreciated. Have a great day.

SENATOR DAUGHERTY ABRAMS (13TH): You too. Next up, we have Soliday Forte -- Solandy, I'm sorry, Forte. Go ahead --

SOLANDY FORTE: It's fine, Solandy Forte. Thank you. Thank you to the Members of the Public Health Committee for having this discussion today. Again, my name is Solandy Forte. I'm a licensed clinical social worker, also I have Doctorate in Applied Behavior Analysis.

I currently am a Director at Milestones Behavioral Services. And we service children that are diagnosed with autism and their families. Right now, I'm running a clinic that was impacted greatly because of the pandemic.

We are currently open in person, but we benefited greatly and our families benefited greatly from the health -- Telehealth service delivery model that was allowed here in Connecticut because of the pandemic.

Through this Telehealth model, we were able to really push forward and continue with conducting assessments for children who were diagnosed with autism and needed applied behavior analysis services. We were able to deliver effective and efficient treatment, through our Telehealth model, provide consultation, triage cases that we're presenting, with some pretty challenging and difficult situations, with regards to the diagnosis of autism.

We were also able to implement a model for diagnosing individuals who had not yet been diagnosed with autism, but who had already been on a waiting list for a year or plus. And because of the pandemic, that had been extended, so the evaluations were just not available for them in person, so we were able to start diagnosing some kids with who, in fact, had autism, so that we wouldn't delay their treatment any further.

But, most importantly, I would like to underscore the -- what Telehealth has actually done for our families. It has provided the opportunity for them to receive a really robust, apparent education program from our clinic. They are learning skills and through Telehealth that are readily available, you know, through this model.

Some barriers that they were facing before Telehealth was available were child care issues, so finding appropriate childcare. Transportation was definitely an issue. A lot of parents work, you know, full time jobs, two jobs, three jobs so loss of wages was something that, you know, they had to consider, if they were going to take time off to participate in our parent education program prior to Telehealth being available. Affordability and also not really interrupting or allowing for that disruption and care, so that's something that Telehealth has also played a big part at -- on with us.

ALEXANDRA DOROTINSKY: Ms. Forte, you've reached your three minutes, if you'd like to give a conclusion.

SOLANDY FORTE: Sure, sure. I think what I'd like to really emphasize here is that we're talking about medically necessary assessment and treatment,and Telehealth has allowed for that, including really taking the opportunity to provide a multidisciplinary approach to that. I'd like to offer -- you know, to answer any questions and again we are -- I am in support of S.B. 1022.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much, Ms. Forte. Appreciate it. My backgrounds in special education, and so I'm really excited to hear that you were able to take advantage of Telehealth during this time. We know how any disruption to services for students on the spectrum.

It can be devastating, so I'm really excited to hear that you took advantage of that, and you found it useful for the clients that you serve, so thank you for coming in testifying today. I don't see any other hands raised, so thank you very much for being here.

SOLANDY FORTE: Okay, thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have number 30, Doris Maldonado. Go right ahead, Ms. Maldonado.

DORIS MALDONADO: Thank you. Buenas tardes. Good afternoon, distinguished leaders of the Insurance Real Estate and Public Health Committees. My name is Doris Maldonado, and I'm a registered Latina voter in West Hartford.

I am here to testify in support of S.B. 1022 and H.B. 5596, as the statewide bilingual Health Information Specialist for PATH CT and National Family Voices Cultural Responsiveness Telehealth Task Force. I offer you my personal and professional expertise.

Telehealth has saved my son last last last year after surviving a false negative COVID test, four deaths in the family and myself, after two subsequent electrical shock treatments to my heart. I am a person with disabilities, adoptive mother of 17-year-old twins with special needs, and a thriving foster daughter.

We are Telehealth commute consumers. Between my children and I, we have over 15 physical and mental health disabilities, resulting and being immuno compromised and adversely impacted.

After 16 days dreading my son's worsening conditions last March, immediately after the world shutdown, I was orphaned and blindsided by my mother's death in

April. Telehealth access like vaccines has always been essential to persons with disabilities.

Health access is an essential human and civil right. Our communities and -- communities remained disparaged by health, housing, food, education and employment and securities.

Those in low-income communities and communities of color have been disproportionately impacted by COVID-19 and are disproportionately likely to struggle with barriers to care, such as transportation and dependent care in non-pandemic times. PATH CT has served hundreds of special health needs families yearly since 1986.

Last month, we've launched a national Telehealth webinar series free to all who benefit from a step-by-step tutorial on how to access Telehealth with meaningful participation in English and Spanish and your support would further the initiative.

Telehealth has increased participation when it's not adding to anxiety because of lack -- Internet bandwidth, adequate devices, and insurance funding to maintain communication.

Our providers are not only limited to mental -- medical health -- Telehealth but also access to peer support groups like Keep the Promise Coalition and CT Casa that service bandaids towards challenges beyond the days when we were forgotten and reminded to isolation.

As an educational translator and advocate in school districts, I assisted in the meaningful participation and continuity of families doing Telehealth by education on health providers and parent teacher conferences.

It's critical to ensure that Telehealth is not simply reactive or a temporary substitute for in-person care, but actively uses the core concepts of

family and person-centered care to enhance the delivery of healthcare systems and services. PATH's core concepts -- .

ALEXANDRA DOROTINSKY: You've reached your three minutes if you like to give a conclusion.

DORIS MALDONADO: Thank you. PATH's core concepts of person-centered Telehealth relate to dignity and respect, information sharing, participation, and collaboration.

Telehealth improves participation in healthcare communication between all team members and across systems and improves quality of life and well-being. Please keep the promise to ensure access to health and the path to better our life force beyond COVID. Gracias.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much, Ms. Daldonado. You bring up such excellent point on how this can help us to address some of the health inequities that we face in our state, including those that exist within the disability community.

DORIS MALDONADO: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): So I really appreciate you bringing that out. And thank you so much for opening your heart and your home the way you have and for the important work that you're doing. I don't see any hands raised, so thank you for being here.

DORIS MALDONADO: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): And thank you for your testimony.

DORIS MALDONADO: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have number 31 Pamela Hoffman. Ms. Hoffman? Go right ahead.

PAMELA HOFFMAN: Hi. Thank you, Members of the Public Health and Insurance in Real Estate Committee. I appreciate the opportunity to testify in strong support of S.B. 1022 AN ACT CONCERNING TELEHEALTH.

I'm Dr. Pamela Hoffman. I'm a resident of New Haven. I'm a Child and Adolescent Psychiatrist, a Clinical Information with concentration in Telehealth and a Medical Director of Telehealth Services at the Yale New Haven Health System and Yale Medicine. I'm representing -- I'm representing Yale University, Yale Health and Yale Medicine in support of S.B. 22.

We have recommendations for modifications to S.B. 1022 that would strongly support our shared aims and wish to work with the Committee to refine the legislation. As a mental health physician in the -- in the emergency department, I am acutely aware of the needs of mental health patients in crisis, especially given the national surge in mental health crises in children and adolescents.

Telehealth has been an essential method for delivering physical and behavioral health services. We strongly support the provisions, which aim to enhance healthcare equity and access, including reimbursement of Telehealth services for no less than the rate for in-person services and permitting audio-only Telehealth to patients.

Currently, the Bill allows providers to deliver Telehealth services, consistent with the scope of practice of their license to an established patient as long as the provider is located in licensed in a border state.

I'd like to add patient stories of countless Yale students who, when they had to return to their homes during the pandemic, were unable to find alternative providers. And unfortunately their providers here are limited in providing care for them once they leave our state.

Yale encourages the Committee to amend the Bill, to encourage reciprocity from neighboring states, as well as to permit reciprocity in temporary locations for people traveling outside the state of their primary provider of healthcare. Struggling students should not have the additional burden of searching for an alternative mental health care provider when they've already developed a therapeutic relationship with one.

As an expert in child and adolescent psychiatry and general psychiatry, I cannot overemphasize the importance of the therapeutic relationship for mental health care, which can be established and maintained over Telehealth. We'd like to bring up provision a private out-of-state providers can they intend to practice in the state with the permissions granted in this Bill.

In the current warning of the Bill, the entities who can track with these providers verify eligibility and credentials. However, who will verify the private practitioners of care, who do not go through a Connecticut-based entity. We encourage the Committee present to consider the implications both for citizens of the State receiving care and for providers out of state reading this bill and recognizing no particular body, who will verify what is expected for them to safely and adequately provide care for me and my fellow residents?

Lastly, in response to Representative Nuccio and masters, the evidence based for Telehealth has been extensively studied, issues with mental health, telestroke endocrinology representative fostered, with the addition of remote patient monitoring, it

can be as successful as regular outpatient or inpatient care.

As others have said, all of this comes down to the clinical impression and decisions of the clinician, provider of care, with respect to each individual patient. We look forward to actively engaging in conversations about ways to expand access to physical and mental health services through Telehealth. We hope the Committee will consider our recommendations. Thank you for your time.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you. I don't see any questions at this time. So I'm going to -- thank you very much.

PAMELA HOFFMAN: I see -- I see two questions from Representative Meskers and and Lesser, but I could be wrong.

SENATOR DAUGHERTY ABRAMS (13TH): No, they're not. They don't have their hands raised. They might be -- .

REP. STEINBERG (136TH): They do actually, Madam Chair. They have their hands raised.

SENATOR DAUGHERTY ABRAMS (13TH): Oh, they do? I apologize. I'm sorry. Oh, I'm in the wrong part. I apologize. I'm glad you saw that. I thought they were just waving to you.

PAMELA HOFFMAN: I'll wave back.

SENATOR DAUGHERTY ABRAMS (13TH): Representative Meskers, thank you.

REP. MESKERS (150TH): Well, I'll defer to Representative Lesser, and then I'll follow up. Go ahead, Matt. Is Matt ready?

SENATOR DAUGHERTY ABRAMS (13TH): Representative Lesser if you want to go first.

SENATOR LESSER (9TH): I would be -- I would be happy to go. Thank you, Madam Chair. Just had a question about your comment about residents or students, who are traveling temporarily out of state. Is it your understanding that a Connecticut residents, who was physically outside of the State of Connecticut would not be covered under the existing Telehealth or the law that expired today but has been extended to the 19th by executive order?

PAMELA HOFFMAN: That is correct. As of the current Bill and every Bill before then, we have been advocating on a national level to change this. But, currently, for example, if a student is based at home in Florida, but they are here for college or for another reason, if they return home, we are required to abide by the laws of the state in which the services are provided.

So -- and that is as it relates to where the patient is at the time of services. So if that patient had to go home to their home -- State of Florida, we have to abide by the Florida state laws. Currently, other states are considering alternative and changes in their state laws that suggest that reciprocity could be adjusted, especially on a temporary level, and that's what we are recommending to consider.

SENATOR LESSER (9TH): If we were to -- and if we were to go as far as, say, hey a Connecticut resident, being seen by a Connecticut provider, who happens to be spending the afternoon in New York City or in Florida were in state for our purposes, they can still run afoul of local law and no matter what we did, right? That could be a scope issue that we would be running into or they could inadvertently run into.

PAMELA HOFFMAN: I'm glad you mentioned it right now. That is a problem and something that we are consistently trying to educate our providers. Because if they happen to be at their aunt's house

in New York, we now must abide by New York's laws. And so, what I would say though is having the laws of our state protect, in some way, shape or form of providers ability to have the -- to have the capacity -- to have the continuity of care that is really essential would be supported.

Right now on another level, New York has already written that into law, where if a New Yorker happens to be out of state, they could be seen by a New York practitioner, so this is something that is probably going to be debated from a much higher level, but from a state's perspective, I think we need to think of our citizens and where and how they'd like to access care.

SENATOR LESSER (9TH): And I assume -- and I take it up a lot of the Committee's time and thank you, Madam Chair for the indulgence. I assume just sort of thinking this through, it's entirely possible that providers are violating this provision every day of the week, because when you Zoom with a patient, you don't really know where they are. Is that -- is that something that's --

PAMELA HOFFMAN: You're absolutely right. And from a healthcare perspective, we have put it in our request, and we have made it part of our education for schedulers, as well as providers to confirm and verify the location of the -- of the patient at the time of service. If a patient happens to be located in an area where they are not permitted to practice medicine, based on our state license requirement, we encourage them to move to a telephone visit. Telephone, given that is a little separate and distinct does not have the same requirements for licensure as video visits.

SENATOR LESSER (9TH): Thank you. This is very helpful. Thank you, Madam Chair.

PAMELA HOFFMAN: That also just reaffirms the need to have telephone-only visits, because if patients

are located in other areas, we need to be able to continue to treat them. Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much for pointing that out. That is is important piece that we consider. Representive Meskers, did you want to go now or do you need to wait?

REP. MESKERS (150TH): Yes. Thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Go ahead.

REP. MESKERS (150TH): Yeah. So, one -- I just wanted to thank a great testimony. And I want to reiterate, it's - I'm not questioning Telehealth. I think the measurement of efficacy and the measure of reimbursement and that discussion should be an open conversation.

There is no question if you look at artificial intelligence and the development. Telehealth is going to be here to stay. And it's just a question of utilization, efficacy, etc., etc when we figure out the -- you know the issue of absolute parity, I -- it's a conversation we're having. It's not that I'm sitting here with the -- I'm locked into a position. So just understand I'm trying to wrestle with with that issue, and that's it.

