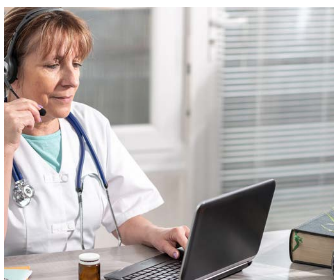

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Policy Brief

Telehealth in Rural North Dakota

This is Part 2 of a telehealth policy brief which discusses the future development of telehealth, barriers to implementation, and policy recommendations. The primary source of data is from a series of qualitative interviews with 19 Critical Access Hospital (CAH) CEOs and representatives from health associations, consultants, and academic centers. The interviews were conducted in August/September 2022.

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Part 2: The Future, Barriers, and Health Policy

What is the future for telehealth?

While the barriers to full utilization were seen as significant and the role of telehealth was perceived to be secondary to face-to-face encounters, the North Dakota respondents expressed confidence in the overall contribution of telehealth and its continuing development. Respondents generally expressed an opinion of slow development over time, with the growth being dependent on increases in the payment rate (e.g., parity with an in person face-to-face encounter) and more open acceptance from providers and patients. However, they generally view telehealth as being best suited for unique service niches such as enhancing emergency care (especially as a supportive system for medical providers) and as a means to address behavioral and mental health access.

According to the latest Community Health Needs Assessment (CHNA) study for North Dakota (2022), mental and behavioral health are the two most common CHNA needs identified in rural North Dakota. As one rural respondent noted, "I can see more use over time, but there are issues we need to address. As it operates now, it has less utility. The utility we saw was in the pandemic when you could not operate face-to-face, but now we can. Still there are potential uses, it takes time. But now back to normal and patients want to be seen face-to-face." Another noted, "it will evolve slowly, no rush, too many issues yet. But over time for rural it will be an option. It won't replace face-to-face but as a backup, yes. We will likely see more utility for behavioral and mental health over time as there it can really help. But our main area, primary care, that will remain face-to-face." Thus, rural providers understand the potential of telehealth; nevertheless, this development will likely be slow and there need to be efforts to address common barriers.

What are the barriers to using telehealth?

Respondents identified four primary barriers and one lower ranked barrier.

- **Payment.** In general, telehealth reimbursement is perceived as below the costs of care and below the face-to-face rate. All 19 respondents identified payment or reimbursement as a barrier, with many ranking it as the primary problem. There are the same fixed costs for

telehealth as found in an office or hospital visit: medical provider salary and time, nursing salary and time, testing and set-up of equipment, supplies, billing office, and other. Providers found the three payers reimburse about the same: Medicare, Medicaid, and commercial insurance. And all are inadequate. Telehealth is presented as a "loss leader" in that providers lose money providing it; however, they need to have some of it available even though the payment structure does not align. There is a belief that telehealth will not expand unless payments can cover costs. There are limited financial incentives.

- **Local providers attitudes and culture.** Sixteen of the 19 respondents raised local providers as barriers. Local providers were characterized as favoring "touch medicine" or face-to-face. It was stated that physicians and others feel being in the presence of the patient is "optimal" care, being able to touch and manipulate skin and limbs, clearly seeing and hearing how patients react, and a general sense that being face-to-face offers more human intimacy. Telehealth is important and can be a beneficial tool; however, it is seen as secondary. It can augment face-to-face but not replace it. It can help for emergency department care, providing access to behavioral and mental health, and helping as a back-up. A new generation of medical providers may be more receptive; however, even there they favor face-to-face.

- **Specialist providers attitudes and culture.** Similar to local providers, specialists presented barriers in that they too are more apt to favor face-to-face. It was framed as depending on the individual specialist, specialty discipline, and sometimes their health system, as not all the tertiaries stress using telehealth. Some specialists do not like to sacrifice their office time for a telehealth consult. One concern raised was specialists may see patients via telehealth but still require one annual face-to-face which can present travel barriers. Another concern was specialists controlling which patients they would see using telehealth. For some patients, the specialists prefer to see face-to-face as that may be a better source of reimbursement; thus, it is not telehealth being available for all types of patients all-the-time. The perception is it is selective.
- **Patient attitudes and culture.** In general, the patient culture was framed as patients too expect to see their medical providers at the doctor's office, face-to-face. During the pandemic, with the opening up of federal rules on telehealth, patients either used telehealth or they did not follow-up their routine care. Respondents identified patient concerns such as not being comfortable using technology, not having self-confidence with themselves, and viewing telehealth as simply a lesser quality of care. Access to technology (internet and/or device) was a concern especially for older patients.

- **Technology and broadband.** Broadband availability was generally assessed as adequate to good. It was not seen as a significant barrier; however, this depends on location. While respondents believed broadband to be widely available, they also identified "broadband deserts." And not all older patients had a reliable device. Rural households in comparison to urban have less internet access. At the federal level, the bipartisan Infrastructure Investment and Jobs Act (IIJA) of 2021 is providing substantial investment in rural communications infrastructure. One new effort from the IIJA is the Broadband Equity, Access, and Deployment program (BEAD), which will distribute over $42 billion to states and territories to fund broadband deployment. The emphasis is on rural areas including tribal nations. North Dakota is pursuing federal funds. A second program found in the IIJA that can be used to help rural and tribal households gain internet access is the Affordable Connectivity Program, which will help lower income households pay for internet access and devices such as laptops and/or tablets.

What are