PAMELA HOFFMAN: I really appreciate that. Thank you, sir. I will add I have been studying this for a while. This has been my interest in passion for decades and the research that I've shown has shown a comparable diagnostic accuracy since the 1990s, comparable treatment outcomes since the early 2000s, and clinical outcomes improvement since the 2000s as well. And this is as far reaching from telemental health, mostly studied through the VA because they can, as well as many studies on telestroke, telepalliative care and endocrinology through Telehealth.

REP. MESKERS (150TH): OK. So that's half of my question is efficacy. And the second would be the wrestling through the insurance companies providers on the cost and the benefits of the efficacy is similar if it's cheaper for either or both parties should be -- should on parity with the physical visit. Its economic questions more than, "I don't have a medical in here, I'm not going down that road," so I appreciate your advice.

PAMELA HOFFMAN: No. I really appreciate the question. And I would only add that if we know from an evidence-based study, is the same then what we're thinking about in cost structures, not just the cost of providing the care, but the cost of avoiding higher levels of care.

So avoiding an inpatient stay, avoiding an emergency room visit. And as a provider of psychiatric emergency care in the in the emergency department, I would love to reduce the burden in the emergency department and Telehealth has been shown to decrease costs in hospitalizations by 24%.

REP. MESKERS (150TH): Thank you. That's -- it's incredibly helpful. All right. That -- thank you, Madam Chair. I'm done.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you Representative. Representative Steinberg?

REP. STEINBERG (136TH): Thank you, Madam Chair, and thank you for your testimony today. I just wanted to follow up on one of the comments you made that audio Telehealth requires a different level of credentialing. Does that concern you at all? Obviously, you know, the purview of these committees is to make sure that we not only assure access that we assure quality. And if credentialing is not held to the same standard, could that be a problem?

PAMELA HOFFMAN: It's an excellent question. Thank you for asking. And I would say that I, perhaps,

misspoke. It's not about the credentialing. it's about the licensing.

So, currently, licensure -- a medical license in each state is required. I think it's like a criminal act in some states if you're practicing medicine, without a license. That criminal act does not apply if you are providing care to your established patient over the phone. So that is the distinction.

I do believe that telephonic care is not the ideal care. Obviously, the ideal care would be either an in-person visit or a Telehealth visit, depending on the clinical nature of the -- of the presentation. Telephone is insufficient, though sometimes necessary, and that's why it needs to be there.

There are patients who have technological literacy issues. There are patients who have socio economic issues, where the data required to perform a video visit is over their monthly budget. And so, we need to be thoughtful of patients needs and, sometimes, we have to compromise care so that care can continue.

So I don't believe that it would be as good as getting them on the video and sometimes it will be good enough and sometimes, as a physician, we need to think about good enough care.

REP. STEINBERG (136TH): Thank you for that. It seems to me that we’re going to have to think about the appropriate conditions, maybe even by -- especially in which that choice telephony is a necessary and appropriate, and not just granted broadly.

It makes -- and more challenging to do it that way, but I agree with you. It is a lifeline to many people in the community, and we should find a pathway for those whom really need that. So, again,

thank you for that clarification. Thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you representative. Representative Carpina.

REP. CARPINO (32ND): Thank you, Madam Chair. Pamela, I just have a couple of quick questions. Most of my questions have already been answered. I -- since this has been a passion of yours, I appreciate, if you have the time and the inclination of you sending over some information, explaining how telephonic care versus video conferencing care. And I may be in artful in my descriptions.

Across state lines is not the unauthorized practice of medicine. I don't -- I have no reason to doubt you, but I want to understand better the differences so that, as we move forward, I personally believe the telemedicine is a wonderful tool, in some instances. And the physicians I've spoken to him have, at least, agreed with me that it is a tool, and it is -- this is not an end all be all.

But I want to understand the difference, so that when we move forward we do it the right way. i don't believe in loopholes, but if we're going to craft legislation, I want to make sure that we understand the framework. So if you don't mind sending over some information, that would be helpful.

PAMELA HOFFMAN: Absolutely. And I can also tell you that from the late 50s, this has been studied, both on video phones in and outside the Indian Health Services through NASA, through University of Nebraska for Telehealth and telemental health. We've been studying Telehealth for a very long time. And I think what we're getting into right now is kind of misunderstandings, based on the lack of a standard definition for Telehealth.

Currently, Telehealth is understood as the -- as the giving and receiving of healthcare at a geographical distance. More importantly telemedicine is often described as the provision of healthcare via video or audio visual needs. And then you get into various aspects. It's already been talked about synchronous, asynchronous care, and that's happening in real time versus in some other outside of time method.

Now, all of this has been studied. Very little was studied for telephonic care, but what often happens in studies, then research that have been happening from the get-go is, obviously, when you're laying down T1 lines in the middle of the 1970s, the bandwidth wasn't always great, and so it often did go back to telephone.

So we know the telephonic care was done, even in the early times. I think what you're getting at is really how do we help to organize the levels of care that are really essential to promote adequate and effective health care? And I think what we need to realize is, from a clinical standpoint, that could be and should really be the clinical decision of the provider of care.

So if, as the provider of care I feel that the care for this patient getting therapy could be done safely effectively over the phone, then that should be a clinical decision that's made using the tools that are available to me. And then, if I feel that seeing additional -- seeing additional parts of the mental health -- mental status exam over video is really essential for me to get a better feel of the patient to treat them better then that should be a different clinical decision. So I do believe that there needs to be some kind of guidance, but I also think we need to remember the clinical decisions and the needs of the patients and the providers.

REP. CARPINO (32ND): You’re almost accurate, but thank you. I'm not looking to make medical

decisions. I'm looking as a policymaker to make sure that our definitions are accurate and reflects what we, as a body want to do. So thank you very much. Thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you Representative. Representative Parker?

REP. PARKER (101ST): Thank you, Madam Chair. Thank you, Dr. Hoffman. It's -- I really just learned a lot from your discussion of the extensive history of this. That was really helpful.

And I wonder if -- can you speak to -- and I know we have physicians that are on this Committee might be able to speak to this as well -- but it just occurred to me to ask is there training that physicians are getting in medical school and continuing education, otherwise to know when it is best to suggest Telehealth versus some of the other distinctions you shared versus, of course, in person, obviously, coming from a place a lot of trust.

But I just wondering, is that something that's discussed specifically? And do you have a sense of if providers are well equipped to do that? Is that another piece of this?

PAMELA HOFFMAN: I am so glad for that question. It was actually my first published article, was discussing the education for telepsychiatry and programs residency programs for psychiatry. I will tell you it's not enough. Training, it -- the -- has not happened, and that's why several states now we're looking at legislation to encourage competency and trainings for providers and schedulers of care. We've tried to make an effort to provide different kind of training.

In the beginning of the pandemic, the clinical decision making was a little bit easier because everyone had to stay home. So it was either, do you

see them over video or can it wait? And that was the extent of it.

Now it actually gets much more intricate, much more elaborate, and much more disease department division specific. So from an endocrine standpoint if they have a bluetooth-enabled glucose monitor, where their blood glucose measurements could be uploaded remotely right into the electronic medical record, a provider and endocrinologist could potentially look at that, see the patient over video and continue to provide exactly an appropriate level of care.

And if they're seeing trending numbers from that electronic transmission, they could suggest that an inpatient visit is more important. So I completely agree with you that the education needs to be there and the varying clinical needs of the patient is going to shift now that we have the added benefit of being able to allow in-person care when appropriate.

REP. PARKER (101ST): Thank you for that answer, I appreciate it.

PAMELA HOFFMAN: Thank you.

REP. PARKER (101ST): Thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative Parker. I think that's it. I think that's all the questions. Sorry for the mix up at the beginning. I guess, a lot of key questions. So I'm glad you were able to be here with us today, and thank you for your testimony.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have Matthew Dimond, number 32. You're done. Go right ahead. We can't hear you. I do not hear you. Mr. Dimond, I see you and that -- doesn't look like you're muted.

Oh, yeah. You are still muted. There we go. Nope? Could it be your volume? According to what I see,

you're unmuted but we don't hear you. I do not hear you still.

Is it -- no. Do you want to try -- why don't you -- why don't you try signing in again? Okay, we'll call when you get here. Number 33 Joseph Quaranta.

DR. JOSEPH QUARANTA: Thank you. Thank you, Senator. And can everybody hear me?

SENATOR DAUGHERTY ABRAMS (13TH): We can hear you. Go right ahead. Thank you for being here, doctor.

DR. JOSEPH QUARANTA: Thank you so much, Madam Chair. I want to thank the Committee for the opportunity to speak today in support of Senate Bill 1022 and House Bill 5596.

My name is Joe Quaranta. I'm a Primary Care Physician in Branford, and I'm also President of Medical Group, which is an organization of over 1,000 primary care behavioral health and specialty clinicians who work in, approximately, 250 independent practices across New Haven Fairfield and New London counties.

I'm here today to express our strong support for the posed legislation, and I've submitted detailed written testimony on that legislation, which I've submitted to the -- to the Committees yesterday. I'll add some comments, in addition to that written testimony.

First, I would like to stress the critical importance that Telehealth has played in our delivery system, both in direct response to the COVID pandemic and in our ability to maintain access for other critical health care needs that were, obviously, impacted by the restrictions placed upon us by COVID>

I also want to point out to the Committees of the efforts that all of our providers, where the small

independent practitioners up to our large institutions made to under significant arrests, particularly the beginning of the pandemic, to implement these telemedicine services for our patients and our communities during those very difficult early days of the pandemic.

I would also add, for the record, that we did so without any guarantees of payments and we faced a complex system eligibility requirements and reimbursement procedures that were very difficult for us to navigate through, nevertheless, we were able to implement these services for our patients, in many cases overnight in some of our practices.

The regulations that were enacted by the Governor and the Legislature through Executive Orders and legislation last year were critical to ensure ability to provide these vital services and is very important that we enact them permanently as this legislation proposes.

I want to add that, without those actions that were in -- put into place last year, it would have been very difficult for some of our practices to actually survive through the pandemic without access to the revenue that telemedicine services provide us at that time.

I want to highlight several concepts, which are critical to maintaining a robust Telehealth service for our communities and our key components to be included in this legislation. I would also add that I raise these issues because these are all real examples of potential restrictions that we face as practicing providers as we tried to implement telemedicine last year during the height of the pandemic.

I'm just going to highlight a few of those examples for the Committee and there's more detail in my written testimony. The first is that we should have a network of telemedicine providers, where any

willing provider can provide telemedicine services and we avoid close Telehealth provider networks.

This was the exact proposal that was meant made to us last year, where we would have closed networks for Telehealth services. We should allow agnostic technology for providers to use for telemedicine services with their patients, assuming compliance with state and federal guidelines.

What we do not want to have our specific technologies for particular insurance companies. Again, this was the proposal that was made to us last year that we would have specific technological requirements for different insurance companies to manage a provider, having to use a different Telehealth platform, depending upon what patient is ensure -- the insurer had used. There should be mandatory coverage for -- .

ALEXANDRA DOROTINSKY: Dr. Quaranta, you've reached your three minutes, if you like, to conclude.

DR. JOSEPH QUARANTA: I will then. Thank you. And mandatory coverage for Telehealth services will be critical. On the final point I will raise is that payment parity for telemedicine services should be put in place to be consistent with services that are provided in person. I want to thank the Committee for their attention to this matter and I'd be glad to answer any questions or any further details.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much, doctor. Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. And thank you, Dr. Quaranta. And thank you for your service on the fairly thankless vaccine advisory group communication subcommittee, where you took a lot of bullets for a lot of people.

DR. JOSEPH QUARANTA: My pleasure.

REP. PETIT (22ND): Can you speak to the -- in your written testimony, you spoke to the issue of prohibiting insurance for opposing global payment restrictions. Can you -- can you can you explain that to the Committee?

DR. JOSEPH QUARANTA: Absolutely. It's a very important component, and this is another restriction that has been talked about. One of the proposals that was made to us was that if the provider provided a telemedicine service, that we'll be restricted from being reimbursed for any subsequent services that we had to provide in a period after that.

DR. JOSEPH QUARANTA: Example being so I do a telemedicine visit for somebody on Sunday or Monday for some particular issue, and then the patient I decide that there's medically appropriate follow-up that's needed two days, three days down the road.

One of the proposals was to limit our ability to actually be reimbursed for those services, which really makes no sense and it's not really part of any other episodic care that we do. I think the theory was the that was trying to avoid that we would be seeing someone for telemedicine service and just bringing them back into the office a day or two later to actually have another visit um, but you can imagine how challenging it would be for us to actually have to provide ongoing care to people who do require multiple visits for appropriate reasons in that context.

REP. PETIT (22ND): Can you speak a little bit to your file for in your testimony in terms of tThe impact on malpractice coverage, if you're seeing people across state lines of previous speaker and spoke to the issue of license in some legal issues, can you speak to the malpractice issue?

DR. JOSEPH QUARANTA: I raised two issues there. And, again, I you know, I was involved in trying to

develop negotiate telemedicine access for our two or 1,000 providers, so we had to go through all these issues in great detail.

It was not clear again at the beginning of the pandemic that our malpractice plans would be covering telemedicine services at all and under what circumstances. A couple couple of issues where it was unclear -- was particularly unclear whether they would allow us to provide telemedicine services to new patients, for example.

The other issue would be if we were providing call medicine services, out of -- across state lines even if we were licensed or eligible via those telemedicine services across state lines. And, in general, there was a lack of clarity about whether telemedicine services and where they fit into the medical malpractice realm.

So our recommendation is that we be somewhat prescriptive about the requirements for a carrier who's going to write medical malpractice coverage that they -- that coverage for telemedicine services is actually covered in that -- in those policies as a standard.

I can tell you there was a period of time providers in this state were trying to figure out whether they were actually covered by telemedicine services that we now consider standard in this process. And I think unless we make that a formality, this could be, can you to be an issue going forward. And I think once we're out of, hopefully, out of the emergency of the pandemic I think those areas could become more murky once again.

REP. PETIT (22ND): Thank you for that. And thank you for your testimony. Thank you, Madam chair.

DR. JOSEPH QUARANTA: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. Representative Comey.

REP. COMEY (102ND): Thank you very much, Madam Chair. Hello, Dr. Quaranta. Thank you so much for your testimony, and appreciate your your patience, I think, with -- in regard to revenue collection and the earlier part of the pandemic. Do you have any issues or concerns about the issue of having to confirm the benefits ahead of the visit?

DR. JOSEPH QUARANTA: Yes, thank you Representive. That is a concern to us, and that's a piece of legislation that we would recommend, perhaps, reconsideration of. I think it would be very challenging and onerous to expect providers to individually confirm the specific availability of a telemedicine benefit for each patient before they provide that service.

One is you can imagine just that -- if it was even a moderately easy task to do the amount of burden that, that would place on our offices for every visit to have to do that before we could comply with that visit, but it is not an easy task to do under even good circumstances. It is very difficult and challenging for us to navigate that type of very specific benefit confirmation, given the complexity that the payers have placed upon these type of benefits. Between the fully-insured market, the self-insured market, and the different benefit packages that they would have, I think it would be near impossible for us to do that in a reasonable way and maintain a efficiency for our services.

REP. COMEY (102ND): Thank you very much, and thanks for the care that you provide. The folks in Branford I think probably one out of seven people I meet go to your practice. So you guys are doing great work, thank you.

DR. JOSEPH QUARANTA: Thank you very much.

SENATOR DAUGHERTY ABRAMS (13TH): Representive Parker.

REP. PARKER (101ST): Thank you, Madam Chair. Thanks Dr. Quaranta. It's nice to see you again. Just wondering if, in the context of payment and fees and trying to get a little bit clear understanding of the economics, could you speak about the impact on overhead, especially for small practices and independent providers when we're talking about the difference between Telehealth or sometimes Telehealth for patients that would then be able to be in person later. Is there a savings on overhead? And if the -- sort of as a follow up because I think I know you're going to say hearing your testimony, if the -- if there wasn't parity, what do you think would be the impact in terms of the services you'd be able to provide folks going forward? Thank you.

DR. JOSEPH QUARANTA: Thank you that's really an important point. The first thing we have to understand is look look at the context in which telemedicine, is being provided. We are not remote-only practices. We don't work out of a bunker somewhere, where we're not delivering in-person services.

Even though we've added telemedicine to the repertoire of things that we provide for our patients, we still have to maintain and provide all of the things that we do. We have to maintain the ability to provide five, six, seven-day a week in person services. We have to have staff in our office to do that.

You know telemedicine, although it's a significant component of the work we do is settling in at a low enough percentage that we cannot online that infrastructure that we have in place and all honesty the infrastructure that we need for our patients and to provide those services.

So in it -- in it -- in a -- in a way, when you look at it, we have not really discovered any lower infrastructure costs because we've had to maintain the same infrastructure we have in the past. The second component is telemedicine costs us money to implement. So now, in addition to our baseline infrastructure, we don't have to pay for the services that are necessary to provide telemedicine.

The final point that I would provide, and this is an interesting issue to think about is, the time that requires the clinician, whether it's a physician or the nurse practitioner during the telemedicine visit is actually higher. Because of the way nature they encounter, I don't know how many of you have done a telemedicine visit, we're kind of taking our patients through the entire visit between logging them in, helping to get set up for their technology. So many of our providers have actually felt that their personal efficiency is a little bit lower and they're seeing less patients in the same amount of time than they were when they doing telemedicine going forward.

The second point I want to make, and I want to -- I want to bring up, and I think this is raised earlier at the -- on the Committee is you know the concept of reduced payments doesn't make a lot of sense because we're still providing the same service. And let me expand on that a little bit. You know providers are compensated based on both the intensity and the complexity of the services that they provide. And we have agreed to very complex and long and negotiated processes with the payers to determine what we're paid for a particular service, and there are strict rules in strict guidance that we all have to file to determine it. And those same guidelines are applied to an in-person visit versus a telemedicine visit.

So if I have a short brief visit or a less complex issue in the office, then I'm paid less for that visit, and I would be so for telemedicine visit.

Even on providing the same service, we're still making sure that we're providing the same benefit the same payment. But if I'm providing a very complex service and the patient and the provider feel that that service is appropriate provided through telemedicine, then we should be paid the same for those services over time.

So to summarize -- one, we are not really seeing any lower cost for providing telemedicine service. We may actually be seeing some increased costs. And all honesty, we're still providing the same level of intensity and complexity of services to our patients. And we have negotiated -- I should say this some groups are able to negotiate.

Many groups, as you heard from some of the organizations here earlier today aren't even able to negotiate those rates from payers. And what the parents have proposed is not a complex or nuance system to try to determine how we should be paid, but blanket reductions taking a percentage of what we were paid in the in-person, setting and a significant reduction in the outpatient setting. And they're just as an event any evidence to match and support that that's rational to do.

REP. PARKER (101ST): Thanks for that. And presumably during the worst of COVID when we've had probably the greatest restrictions, hopefully, for a while, where we're going to face again with the highest need for telemedicine, if you didn't see reductions and operations, then and overhead presumably going forward when this is going to be a smaller piece, although still important, it's not likely that you would or individual practices would start to find those, as we, I don't know, get better at it or or and, again, I'm reminded of a recent person testified saying we've been actually doing this for a long, long time and so presently we're pretty good at it already, but just it -- do you have a sense of what might change going forward out of COVID?

DR. JOSEPH QUARANTA: Well, so it's a great point. So a couple things I mentioned. First of all, is you know the concept of trying to lower payments for these services, we're sitting here in a -- in a -- in a state where we're trying to actually find ways to support our medical practices, particularly our primary care services. And since the services provided by telemedicine, the typical, E&M filled regular visits are the bread and butter of those groups, if we apply a discount to those services it would tremendously impact our practices.

Even if you took an assumption that telemedicine is 15% or 10% of our of -- our volume going forward, which may be about right depending where things are. If you apply to a small practice a 25% reduction in that revenue, that eats into the margin of the practice.

Those practice would go from being solvent to insolvent. So I will -- I would say this really clearly if there is a reduction in reimbursements for telemedicine services, practices and provider groups are going to have to look at living the services. There's no way that we can actually continue to provide open access full patient choice to a telemedicine, or in-person service if we're going to be paid at a discount. It just won't work for us. We're not going to be able to support it, or do it going forward. Thanks, Dr. Quaranta. Thank you Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. Representative Nuccio. We can't hear you. It looks like you're it says that your microphone is on but not hearing you. Still can't hear you.

REP. NUCCIO (53RD): Is that better?

SENATOR DAUGHERTY ABRAMS (13TH): Here we go. right ahead.

REP. NUCCIO (53RD): Sorry. This is what happens when you've got multiple meetings on at the same time. Good afternoon, doctor. how are you?

DR. JOSEPH QUARANTA: Good afternoon, Representative. So you brought up something that, I think, again, I would like to kind of dig into a little bit. You had mentioned that doctors who are providing Telehealth right now are providing the same services. And you mentioned the fee schedule.

But my concern is right now that there should be no insurance providers that are paying less right now because the Governor's Executive Order demanded parity that whatever a doctor was getting for an office visit, they should get for Telehealth.

So I know, in the past though, Telehealth calls were handled differently, and they were actually organizations like Medlive and stuff like that, who did it, and they were definitely paid less because the services that they were providing were not the same services as you would get when you went into a doctor's office.

So I guess, my question is as a provider, do you think it would be fair for us to maybe extend this for a short period of time, but then have a task force to look at the actual parity and care received in the parity and how we're -- excuse me, how we're paying.

Because I struggle with the idea or the assumption that you're getting the same exact service through Telehealth as you are being physically present in your doctor's office. And I think about things like the rules that we put in place, you know you can't call a doctor now and get any biotics without physically being seen.

We have practices in place regarding issuance of opioids and stuff like that, things that require

doctors have eyes on visits. I am looking at providers who are trying to do things through a cell phone that require them to physically, be able to help and touch and look at -- you know I've seen dermatologists try to schedule exams that are full body exams over a cell phone.

So I would be interested in looking at the actual parity in the -- in the services that we're receiving, the quality of care that we're getting and then allowing, like you said, for level -- of levels of intricacy more intense visits and stuff like that, for that to be part of the process of a negotiated rate, rather than a one-size-fits-all.

Right now, you pay the exact same rate across the board, because in trying to find ways to control healthcare costs, having this additional -- those additional method, it -- for a level of care that's not the same is going to increase the cost of health care and not the value of healthcare.

So would that be something that you think you're --- you could get behind like an actual study or research or looking into the different levels of care and then applicable levels of reimbursement, rather than a one-size-fits-all you have to pay one rate across the board?

DR. JOSEPH QUARANTA: I think those are all excellent points, Representative. And the first thing I would say is that, I think, you alluded to some tell of health -- Telehealth and telemedicine models, which I think are fundamentally different than what I think those of us who have established practices in the state or have.

And these are truly remote telemedicine models that aren't providing comprehensive services to patients, they're on call, essentially urgently available telemedicine services. And very historically those organizations did this, and in pre-negotiated rate at a discount.

But they also don't provide the full gamut of services, right? There very different structure, very different purpose. And so, I think -- I would approach -- setting that aside, because now we really are talking about are really as an extension of your established care team and your care network providing you telemedicine services in the context of that delivery model. I just was -- so to set the base -- baseline for that.

The second point I want -- I want to talk about is that when we say parity for services, again, what I'm not saying is that you get paid the exact same for something in person, as you would do something by telemedicine. What I'm saying is we apply the same set of rules and the same set of already negotiated contracted rates for that applied to the rules for what with services we provide.

And so it doesn't mean that you can do everything by medicine that you could do in-person, and it also doesn't mean that, on average, you could provide more intensive services and more complex services in-person than you could by telemedicine, and therefore get paid for them.

What it means is that we have an agreed upon set of rules and agreed upon set of negotiated rates that if we qualify for the level of intensity that we provide by telemedicine, we should be paid the same for those. Because we've already negotiated those rates and we've already learned to live by those rules.

And I do think your point is well taken. I think it was alluded to in the previous speaker, or two speakers ago. We do have to continue to study and learn about what are the appropriate services that could be done by telemedicine, and what or not. And I think going forward that it's important.

My only concern, Representive, about having a time limited legislation is that our providers need security. We need to understand that if we invest in these services that they're going to be there for us going forward. I also think we need to understand that if there's a time limit on this, that eventually if there's a time when this is not in the middle of the public attention, it does not seem as much as an urgent need, then that -- all of a sudden, we have a service that we've provided that goes away.

So, I would certainly be always supportive of doing a study and understanding what the terms are. There was also an opportunity for providers and payers to continually negotiate those rates, and there's nothing for him, being a provider in the future from agreeing to a different rate with the payers.

What we're proposing is the payers uniformly through their policy and procedures power that they hold in their contracts that they don't allow us to actually change saying, "Tomorrow we're just going to give you a discount for all the services that we're providing." And that's why we need to legislators to port on the parity question.

REP. NUCCIO (53RD): So I think that's -- I think we agree on that. I think -- you know I think We absolutely agree on that. Where I struggle with this legislation is it's just continuing the Executive Order that dictated whatever you pay for an office visit is what you're going to pay for Telehealth. And it doesn't give that nuance, which I think what you were saying the same thing.

There's a difference new -- different nuance of care that's involved with, you know, an office visit, in a Telehealth visit. There are certain times that Telehealth 100% meet that need, and then there's a time that you can't, and like you're going to have to go in and make that second doctor's appointment to actually physically be with the doctor. And

then, you know there's, the complexity of double billing and everything else.

So to me I think we're saying the same thing. And my only point with the six month is my struggle right now with this legislation is that it is broad based. It is wholehearted just parity and payment. And there -- it's not -- I take in that nuance into consideration, but I would consider voting for something like this.

If I knew within six months, we would have had those conversations and we would have them developed like for you guys for doctors and for the insurance companies to have that the conversation that says level of care, level of reimbursement, what can and what can't.

Well, I don't think this Bill does that I think it just says extend Telehealth and extend paying the same amount, period. I know it doesn't -- it doesn't give the level of detail and I really think we need to be giving this because, again, I think there's some things that I think you could almost exclusively move to Telehealth for. And then there's some that I think you absolutely can't. And to say you know you have to pay the same amount that you're paying right now for an office visit, regardless to me, just inflates the cost of health care. And that's a concern of mine across the board is is the cost of health care.

So I think we're saying pretty much the same things. I just wanted to clarify that the time limit for me was more just about if I were to then become favorable and say, "Yes, I would vote for this." I would want to guarantee that within six months, we would have had groups together working groups, you know, everybody at the table to come up with a plan so that it makes sense, moving forward, that benefits everybody.

That -- that's my time limit thing. I -- and maybe six months isn't that right number. But I have a hard time just getting behind the legislation exactly as it's written because I don't think it helps us move forward in a -- in a productive way, but thank you very much for your response, and please feel free to --

DR. JOSEPH QUARANTA: One thing I would add, about I just want to speak very honestly about the impact, times have had. Our practices and providers have been living under deadline extensions and time limits for these services for a year now.

REP. NUCCIO (53RD): Yeah.

DR. JOSEPH QUARANTA: And it's been incredibly challenging for us to see and plan forward to keep our practices going and to provide the services. And I think that -- I think -- I am very personally, you know, concerned about the issues that you -- you'd mentioned about making sure that care is delivered appropriately and appropriate care is given in the right right place and right time. And I think that, unfortunately, I don't think a six-month timeframe is going to give us enough time to really do the deep studies and the -- get the information that you want.

What I'm concerned about, though, is without your help that the provider groups are going to be severely disadvantaged going forward, in terms of how these policies are put into place. And I think that we have groups already that are barely making it out there.

And if we take away this revenue stream or add more overhead to this revenue stream, I don't think they're going to be able to make it or they're going to have to get rid of these services altogether because for some practices, things are that challenging now. And we, what we need now, more than anything else to certainty, and I think that's

one of the big arguments to put in place something without timelines. The -- this this body can always come back and we address this, if it turns out that there is a issue with services, then we can actually come back and readdress it.

And maybe given everything the providers have done for the last year, maybe on this one we get the benefit of the doubt and if the insurance companies want to change it, they have to come to you and asked you to change the legislation leave our policies in place. And it's really the same difference it's just a matter of who initiates the process.

REP. NUCCIO (53RD): I see that but it's not the insurance companies that suffer for this. You know when you look at it, it's -- the employers are the ones who decide. Insurance companies just administer. So it's the -- it's the employers who are going to
bear the brunt of the cost of this too, going forward, as you say you are too, along with several other businesses in Connecticut and in the country that are bearing the brunt of how COVID is impacting them and how we are then supplementing that business.

So, you know, it's broad scope to me. And I don't think it can be narrowed down to, you know, one group is suffering more than another when it comes to that. And I'm hoping that as the vaccines rollout and stuff, we'll be able to see people going back to their normal expected behaviors and go into the doctors and not having to be home and be afraid and be on Telehealth, which I think is an opportunity, again, to look at what services makes sense from a Telehealth perspective, and which ones are beneficial to continue going forward. In which ones, we would want to see people going back into the office for?

So, I think, it's just a really complex thing. And my -- again my problem with the time limit is that if we don't -- and we just say we're going to continue to pay providers the same exact dollar amount for Telehealth call, as it requires for going into the office, then we're going to -- we're not going to do anything to help the cost of health care in that, you know, but again we're just -- we can go back and forth. I appreciate your -- I appreciate your input though. There's a lot of stuff to think about. And I -- and I really do appreciate the back and forth.

DR. JOSEPH QUARANTA: I might add one thing just to think about, I think, in terms of talking about the cost of health care, you know the state's own efforts looking at where the cost of healthcare has been driven over the last several years and looking at the cost benchmarking trends.

If you look at where that cost growth has been driven you break it down into buckets, it's not the professional services provided by physicians where that has been done. We've actually come in below the cost of living and the cost growth targets.

And so, in some respects, we've actually already been kind of providing care and efficiency. It really is hospital-based services and pharmaceutical services.

REP. NUCCIO (53RD): Yeah, absolutely.

DR. JOSEPH QUARANTA: Again, I think, I agree with your point. But, boy, we are having a hard time making it as it is. And I think this is a relatively small piece of the bucket. There's so many other opportunities that -- and then we could certainly have conversations about this in another forum about really driving health care costs down in those categories that are truly driving the spend.

I don't think that us having a parity for telemedicine is going to -- is going to affect those buckets very much where the real cost spending so that's the final thing I'll say. I really, thank you for the conversation.

REP. NUCCIO (53RD): Yeah.

DR. JOSEPH QUARANTA: Really appreciate it.

REP. NUCCIO (53RD): No, please, and if you would like my contact information, I'm pretty easy to find, but I would love to continue on the conversation, because you did mention something that is very near and dear to my heart, and that is the actual cost of health care and making it more affordable, and I agree with you wholeheartedly, you know, hospitals and drug care -- drug cost is really where we need to focus.

SENATOR DAUGHERTY ABRAMS (13TH): Representative? Representative, I'm just wondering if it'd be okay if we move ahead, because we have other people that need to testify.

REP. NUCCIO (53RD): Yep, yep.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much. Thank you. Thank you, doctor. I don't see any other questions.

Next, we will go back through Matthews Dimond. I think I saw you on. We'll see if we can get you heard this time.

DR. MATTHEW DIMOND: Perfect. Is it working this time?

SENATOR DAUGHERTY ABRAMS (13TH): Perfect. It is working. Go right ahead.

DR. MATTHEW DIMOND: Wonderful. Thank you good afternoon and certainly for your patience, Committee Members.

I'm Dr. Matthew Dimond. I'm a Doctor of Chiropractic and Assistant Professor and Clinician at the University of Bridgeport. And tell you with regards to our dress to Senate Bill 1022, AN ACT CONCERNING TELEHEALTH, our request is simply that chiropractic profession remain part of the variety of health care providers eligible to provide Telehealth services.

As you may know, chiropractic is a profession that's recognized as a provider of this service, and has been, since the initial law passed in 2015. On the point of equity, Telehealth makes healthcare more available to low income communities and the convenience of using online or dial-in services gives those access, where missed work travel or other associated costs could be barriers to regular care.

On the point of our current situation in this pandemic, now more than ever, people are in need of alternative care delivery pathways. And I can speak from personal experience how important it was to be able to provide this care in this way.

It was during this last summer when early COVID precautions did not permit patients to be seen in person, yet it was through telemedicine I was able to not only maintain current treatments for patients but also provide relief for many new to chiropractic.

One patient in particular, who has an ongoing immune issue recently wrote that she wanted to thank me for sharing expertise and taking time to help me. And now she's running every morning and she's lifting weights again. And if anybody's on their video, here's my little Thank You card. I can't open it but here's a little Thank You card from her. As

access -- as access to needed services continues to be a barrier for appropriate care delivery, we believe that these expansions and inclusions of chiropractic should continue in the Senate Bill 1022. Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much. Thank you for being so efficient in your testimony. I do not see any hands raised this time, so thank you so much and thank you for your patience and getting that technological part of this fixed. So I'm glad you're able to testify. Have a great day.

Next up, we have number 34, Dr. Gregory Shangold. Doctor, are you there?

DR. GREGORY SHANGOLD: Yes, hi. Good afternoon.

SENATOR DAUGHERTY ABRAMS (13TH): Go right ahead.

DR. GREGORY SHANGOLD: So good afternoon, Members of the Insurance and Real Estate Committee and the Public Health Communittee. My name is Greg Shangold. I'm the President of the Connecticut State Medical Society, which represents over 4,000 of connecticut's physicians. Thank you for the opportunity to provide supporting testimony for Senate Bill 1022 and House Bill 5596.

In general, we strongly support the effort and concept raised by these two Bills. However, we do have some concerns with the specifics that we hope we can -- that can be modified for the final version. I would like to refer you to the written testimony for much of the detail, so just going through some of the highlights.

Although Telehealth has been having an increasing footprint over the past years, by then, mostly driven by the necessity of the COVID-19 pandemic, physicians needed to rapidly incorporate Telehealth to continue to provide care for connecticut's resonance.

There -- in these two Bills here today, 1022 seems to have the details, where 5596 still has not much language beyond the concept so it's hard for us to comment on that. We applaud these Bills' proposed changes to the Connecticut statute requiring parity with the services, as Representative Nuccio and Dr. Quaranta just went through in detail.

But coverage alone is not sufficient for facilitating expansion of Telehealth. So, in the past, without these sort of laws, many ensures have reduced arbitrarily those rates. And so, we do applaud that section within the -- within this statue.

I just wanted to address a few other issues. And I think you've heard, most of these throughout the day, but we do not agree that phone-only should be excluded. There are times such as the student issue that was brought up before or the elderly with -- trouble with equipment, where there is an appropriate time for phone-only and audio.

Also, this idea of having to know a person's, whether they're in a self-funded plan or a fully-insured plan before they provide services, this is impossible. One solution we've brought forward in the past, is to have this information on people's medical cards, but even when you get EOBs, often that information is not there. And, given the commercial network in Connecticut where about 30% are fully insured and 70% are self-insured, this often does cause many ramifications and a lot of problems for doctors offices.

We wanted to talk about the out of state providers as well, again, going back to the College student from Connecticut is out of service, where there's a continuation of care that, you know, there are appropriate times. Also some people in Connecticut do seek second opinions and referrals out of state but to open the floodgates or --

ALEXANDRA DOROTINSKY: Dr. Shangold, you've reached your three minutes, if you'd like to give a conclusion.

DR. GREGORY SHANGOLD: Yes, so to open the floodgates to out-of-state providers doesn't seem like the best solution. So, in closing, we support this legislation, particularly the issues with parity, as Dr. Quaranta eloquently explained and we look forward to working with the Committee figuring out how to do this for connecticut's patients.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much, doctor. And you did put those suggestions into your written testimony, I will assume.

DR. GREGORY SHANGOLD: Yes, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you. Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you, Dr. Shangold. Could you -- when you've reached out to the can I go say macrostudy, your constituents,
what have been the top two complaints in terms of being able to effectively administer Telehealth? What's been the biggest blocks for people in terms of participation of doing it successfully?

DR. GREGORY SHANGOLD: For the patients or for the providers?

REP. PETIT (22ND): For the -- from the provider point of view, so I assume you're -- you know talking -- they're talking to you and telling you what -- giving you all their complaints.

DR. GREGORY SHANGOLD: Right. Well, I think -- one, like Dr. Quaranta has said that it's sort of been a moving target over the past year, where there was an

extension and another extension, and we've been living by this Executive Order.

Meanwhile physicians wanted to take care of their patients, and they had to find the means to do so. So the uncertainty has been one of their biggest problems. Many have made this investment. I believe, others are sort of pausing on how much they're going to invest, until they know this is a temporary process or it is a -- go to be a continuing process. So I think that's number one.

Though, you know, one thing that hasn't been mentioned, I'm trying not to be redundant and all the other testimony that you heard. But seeing a patient and laying on the hands provide certain benefits but talking to a patient, listening to their voice. I think in Medical School, they said 90% of your diagnosis is going to come from the history, right? This was something that we were taught.

And when you go through that type of history, people have realized that this is important. I am an emergency physician so I'm never going to be using Telehealth in my -- in the emergency department. That -- that's not what we're there for, but I have experienced it both with the patients and the -- and how they presented, where someone's concerned because of a Telehealth visit.

And also we've been using it for telling neurology, and it really has been practicing in Eastern Connecticut or in a small rural hospital definitely helped to augment those places, where they couldn't get traditional care. And so, I think we're all starting to see how this really can be a value to society.

REP. PETIT (22ND): Are you able to speak to it all the -- you referred to the investments people weren't sure they wanted to make it. You -- could you speak to what would be a typical number for a

practice or what kind of things that they're investing in with small practices to come up to speed?

DR. GREGORY SHANGOLD: I think there's a lot of things, Representative, first of all, obviously all the hardware that that's there, how much bandwidth they're going to need on an ongoing monthly costs to make sure that they have the technology. I do believe the support staff needs to be there to help patients guide through, as some people don't have the same literacy as other people do.

There are some times monthly charges if you're using a software that does have the HIPAA protections that are in there and necessary for this to develop those platforms, and those are some ongoing technology concerns.

And so, you know, all of these are sort of ongoing those typically monthly expenses. Remember still about half of Connecticut's physicians are private practice small physicians without a running a business. And I think to what Dr. Quaranta said they want to be there for their patients, but they can't run their business at a loss. And when these costs are there, they need to know that they're going to be covered, not to mention many of the fixed costs with the setting up.

REP. PETIT (22ND): Thank you. Thank you, Dr. Shangold. Thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. I do not see any other questions, doctor. So thank you so much for being here. Thank you for your testimony today.

DR. GREGORY SHANGOLD: And, thank you. Have a good day.

SENATOR DAUGHERTY ABRAMS (13TH): You too. Next is Steven Madonick.

DR. STEVEN MADONICK: Yeah.

SENATOR DAUGHERTY ABRAMS (13TH): Go right ahead, sir.

DR. STEVEN MADONICK: Okay, thank you very much, Madam Chair, and honorable Members of the Committee. My name is Dr. Steven Madonick. I'm a Physician and President of the Connecticut Psychiatric Society and Organization, representing nearly 800 psychiatrists, who are medical doctors specializing in psychiatry.

I'm testifying today, in support of Bills 5596 and 1022. We learned during the pandemic that Telehealth improves mental health service -- improves access to mental health services. No show rates with Telehealth of 5% to 10%, compared to up to 30% with in-person care. At our clinic, one patient with the history of trauma missed three appointments in a row with her psychiatrist. She ended up being nearly discharged because it -- the people in the clinic thought she wasn't interested in treatment.

In fact, she couldn't travel to her appointments. She couldn't afford to repair her car and a trauma symptoms prevented her from getting on a bus or using a ride service. She was ashamed to tell people at the clinic the reasons why she wasn't able to attend her appointments.

However, when COVID-19 hit and Telehealth was reimbursed as part of the emergency measures, she was able to see a psychiatrist without leaving home. She not -- she didn't miss any more appointments after that time.

Another benefit of the emergency measures was full reimbursement for telephonic appointments. We had an older man with psychotic symptoms, who lived in a single-room occupancy hotel. He had no access to most technology, didn't have a computer, didn't have a smartphone, didn't have broadband, and he was not

able to get treatment by Telehealth. Without treatment, he likely would have required hospitalization during the pandemic.

Fortunately, he was able to -- he did have a State-issued cell phone and he was able to continue treatment by telephone, and he did remain stable. With telephonic care, more people with serious and persistent mental illness or SPMI getting the treatment that they need. Audio alone treatment is crucial for increasing outreach to SPMI patients often insured by Medicaid and supporting their recovery.

In conclusion, Telehealth and telephonic care help us to reach the nearly 30% of patients who currently do not consistently attend in-patient appointments, and it meet -- in a Community psychiatry setting. The continuation of Telehealth and telephonic care will help to expand access to mental health and substance use services, which we will need to care for the increased number of people likely to seek mental health and substance use treatment as a result of the pandemic. Connecticut needs to pass necessary laws to continue Telehealth and telephonic care, and I'll answer any questions if anybody has any.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much for that testimony, doctor. I really appreciate it you sharing some real stories of how this can be so impactful for the people that you serve. So I appreciate that part of your testimony very much.

I don't see any hands raised, so I will thank you for your time today and for --

DR. STEVEN MADONICK: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Your testimony. Thank you.

DR. STEVEN MADONICK: Okay, thanks.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have Tracy Wodatch.

TRACY WODATCH: Thank you. Good afternoon to the distinguished Members of the Insurance and Real Estate and the Public Health Committees. My name is Tracy Wodatch, President and CEO of the Connecticut Association for HealthCare at Home.

The association is the united voice for the licensed skilled home health and hospice agencies. I'm testifying today in support of S.B. 1022 AN ACT CONCERNING TELEHEATH. Let me explain how Telehealth has been used by our home and community based providers.

Historically, some of our larger home health agencies have utilized telemonitoring, as part of the physician ordered plans of care for higher risk cardiac pulmonary and diabetic patients. Through telemonitoring, a tablet, along with a blood pressure cuff, a pulse oximeter, and a scale, are placed in the patient's home for daily monitoring and transmission of data to the home health office, where a nurse reviews trends to catch early warning signs, such as a sudden rise in blood pressure or weight and to communicate with physicians for treatment changes with a goal of avoiding emergency room evaluation or hospitalizations. This type of Telehealth has been used since the mid-90s, yet has never been covered by any insurance.

More recently, and especially during the pandemic, both home health and hospice agencies have been using physician-ordered Telehealth via tablets and or smartphones for face-to-face remote visits to evaluate a far greater population of patients in both the community and facility settings. For hospice patients living in nursing homes and assisted living, early on in the pandemic, it was the only way for our hospice experts to see their patients, as we were not allowed into facilities.

As you know, so many lives were lost during the pandemic and not being able to support the patients in person, as they journey through their final days has been particularly disturbing for both the patients loss, the families left behind and the providers.

For home health, we appreciate the temporary Medicaid Telehealth coverage during the public health emergency and have proven the value and benefits of being able to remotely access our patients and their families. Examples include behavioral health nursing and social work visits, nursing visits for a wide variety of medical and post surgical assessments, therapy disciplines, including physical occupational and speech.

Given the population, we serve, there is a need for audio-only, as a large number of patients do not have the technology, including Internet in their homes. Also, unfortunately, for home health, there is still no Medicare or commercial insurance coverage and the Medicaid coverage is currently set to expire at the end of the public health emergency.

Moving forward we envision mostly in-person visits, but find that Telehealth visits as an option should be a permanent tool in our toolkit to be able to effectively reach and evaluate our patient population. We encourage you to make Telehealth coverage permanent Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you for that. And I like the way you put it, that is just another tool in the toolkit. Yeah, I don't think it needs to be thought of as a replacement for things but I think it's an expansion and a way for us to just provide access to healthcare to some people who might not otherwise have it. So thank you so much for your testimony, and I don't see any hands raised, so have a good day.

TRACY WODATCH: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Good to see you. Next, we are moving on to number 44, Scott Sussman. Mr. Sussman, go right ahead.

DR. SCOTT SUSSMAN: Good afternoon, on behalf of the Yale New Haven Health, thank you for providing the opportunity to testify in support of S.B. 1022 AN ACT CONCERNING TELEHEALTH, though not in support of H.B. 5596. My name is Scott Sussman. I'm the Physician Executive Director of Telehealth for Yale New Haven Health System. I work clinically as a hospitalist at Yale New Haven Hospital.

Despite Telehealth existing for over 50 years, Telehealth adoption in Connecticut was low prior to COVID. One year ago we rapidly embraced it. And because ultimately Telehealth is about making connections and providing care, Yale New Haven Health went from providing fewer than 400 Telehealth visits in 2019 to over half a million in 2020.

Used appropriately, telehealht meets the Institute of Medicine's six domains of quality. It's equitable, patient-centered, timely, effective, efficient, and safe. It can complement in-person visits with for some conditions may still be clinically appropriate and Telehealth should be incorporated seamlessly into healthcare delivery and be one of the tools that clinicians can use to provide comprehensive patient care.

Through increases and thankfully decreases in COVID rates, we've seen that a combination of face-to-face, remote patient monitoring and Telehealth either video or, in some cases, audio-only delivered high quality healthcare. Early in COVID as we've heard and all experience, Telehealth was the only option, and now the decision for face-to-face or Telehealth depends upon clinical appropriateness and patient preference.

This flexibility to consider Telehealth visits or face to face provides high value patient-centered care. And it really underscores the need to have ongoing equal coverage for both video and telephone-only visits, along with equal reimbursement, as well as coverage for remote patient monitoring. The Hippocratic Oath we take states first, "Do no harm," and clinicians want to do the right thing for our patients, including selecting in-person or Telehealth based upon clinical appropriateness.

COVID highlighted opportunities to ensure healthcare equity, and as a stepping stone in this journey, we need to include voice-only care for patients who may lack access to technology or have low technological literacy. While these gaps are being addressed, phone-only Telehealth can provide meaningful care for select patients, as we've heard many of the other speakers today.

In our primary care clinics, we've seen decreased no shows for scheduled routine office visits over Telehealth. This is particularly important since preventative care is both better for patients and more cost effective, since it decreases the need for expensive urgency rescued care. Engaging patients for healthcare in meaningful ways improves health and using Telehealth to do this, remove some of the barriers that are associated with in-person visits, especially for some of our more vulnerable patients.

Telehealth has been and will remain an essential method for equitably delivering clinical and behavioral health services and it's useful engage patients and enhance access. Earlier today, we heard that some of the members on this Committee --

ALEXANDRA DOROTINSKY: No, you've reached your minute mark, if you like to give a conclusion.

DR. SCOTT SUSSMAN: Great, thank you. Have -- some of the members of these Committees have received every at Telehealth and know the value it provide

and understand the need for ongoing equal coverage with video and telephone-only visit, along with a reimbursement for remote patient monitoring. On behalf of Yale North Haven Health, I strongly urge you to support S.B. 1022, and thank you for your consideration.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much, Dr. Sussman. Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Dr. Sussman, you alluded to it, and it's something I've asked a couple other providers of -- are you starting to gather data on your patient such that by increasing -- by decreasing amount of these visits, you're preventing people from showing up for urgent or emergency care. Have you started to compile data on that specific issue?

DR. SCOTT SUSSMAN: So we're starting to collect it now. We don't have the data yet. Though it is something that we'll probably see some information in the short term. Other things are going to be longer term if we think about chronic conditions for retreating patients hypertension that's going to prevent a heart attack in 10 years. So some of the data will be much more longitudinal but in terms of some of the visits for heart failure exacerbations, COPD, or asthma, those are things that we are looking to quantify and we have groups looking at that currently.

REP. PETIT (22ND): Thank you. Anything you have, even preliminary that you could forward to the Committee, like you forward a testimony would be helpful to us in our deliberation, so thank you very much. Thank you, Madam Chair. Thank you.

DR. SCOTT SUSSMAN: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. I agree with your comments and just hearing going from 400 to half a million is pretty

mind boggling really, so it's good to have that information. It's -- so whatever you can provide us is very much appreciated.

DR. SCOTT SUSSMAN: Great, thank you for the opportunity.

SENATOR DAUGHERTY ABRAMS (13TH): I don't see an+y other questions at this time, so thank you for being with us, Dr. Sussman.

DR. SCOTT SUSSMAN: Thank you. Have a good afternoon. Number 45, Katherine Rodriguez.

KATHERINE RODRIGUEZ: Hello, thank you. Good afternoon, Members of the Public Health and Insurance and Real Estate Committees and the general assembly. My name is Katherine Rodriguez, I'm a social work student from Southern Connecticut State University, and a resident of Waterbury Connecticut. I stand in support of Senate Bill Number 1020, AN ACT CONCERNING TELEHEALTH.

Telehealth has become essential to providing health care during the COVID-19 pandemic and should be continued permanently. It is unknown when this pandemic will end, and as Connecticut safely transitions to more face-to-face interactions, it is not certain that everyone will be comfortable with in-person treatment just yet. Providers and clients may feel safe -- may feel comfortable and doing in-person treatment while others may not or cannot do to help conditions that make it too risky.

Telehealth offers providers and clients the option to -- sorry. Telehealth offers providers and clients the option to choose, unable to live or receive treatment based on their personal safety concerns and needs. Telehealth has served as a safe and useful tool in treating clients who used to be seen in person, but more importantly, it has opened the door to mental health treatment for populations

who previously fall through the cracks due to lack of accessibility.

These people, include single parents who lack child care, people with physical disabilities, people who lack transportation people who live in rural areas, people who have mental health disorders that prevent them from leaving their home, such as agoraphobia and so many more.

Telehealth addresses their needs and find some of the flexibility that in-person treatment lacks. These populations have been overlooked for too long, but have finally made help.

My personal connection to Telehealth is my mother. She is a licensed clinical social worker who, before the pandemic, provided in-home therapy to clients. Throughout the COVID-19 pandemic, she's been using Telehealth to provide mental health services to the clients. She has underlying medical conditions that, for her health, that even more of a risk of severe illness from COVID-19.

However, Telehealth has enabled her to continue treating her clients, despite her conditions. I fear, her having to choose between her safety and treating her clients should Telehealth services be discontinued. Senate Bill Number 1022 will allow for treatment delivery choice underserved populations to continue receiving services and my mother to stay safe.

Telehealth has shown to be an invaluable safe and unique tool for treatment. To end Telehealth services would be to take a major step backward in Connecticut's progress in making mental health care services safe and accessible to all. I stand in support of Senate Bill Number 1022. As a social student and daughter, I urge the Committee to support this legislation. Thank you for your time.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you so much, Ms. Rodriguez. Have you ever testified before in front of a Committee?

KATHERINE RODRIGUEZ: No, it's my first time.

SENATOR DAUGHERTY ABRAMS (13TH): Well, you did a very good job, so I hope it's not your last time. And advocating --

KATHERINE RODRIGUEZ: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Yes, advocating for your profession and looking out for your mom, so ...

KATHERINE RODRIGUEZ: Yes.

SENATOR DAUGHERTY ABRAMS (13TH): Great job.

KATHERINE RODRIGUEZ: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Representative Farrar?

REP. FARRAR (20TH): Thank you, Chair. Thank you, Katherine, for being here. I just wanted to comment it's refreshing to hear a little bit about the provider perspective because I think, you know, sometimes when we're thinking about those who need to provide this care, you highlighted so clearly that, for our providers, they might have underlying health conditions that require them to be at home, so thank you for illuminating that so brightly. And as Senator Abrams said, I have no doubt your mom would be very proud.

KATHERINE RODRIGUEZ: Thank you, I appreciate your comment.

SENATOR DAUGHERTY ABRAMS (13TH): I don't see any other questions or comments, so thank you so much for being here, Ms. Rodriguez and, again, I hope

that we see you again. Next up, we have number -- oh, we're going to go back to number 40 Trisha Farmer.

TRISHA FARMER: Good afternoon.

SENATOR DAUGHERTY ABRAMS (13TH): Yes, go right ahead.

TRISHA FARMER: Yep. Thank you. So Senator Lesser and Abrams, Representative Woods and Steinberg and other Members of the Insurance and Real Estate Committee, as well as the Public Health Committee, thank you for the opportunity to share our support of these two bills. My name is Trisha Farmer. I am the Vice President of Regional Partnerships and Operations at Connecticut Children's. And I oversee our telemedicine program throughout our health system.

So Connecticut Children's is the only children's hospital dedicated exclusively for children. We provide care for children in every corner of the state and address both clinical needs and the social determinants of health. And we know the pandemic exacerbated many of the challenges our families and our children face and we use telemedicine, to make sure our children had safe access to care when they needed it.

So we've completed 70,000 telemedicine visits at this time, and we average about 300 visits, virtual visits per day. However, we are concerned that in Section 2 of the Bill 1022 audio only visits for out of network providers would not be permitted. Some patients would be prevented from receiving care from their preferred provider through audio only and this might impact or compromise their continuity of care. And families might be responsible for higher out of network cost and this -- and not be able to afford to see their regular provider, and this could become an health equity issue. Especially for our lower income families that need this -- need the care.

So telemedicine has allowed providers to network and share practices with community pediatricians and hospital providers. This can reduce hospital visits nd allows the child to receive care without parents having to find transportation take additional time off from work, have to pay for gas, have to pay for parking and then travel to different sites.

Telehealth takes away some of these barriers and allows the child to be seen by the provider were, previously, they might have been late to an appointment or missed an appointment all together. And telemedicine also allows in, you know, compromise children and children with complex medical or behavioral health needs to be seen safely in a familiar setting.

So an example is Lauren. She's a 16-year-old patient of ours, and she's on the autism spectrum. Telemedicine has supported her continuity of care, by allowing her to have virtual visits were with her developmental pediatrician. And this has helped her throughout the school year and help with her transition, as she moves towards adulthood.

Three-year-old Jackson has had virtual visits with his provider for chronic bowel issues and needs close monitoring. Virtual visits have made it easier for Jackson's mom to adhere to his care plan. Jackson's mom has had some difficulties, making in-person visits. She has limited resources, she works full time and she has other children.

And 16-year-old Maddie, a Type I diabetic could benefit from remote monitoring. This would allow her blood sugar fluctuations, to be identified and treated more quickly. And as a result, she would have less complicate -- less complications, potentially less hospitalizations and better long term quality of life overtime.

ALEXANDRA DOROTINSKY: Ms. Farmer, you've reached your three minutes, if you'd like to give a conclusion.

TRISHA FARMER: Yep. So I'd like to share it just a concern with Section 1-I of the Bill 1022 that states providers should be reimbursed at Medicaid rates for out of network visits. The amount charged should be in line with the entities financial policy and not tied to Medicare rates. And I also urge the Legislature to adopt reimbursement rate parity for Telehealth and in-person visits. Telehealth is an important tool in the future of healthcare delivery and can be just as effective for providers and patients as in-person visits. So -- and thank you for your consideration today.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much, Ms. Farmer. Appreciate your testimony. And I appreciate you bringing the benefit to the children to our attention. Senator Lesser?

SENATOR LESSER (9TH): Yes, thank you, Madam Chair, and thank you for your testimony. Just a question about that provision about out-of-network providers. A big chunk of the Bill that's before us is simply codifying many of the Governor's Executive Orders, certainly the Legislature put our stamp on it when we added a parity and platform neutrality. But I -- that particular provision about the out-of-network providers was in one of the Governor's Executive Orders. Do you have any kind of legislative history about what was the genesis of that? Was that about incentivizing carriers to provide the service? What was -- what -- from your perspective, do you have any sense of where that came from?

TRISHA FARMER: I believe that was exactly what you said, but I could look into that a little bit further for you. I mean it's -- for us it goes back to -- it's all about access for care and if children have regular providers, they should be able to see

those regular providers for continuity. It's about access and continuity and delivering the best care.

SENATOR LESSER (9TH): Great, thank you.

TRISHA FARMER: You're welcome.

SENATOR DAUGHERTY ABRAMS (13TH): Representive Petit. Thank you, Madam. Thank you, Madam Chair. My question I don't know if it's in your area, Ms. Farmer is whether you knew anything about the insurance companies you deal with, whether most of them now have separate telemedicine companies or you're dealing directly with the insurance companies or telemedicine companies that they're now associated with our purchase. Do you have any knowledge of that specific area?

TRISHA FARMER: I think that is changing and expanding over time, but at this point, we're dealing with the insurance companies. And the platform that we use when we deliver telemedicine is we use our medical record, which is Epic with Zoom technology. And a patient family can use a smartphone, an iPad, a desktop to connect with us so it's as easy -- we make it as easy as possible. And we set them up ahead of time, we have so teaching tutorials to really help them out so it's been very, very successful.

REP. PETIT (22ND): Thank you. Thank you for your good work and thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you. Representative Carpino.

REP. CARPINO (32ND): Thank you. Just one comment and one suggestion. So i've actually had the ability to use a virtual telemedicine visit with one of your specialists. And it went remarkably well. I have to tell you I wasn't surprised because this particular physician is one of your rock stars. I have nothing but wonderful things to say to him.

But I have to tell you from my patient family perspective, how successful it was and how easy and straightforward it was. But now to my suggestion it was very appropriate for that particular type of visit as dictated by the provider, which is why I always believe that the provider should be the one making the determination.

But as we're looking at expanding these oftentimes when you're dealing with bringing a child for care, whether it is with you guys are even a local pediatrician, there's often a diagnostic component for some of our children. And if there's a way of uncoupling whether it's a an X-ray, lab work so that a patient parents or caregiver has the ability to take care of that, so that it could be with the physician, in advance of that meeting.

I know that's one additional step, but just something to be considered as we're looking to make patient access greater through this technology, but please my takeaway for you, is it was a wonderful success and I thank everybody at Connecticut Children's.

TRISHA FARMER: Great, thank you. That's wonderful here -- to hear. And that is something we're working on to make sure the diagnostic, the tests are connected through the technology. So when the provider does the visit, they have all the scans, they have everything right in front of them, they have the patient record to make sure that patient gets the best care that they can possibly get.

REP. CARPINO (32ND): But if I could just finish, Madam Chairwoman. I think it's one additional step, perhaps, for staff to think. And I know they're already busy to, perhaps, schedule that X-ray or schedule that that test in advance, so that it is available for the -- for the particular provider, but thank you, ma'am. Thank you, Madam Chairwoman.

TRISHA FARMER: Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. I don't see any other questions or comments, so thank you so much for your time Ms. Farmer, for being here today and for the work you do on behalf of the children of our state. Appreciate it.

TRISHA FARMER: Thank you. Thank you for allowing me to be here today.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have number 46, Dr. Christopher Gargamelli. I apologize if I'm mispronouncing your name.

DR. CHRISTOPHER GARGAMELLI: Oh, no worries at all. Thank you --

SENATOR DAUGHERTY ABRAMS (13TH): Go right ahead.

DR. CHRISTOPHER GARGAMELLI: Thank you very much, certainly. So I'm Dr. Chris Gargamelli. Thank you for having me here today, Members of the Public Health Insurance Communities. I represent the Connecticut Veterinary Medical Association, the largest organization of professional veterinarians in the state.

I am here before you today to claim that while oversight and regulation of telemedicine is so important in human health care, it is even more important in veterinary medicine. I, therefore, asked you to amend House Bill 5596 to include the veterinary medicine.

The statute regulating veterinary practice protect the health, safety, and welfare of both the public and animals for which we provide care. Within those statutes, there are no regulations regarding veterinary medicine and telling -- Telehealth, allowing for potential harm to animal and public health.

Amending House Bill 5596 to include veterinary medicine would update regulations, some of which are over 70 years old, by defining the veterinary client-patient relationship as a basis for veterinary care.

Doing so ensures that the licensed veterinarian has the necessary knowledge of his or her patient to provide proper care. That patient may be a single dog or cat or an entire herd or flock. Connecticut is one of the few states that has yet to define the DCPR.

As such, our citizens and their animals are at risk from outside entities trying to push the boundaries of having sufficient knowledge of the patient to provide proper care. Without a DCPR, a veterinarian may need to be located nor licensed in Connecticut could diagnose or treat a patient in Connecticut via electronic or telephonic communication. That animal and its owners would not be protected by the regulatory powers of the Connecticut Board of Veterinary Medicine and Department of Public Health.

As shown by the COVID pandemic and legislation passed by the Connecticut General Assembly last summer, there is utility to Telehealth and human medicine. However, a human medical doctor can speak with his or her patient and ask a multitude of questions to reach a diagnosis. In veterinary medicine, we don't have that luxury.

The hands on physical exam is the primary tool of veterinarian uses in formulating that initial diagnostic and treatment. Given that our patients do not speak in often hide their illnesses and injuries from us and their owners, the in-person physical exam is key to properly diagnosing a patient.

Imagine if a rabid animal symptoms were missed by a veterinarian diagnosing the patient over faith.

Amending House Bill 5596 would elevate Connecticut to the standard of care of 47 other states and recommended policy of the American Veterinary Medical. By including language regarding veterinary medicine, AN ACT CONCERNING TELEHEALTH, you protect the health, safety, and welfare of the public and animals. Thank you very much. I'd love to take any questions you may have.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you for being here, doctor. Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you, doctor. Your group rather represents and certainly been before public health over the last two or three years, in terms of Telehealth and veterinary services. I wonder if you'd make a comment on, a topic that's often come up at least in public health, and that is whether or not a prior relationship with the veterinarian and the animal in question is needed, or that you could -- whether you could do quote "new patient" visits from a veterinary point of view?

DR. CHRISTOPHER GARGAMELLI: Great. Thank you for allowing me to clarify that issue. So what we're asking for is the establishment of the veterinary client-patient relationship. So what that defined is that there is an initial in-person visit. So follow-up here lends itself oftentimes well to Telehealth, but there needs to be that establishment of that veterinary client-patient relationship with an in-person examination initially before we can do follow up with Telehealth.

And, you know, follow up can be in so many different ways, but in order not to miss something, and in order to establish that initial relationship, we need that veterinary client-patient relationship.

REP. PETIT (22ND): And can you speak to the benefits that you've seen during the pandemic in terms of veterinary Telehealth? Or that it's either

for the patient, the animal or for the owners per se, especially a lot of, I assume elderly patients who weren't able to travel or felt they should quarantine for safety reasons?

DR. CHRISTOPHER GARGAMELLI: So where we've seen it be useful is in that follow-up care if we're monitoring something. So if we're monitoring a wound healing if we're monitoring patient's response to treatment for hypertension. That was -- you know earlier in the day, they were talking about how that lend itself well in, you know, human healthcare.

In veterinary medicine, we can monitor for response to treatment to medication very well via Telehealth. So I think for the monitoring and follow-up, there is some usefulness, as long as it is within that veterinary client-patient relationship.

REP. PETIT (22ND): Thank you, doctor, for your testimony. Thank you, Madam chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you Representative. Representative Dathan?

REP. DATHAN (142ND): Thank you very much, Madam Chair, and thank you so much for your testimony today. One area where i'd see a benefit -- I mean, I agree with you initial consultation should be done in office, but sometimes my dogs when we go to the vet, have a completely different temperament than we have at home.

And so, what I was going to say is if, in those circumstances, you know, where I can kind of show the vet that, yes, indeed my dog is ill or this is, you know, some evidence, it is beneficial then. I don't know if you have any comments on that, where you think it could be beneficial for outside of the pandemic.

DR. CHRISTOPHER GARGAMELLI: So in that particular case in -- you know the area of veterinary medicine

that you bring up in particular is behavior, right? So the specialty of behavior where we're looking at, you know, how an animal interact in the home, how they interact with the other animals, how they interact with people, that is a great opportunity, especially with video to be able to use Telehealth.

But, again, you know all of this needs to be established with that initial visionary client-patient relationship, and the reason being is so many things in veterinary medicine that we look at our animals and think is a behavioral problem. So, for example, a cat not using a litter box, you know, oftentimes gets pawned off. "Oh, the cat doesn't want to use the litter box, is there something wrong with their behavior?"

You know that could be a urinary tract infection or arthritis along, and not to get into the litter box, so I think you need that still initial physical exam rule out the medical side of things and then that lends itself once you do that, you know, perfect opportunity to follow up with Telehealth and you look at the home, look at how the animals interacting. So thank you for that question because I think it allows us to clarify that useful.

REP. DATHAN (142ND): and I’m just speaking about pet insurance, which I don't have a huge amount of experience in, but do you, as a practitioner, have issues with reimbursement during the pandemic for Telehealth visits for certain patients that you may have had Telehealth visits for?

DR. CHRISTOPHER GARGAMELLI: So in veterinary medicine, our insurance were way different than on the human health care side. It is on a complete client reimbursement side. So upfront, the client still pays the veterinarian. And, you know, we provide all of the medical paperwork that they submit to their insurance carrier. And we have not heard of a case, where they've been denied.

But, again, you know we're conscious. So we're, as a profession, already from just based on our national guidelines falling under that veterinary client-patient relationship. So most of us are already doing this, where we have a physical relationship and, you know, maybe follow up with Telehealth. So it hasn't come up because the majority of the cases are still that in-person initial with maybe some Telehealth follow-up.

REP. DATHAN (142ND): That makes sense. Okay, thank you so much for your present -- or your testimony. And thank you, Madam Chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. I don't see any other questions at this time, doctor. So thank you for being here and giving us this to consider, as we move forward with the Bill.

DR. CHRISTOPHER GARGAMELLI: Thank you all very much.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have number 47 Emily Morrison.

EMILY MORRISON: Hello, everyone. Good afternoon, Senators and Representatives, Members of the Insurance and Real Estate and Public Health Committees.

EMILY MORRISON: My name is Emily Morrison, I'm a Putnam Resident. And I'm Director of Development here at United Services Incorporated in Dayville. United Services is the local mental health authority for 21 towns in Northeastern Connecticut. We provide more than 30 programs under one administration, including outpatient mental health, substance abuse treatment, family and parenting programs and crisis services.

Thank you for the opportunity to provide testimony and support of H.B. 5596 and S.B. 1022 ACTS

CONCERNING TELEHEALTH. United Services supports efforts and the Legislature to codify and the expansion of Telehealth services has occurred over the last year and showing that Connecticut continues to pay for Telehealth at the same rate as in-person visits allows telephonic or audio-only sessions. This is especially important for the many low-incomes people that we serve, people that do not have access to the technology required for video conferencing and allows the use of any HIPAA compliant platform.

So when COVID-19 hit last March, United Services was directed by our state funders to stop seeing people in person, for most of our programs, which we did, and we quickly switched and launched to Telehealth. And this allowed us to safely connect with our patients and continue providing our critical care during a time when it was not safe to see them in person.

We have also been providing in-person care since June 2020. But we have continued to deliver services over Telehealth. So this has been especially important when we have clients who have had to quarantine due to COVID-19 exposure or have had COVID themselves. We at a -- we have other clients who remain anxious about being in public spaces, including our clinics, and Telehealth has allowed them to stay engaged in their treatment and continue to care for their mental health.

We are seeing huge increases that our programs. Some of our programs are operating at a more than 200% increase in services month to month from those good old pre-COVID times. And Telehealth has helped us to stay connected with everybody. COVID has, without a doubt, greatly impacted the mental health of adults, children and families and helps us to stay connected to everyone in need of these services.

We urge the Committees to pass robust Telehealth legislation that guarantees all people in Connecticut will continue to have access to Telehealth services using the device of their choosing and providers continued to be paid at the same rate as in-person services moving into the future. Thank you so much for your time and your consideration of this important issue.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much for your testimony. I don't see any hands raised. So …

REP. MCCARTY (38TH): Yes.

SENATOR DAUGHERTY ABRAMS (13TH): Oh, I do I'm sorry. Representative McCarty.

REP. MCCARTY (38TH): Sorry. Thank you.

SENATOR DAUGHERTY ABRAMS (13TH): I was going forth, and I forgot. So thank you, Represenative. Go right ahead.

REP. MCCARTY (38TH): And I apologize. Thank you so much, Madam Chair. I just have a very quick question. And this morning, I asked of another person testifying: And you just mentioned that audio only is used quite a bit at your -- at United Services. Do you have any idea of what percentage of the clients may need to use audio only? Because this morning, we heard that it was as high as 40% in one of the providers. So if you could just kind of – you know it doesn't have to be definite but just an idea of how much the audio-only means to your your organization?

EMILY MORRISON: I don't have statistics right in front of me on the number of patients that we've needed to use audio only. I can get those and refer them back to the Committee. But I will say the clientele that United Services services is largely a

low income, about 78% of our clients who use medicare Medicaid for their primary insurance.

And so, issues like a smartphone or an Internet or computer are definitely things that we see in our clients and we work to problem solve that. We were able to get a lot of people smartphones, or help them get Internet connections at the beginning of the pandemic, and so we were able to work through and problem solve for a lot of our clients to be able to connect to them, and we certainly prefer video conferencing, but there are times when it's not possible, and it's important to be able to stay connected and to keep providing that with service that's what's most important for us. I would not say it's as high as 40% for us. But like I said I can -- I can get that data. With us, it's more of a almost emergency-only situation.

REP. MCCARTY (38TH): Right. And I think that would be useful information for us to have as we go forward. I know you highlighted that it's important that we offer equal access. And for those individuals that don't have any other means of staying connected, I think it's important to recognize, so thank you for your testimony. Thank you, Madam chair.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you, Representative. Ms. Morrison, i'd like to -- Morrison, I'd like to believe that this might be a way to help us address some of the health and equities that exist in our state, but at the same time, we have to be aware of some of the challenges that you testified to, that exist, so that we can, indeed, make it more equitable. Thank you very much for that. I don't see any other questions, so thank you for your time.

SENATOR DAUGHERTY ABRAMS (13TH): Next, we have Dr. Melissa Olive. Doctor, go ahead.

DR. MELISSA OLIVE: Thank you, Madam Chair, and thank you all for giving your time today on such an important issue. I am Dr. Melissa Olive, and I actually have a couple of different pieces of testimony that you would have gotten in your packet.

So I'm first going to talk about Connecticut Association for Behavior Analysis, which is my background. I'm on the -- well, I Chair the Public Policy and Legislative Outreach Committee, and we work with a Board of Directors to submit our testimony, which I'm not going to read to you. I'm also the Chief Clinical Officer in a very large organization, and we provide services in 11 different states.

And so, what I do want to say is applied behavior analysis services are very different from the other services that have been described today, including mental health. So we're behavioral health service. We will have what's called a register behavior technician who works directly with the child. It may be a child, with autism, in most cases, but we also serve a variety of other children.

The Board certified behavior analyst or the licensed behavior analyst, as is named in this law, supervises the work of the technician, and then provides coaching and instruction and feedback for that technician. We have a number of services that we Bill through the CPT code, and so that can be -- that direct therapy -- it's also that supervision of the direct therapy or what we call "protocol modification". But some payers actually asked that we include parent training or parental guidance, which I referenced in the written testimony, which is CPT Code 97156.

And in that service, we're working directly with a parent, with or without their child with behavior challenges present. The other way that our sessions are very different from other practitioners, is that they can range anywhere from three or more hours at

a time. And so, when you talk about working with a parent, who might have to take off work, when you add that drive time and parking, and coming in that can be a major source of stress.

I did want to highlight some of the testimony that Dr. Hoffman provided and also Dr. Quaranta because while they are MDs, they're exactly right. We have some of those same issues in that preparing for Telehealth services is more work than providing the service directly. And it may be having to come up with your creative way to get the student engaged over Telehealth to being able to quickly modify what we're doing in the moment because the child has eloped from the camera and to try to get them back, so it is definitely more challenging and should not have a reduction in price.

The other piece that we have to do is go into each member's benefits and actually verify that they do have a Telehealth benefit because they don't -- particularly if they're self-funded, they don't have that coverage is and so that takes extra time. And then I do want to add that a number of behavior analysts work in school settings. And while we're here for Telehealth and not not necessarily for distance learning, we've been providing distance learning or I've been providing to somebody since 1999, and so we work with the school --

ALEXANDRA DOROTINSKY: Dr. Olive, you've reached your three minutes, if you'd like to give a conclusion.

DR. MELISSA OLIVE: Awesome. So we work with different districts and providers. And then, finally, I am a guardian of an adult with autism and developmental disabilities. And we have used Telehealth multiple times in the past year. And the amount of stress that it relieves for him to be able to do it on Telehealth is tremendous Thank you, all.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you very much, doctor. Appreciate that. I don't see any questions at this time, so you very much for your testimony and for being here today. Next, we have Alison Weir.

ALISON WEIR: Good afternoon, Senator Abrams and Members of the Insurance and Public Health Committees. My name is Alison Weir, and I'm a Policy Advocate/Staff Attorney at Greater Hartford Legal Aid. I'm writing in support of raised Bill 1022, and I urge the Committees to fully commit to making Telehealth an enduring method of public -- providing health care and not take the option to say, the issue was proposed by raised Bill 5596.

The legal services programs of connecticut are big proponents of Telehealth, is been a critical tool during the pandemic, but you find this utility goes well beyond the pandemic and it serve to keep our clients healthy by minimizing unnecessary visits to the doctor. But it also improves access to health care for those with mobility impairments, those with limited transportation options or those who are located in remote areas.

As wonderful as Telehealth can be, however, we caution they must always be at the patient's option. We applaud the continuation of audio health for as an option for Telehealth. Of all the Executive Orders addressing Telehealth, arguably, the provisions allowing for payment for Telehealth audio services has been the most beneficial for our clients.

Without this, patients do not have access to computer, a computer with a camera or a smartphone or for those who have had difficulty with the Telehealth video sell -- software platforms but largely denied access to their medical providers during the pandemic. We also support the extensive list of providers to whom -- for whom Telehealth would be an option for serving their patients.

All that said, we caution that making Telehealth a permanent option must always be an option not mandate for patients. While Telehealth is proven very effective, there are many medical services that are best conducted in person and for those -- and there are those individuals, including individuals' certain communication disabilities for whom in-person visits are always going to be much more effective.

When providers' office is open, patient should have the option to conduct their appointments in person. And we ask additionally for the protection of our Medicaid clients that Committee require participating Medicaid providers to make in-person and Telehealth appointments equally available to the extent permitted -- permissible by public health conditions, to allow the patients the true choice in deciding, whether to schedule an in-person appointment or Telehealth appointment. Thank you for the opportunity to testify, and I urge to support S.B. 1022.

SENATOR DAUGHERTY ABRAMS (13TH): Thank you. Thank you so much for your testimony today. I don't see any hands, so have a great day. Thank you.

ALISON WEIR: You too. Thank you very much.

SENATOR DAUGHERTY ABRAMS (13TH): Next up, we have Brian Conner. Mr. Conner, go right ahead.

DR. BRIAN CONNER: Good afternoon, and thank you to the Committee Members, Senators and Representatives. Hi, I'm Dr. Brian Conner. I am a Chiropractor Nutritionist and a CME-Certified Medical Examiner, Board-Certified in Functional Medicine and Medical Director at Healthy Ways Wellness Center in Brookfield, and resident of Bridgewater. I'm also an adjunct professor at the University of Bridgeport School of Chiropractic.

Telehealth is a vital and important part of the chiropractic profession, especially during these trying times of the COVID-19 global pandemic. Obviously, we can adjust over the phone but weight management, nutrition, supplements, and herbs fall under the chiropractic scope of practice in Connecticut. Also rehab, including stretches, exercises, and strength training falls under our scope.

Telehealth visits have saved my patients' health last year. I was able to keep them from going to the er for unnecessary visits by reviewing different pain management techniques and therapies. I was able to discuss diet and exercise plans with them over the phone or using HIPAA-compliant video chat software from OptiMantra. And I was able to email and review stretching and exercise videos from chiro up with patients, so that their health could continue to improve, even though they weren't coming into the office. Please continue to keep chiropractic in the Telehealth Bill. Thank you very much.

SENATOR LESSER (9TH): Thank you for your testimony. Are there comments or questions from Members of the Committee? Seeing no hands. I want to thank you, Brian, for your testimony.

DR. BRIAN CONNER: Thank you.

SENATOR LESSER (9TH): Next up, we have Melissa Demma, followed by Mark Spellmann.

MELISSA DEMMA: Thank you, Respective Senators and Representatives and Members of the Insurance and Real Estate and Public Health Committees. My name is Melissa Demma, and I'm the Division Director of Clinical Services with United Services.

And the programs that I received were serving adults children, families and providing them with individual and family therapy to assist both with

mental health and substance use challenges and providing emergency response services. United Services, a local mental health authority for 21 towns in North Eastern Connecticut and we are a nonprofit organization providing more than 30 different programs to our communities.

So I want to thank you for the opportunity to provide testimony and support of the Health Bill 5596 and the Senate Bill 1022, and regarding ACTS CONCERNING TELEHEALTH services. We support efforts in the legislation to codify the expansion of Telehealth services that has occurred over the last year, ensuring that Connecticut continues to pay for Telehealth at the same rate as in-person visits allows telephonic and audio-only sessions and allows the use of any HIPAA-compliant platform.

When COVID hit last March, we were ordered by our state funders to stop seeing people in-person at most of our programs, and United Services remained open and quickly deployed Telehealth. This has allowed us to safely connect with our patients and continue to provide the critical care that they depend from us.

Our offices had been providing in-person care since July 2020, but we still continue to deliver services through Telehealth. And this has been really helpful for a lot of our patients that may have had to meet a quarantine, have had COVID exposure or COVID themselves, and we have other clients who are just really anxious during this time, and not wanting to enter a public space to continue getting the mental health or substance use services that they need.

Telehealth does allow them to stay engage with treatments and continue to care for those needs that they have. We urge the Committees to pass robust Telehealth legislation that guarantees that all people in Connecticut to continue to have access to Telehealth services using the devices of their

choosing and that providers continued to be paid at the same rate as in-person services moving forward. So thank you for your time and consideration on this important issue.

SENATOR LESSER (9TH): Thank you very much for your testimony. Other -- are there questions from Members of the Committee -- questions from Members of the Committee? If not, thank you, Melissa, your testimony.

MELISSA DEMMA: Thank you.

SENATOR LESSER (9TH): Next up, we have Mark Spellmann, followed by Thomas Burr.

MARK SPELLMANN: Good afternoon. I'd like to thank the Chair and the Committee for hearing our testimony today. I'm speaking on behalf of the Connecticut Psychological Association. I'm also a private practitioner in New Fairfield. Over the past year, we've seen that Telehealth works for delivering high quality psychological services and sometimes it's the best way to work. We appreciate that S.B. 1022 will maximize access to high-quality care for our citizens. We particularly value the parity of payment provision.

There was a survey was fueled by the State of Pennsylvania, that I included in my written testimony that answers many of the questions quantifies the answers that have come up today. In Pennsylvania after the PHE occurred in rules are relaxed, service utilization went up 37% for -- 37% of respondents were able to get even more services than before, 75% want to continue using Telehealth even after they can meet in person, 83% of providers that Telehealth is an effective way to start therapy. The full range of statistics are included in my testimony.

But I'd like to paint a picture of a patient needs telephone-only services to bring it to life if I

may. I see a woman who is the mother of three children, her husband had bipolar disorder and eventually it worse, and as it often does. And for the safety of herself and her children, she had to leave him and moved in here in New Fairfield with her dad and his little three-bedroom house. Her oldest daughter is 18, she's inherited her dad's bipolar condition, needed a tremendous amount of support from mom to connect with a psychiatrist, a new therapist and get started at [inaudible] on her associates degree.

16-year-old daughter inherited dad's depression, needed a lot of support connecting to her new school to a psychiatrist and a therapist, 12-year-old son has been diagnosed with ADHD, hates remote learning needs a lot of support and guidance, and mom needs her own schooling to continue to finish her Master's in Science.

Telehealth has enabled me to provide her the support and coaching she needs to stay positive, encouraging, not nagging, and not burned out for her children's needs. Now, if you are counting children and bedrooms, you can well imagine all the devices are busy when mom needs to talk to me, and there's no privacy. So she goes to her mobile office, which is her car and calls me on the phone and that's how we stayed in touch. And that's not going to change, even after the pandemic. We want to thank you for the opportunity to testify, we strongly support S.B. 1022.

SENATOR LESSER (9TH): Thank you for your testimony. Are there questions from Members of the Committee? Yes, Representative Dathan.

REP. DATHAN (142ND): All right. It's a bit slow at raising my hand there, but thank you very much, Mr. Chairman. I am -- agree that there's so many instances, where Telehealth can help with mental health and addictive services, particularly people

who might be in a crisis and need to get in pretty quickly, and I think Telehealth has engaged that.

Just wanted to find out if you have any studies or if there's any studies that have been done that would illustrate maybe the, the number of hospitalizations that have been saved in the mental health field, as a result of Telehealth visits?

MARK SPELLMANN: I don't but I got friends in APA who might. I'll try to look that up -- look that up for you. And, you know, everybody got 33% worse because of the pandemic. Depressed people got 33% more depressed, anxious people got 33% more anxious. Those of us who drink too much drink 33% more, that's what I've seen. So I bet we've saved 33% hospitalizations, but that's just a clinical opinion. I'll try to get you some data.

REP. DATHAN (142ND): Thank you, if you can just circulate it to the the clerk -- to the Committee, that would be fantastic. Thank you so much for your testimony today, and thank you, Mr Chairman.

MARK SPELLMANN: Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other comments or questions from Members of the Committee? Seeing none, thank you for your testimony.

MARK SPELLMANN: Thank you. Thomas Burr, followed by Dr. Deborah Desir.

THOMAS BURR: Yes, good afternoon, Senator Lester, and Members of the Public Health and Insurance and Real Estate Committees. As a Community and Affiliates Relations Manager the Connecticut State Office of the National Alliance on Mental Illness Connecticut -- you know, otherwise known as NAMI Connecticut, I'm writing today regarding S.B. 1022, AN ACT CONCERNING TELEHEALTH.

For those of you who are not familiar with NAMI, we are the nation's largest mental health organization, dedicated to building better lives for all people affected by mental health conditions. NAMI Connecticut and it's nine local affiliates provide support groups and educational programs for people with mental health conditions and their loved ones, and advocates for policies to improve the lives of people affected by mental health conditions.

We, as an organization. fully support Telehealth as a delivery mechanism, and feel strongly, it should be made permanent. Increased use of Telehealth has helped many people, including those with mental health conditions, continue to receive needed services during the COVID-19 pandemic. Also, as you've heard today, some providers have seen their appointment cancellation and no show rates dropped significantly with Telehealth. In other words, more people are receiving the care that they so desperately need.

Certainly, people in Connecticut do not have easy at who -- do not have easy access to transportation or child car -- care find Telehealth a God send. Whether you ask providers are the people they serve, both are experiencing the benefits of Telehealth and, of course, Telehealth should always be covered parity with in-person services where care can be appropriately delivered via Telehealth. You have my written testimony with it citations, and I just want to echo that many people have spoken today. You know they've really extolled the benefits Telehealth.

You may also have likely received email from some of our Members who support this bill. I can tell you from my own personal experience with my son and his path to recovery from bipolar disorder is that I wish we had this option back then when he was ill.

Getting John to an appointment was often a monumental task, whereas if we could have used the

Telehealth solution like Zoom or Skype, we may have had a much easier time getting him the treatment he so desperately neede, back then.

And we're -- quick note about utilization rates, I'd like to mention that many people with mental health conditions don't access services. So anything that increases access to care isn't a good thing, it's a great thing. The cost of people in society, due to untreated mental health conditions is really significant.

So anyway in summary, NAMI Connecticut and our members are fully behind Telehealth as Telehealth benefits to people are beyond dispute at this point. We are also opposed to any sunset provision would prefer that Telehealth be available and covered by all types of public and private insurance permanently. Thank you all for your time and attention and thanks to Governor Lamont for extending the coverage of Telehealth until April 20th, and I hope this booking be passed and put in effect before then, and I will gladly answer any questions that anyone should have.

SENATOR LESSER (9TH): Thank you, Thomas. Are there questions from Members of the Committee? Questions from Members of the Committee? If not, thank you for testifying.

THOMAS BURR: Thank you.

SENATOR LESSER (9TH): Next up, we have Dr. Desir, followed by Sheila Cooperman.

DR. DEBORAH DESIR: Good afternoon. My name is Dr. Deborah Dyett Desir. I live in Woodbridge, Connecticut. And I'm a Rheumatologist practicing in Hamden, Connecticut for nearly 30 years, initially as the owner and Medical Director of the Arthritis and Osteoporosis Center and, most recently, as the Medical Director of the Yale Rheumatology Hamden site.

On behalf of the physicians and physicians and training of the Connecticut State Medical Society, thank you to the distinguished Members of the Insurance and Real Estate Committee and the Public Health Committee to providing me this opportunity to testify on Senate Bill 1022 and House Bill 5596. I strongly support this legislation with specific modifications that are outlined in the written testimony that was submitted earlier by the Connecticut State Medical Society.

Why do I support this legislation? Prior to the COVID-19 pandemic, we had never done a Telehealth visit. On Thursday March 13th, 2020, we were forced to close our practice because of the worldwide COVID-19 pandemic. Exactly one business day later on, Monday, March 16th, 2020, we began seeing virtually 100% of our patients via video telemedicine or video or audio-only telemedicine.

I strongly support this legislation, as Telehealth enabled us to be able to continue to deliver care to every single patient that needed care, and the height of the COVID-19 public health emergency. These patients could not have been cared for in any other way. And, as you know, a rheumatologist, we take care of patients with chronic disease, autoimmune disease on medicines that need to be monitored closely.

As we go forward and restrictions are lifted, why should we preserve access to Telehealth visits? We need to preserve access to Telehealth visits, because there are a subset of patients who benefit from need or simply prefer having the option of Telehealth telemedicine visits. Our elderly patients with transportation issues, especially in a New England winter, parents with children and childcare issues, working patients with limited time off all benefit from having the option of a Telehealth visit.

Telehealth visits must be reimbursed as this -- at the same rate as in-person visits. They require the same and, at times, additional physician time. They require the same and, at times, additional staff time. And they require added technology and infrastructure support.

One last point, audio-only visits are often necessary for elderly patients, who have difficulty mastering the technology necessary for a video visit. They are also necessary for patients who, for economic reasons, have limited access to the Internet and computer equipment. Audio-only visits must be reimbursed equally, as they are as vital as video visits.

SENATOR LESSER (9TH): Thank you, Dr. Desir, for you testimony. Are there questions from Members of the Committee? Seeing none, thank you so much for your testimony and for your 30 years of practice. Next up Sheila Cooperman, followed by Pareesa Goodwin.

DR. SHEILA COOPERMAN: Good afternoon, I'm Dr. Sheila Cooperman. I'm a Psychiatrist, who specializes in mental health and addiction psychiatry. I'm here as a representative, the Connecticut Psychiatric Society. I'm the immediate past President and continuing Member of the Executive Council.

We represent over 800 psychiatrists in the state, and we support Senate Bill 1022 and House Bill 5596. We believe that, over the course of this last year, that Telehealth has been a life-saving intervention for our patients, who have been struggling with anxiety, depression, post-traumatic stress disorder, serious mental illness, and substance use disorders.

We echo the fact that we see this as, in addition to face-to-face interventions. We don't see this as something that would take the place of face-to-face sessions. I do think it's important to note that

this is a way to increase the access to patients who live in rural communities to those who are diverse and I think for women or for family members, who are caring for infants and children and elderly family members or family members who may be ill that, as you know, the majority of women do take care of their newborns or their children at home and has been -- has been said before. That I -- it is much easier to do this Telehealth either by audio or by video, rather than having a new mother trying to arrange for childcare, in order to come and continue her therapy. So these are some of the variety of ways that we think it would be helpful to continue the reimbursement rate that we now enjoy.

Also, we do think that in crisis intervention services that being able to have a crisis team bring a tablet, for example, to a patient's home that needs evaluation that they can benefit from the psychiatrist's input. Also if someone needs to go to the emergency room, a video conferencing at three o'clock in the morning via video can be very helpful in assessing whether or not someone needs to be admitted, or can be discharged. Clearly, this frees up the emergency room staff to tend to other patients who may need further evaluation. Another addition to Telehealth is that for psychiatrists who may be immunocompromised or have limited --

ALEXANDRA DOROTINSKY: Ms. Cooperman, you've reached your three minutes, if you'd like to give a conclusion.

DR. SHEILA COOPERMAN: That is it. That I thank you for your time. I think we can continue to appreciate the reimbursement for both audio and video. Thank you.

SENATOR LESSER (9TH): Thank you, Ms.-- Forgive me. Thank you, Ms. Cooperman, for your testimony. And speaking personally, I'm always interested in services for new parents. Are there questions from Members of the Committee? not, thank you very much

for your testimony this afternoon. Next up. And I believe the last person we have signed up to testify is Pareesa Goodwin. Pareesa, the floor is yours.

PAREESA CHARMCHI GOODWIN: Thank you so much, Senator Lesser, and thank you and hello to all members of both the Public Health Committee and the Insurance and Real Estate Committee. My name is Pareesa Charmchi Goodwin, and I'm testifying on behalf of the Connecticut Oral Health Initiative in my role as Executive Director. COHI is a nonprofit oral health policy and advocacy organization with the mission of increasing access to quality and affordable oral services for all Connecticut residents.

We are here testifying in support of Senate Bill 1022. I'm particularly supporting the inclusion of oral health and the inclusion of licensed dentists, as Telehealth providers. We would also recommend adding registered dental hygienist as Telehealth providers as they're an important member of the dental team and oftentimes actually the ones connecting people to care and sometimes you can use both teledentistry and alternative setting care to connect people to care so that would mean dental hygienists might be in a school setting or at a nursing home, where people are not engaged in traditional dental office settings or not going to the dentist office. So, a registered dental hygienist or a dental therapist once we get those -- that workforce really started in Connecticut might be providing that care and then sharing the records and information with a dentist, which is really a wonderful way to expand access to care.

So teledental became really important during the pandemic. As we saw, we were hearing that people are showing up in the ER for emerging dental needs because offices weren't open and they didn't know where to go. So teledentistry helped screen people when there were emergent needs and then, sometimes when the hygienist, who testified earlier today

mentioned, sometimes you can prescribe a pharmacological regimen and get someone kind of taken care of that way. Or you can direct them to the appropriate place. You really want to direct people away from the ER for dental care because there are not dental services typically there.

As I mentioned there's also these kind of lasting benefits, where you can increase connection to care, particularly for people that are not engaged in traditional settings. So I won't read my -- all of my testimony which you have that has some links to other information as to why this will be helpful and but it's really, really helpful for people that have transportation issues or limited mobility or really those difficult-to-reach populations that are not engaged and in the traditional settings, so I'm happy to answer any questions you might have. Thank you so much for your time today.

SENATOR LESSER (9TH): Well, thank you, Pareesa. Thanks for staying under the three minutes. Appreciate your work over at COHI. Are there any questions or comments from Members of the Committee for Ms. Goodwin? Wow, nothing. Wow, okay. Well, thank you so much appreciate your your feedback and good to see you.

PAREESA CHARMCHI GOODWIN: Thank you. Good to see as well. Have a good day.

SENATOR LESSER (9TH): And I believe that concludes our list of folks signed up to testify in front of the joint public hearing. Is there anyone else who's present, who wishes to testify?

Okay, well in the -- since there arent, I think I want to thank everyone for participating. This is a bit of an experiment. But we're going to continue. I think the two companies are going to continue to collaborate on this issue going forward and appreciate hearing from the public today.

So with that I'd entertain a motion to adjourn.

MALE: So moved.

REP. WOOD (29TH): [inaudible]

SENATOR LESSER (9TH): Motion by Representive Woods, second by ...

REP. TERCYAK (26TH): I second, second.

SENATOR LESSER (9TH): Second by Representative Tercyak.

MALE: Let's get out of here before the baby cries.

SENATOR LESSER (9TH): That baby may have voted too, but that's not in order.

SENATOR LESSER (9TH): All in -- all in favor?

MALE: Aye.

FEMALE: Aye.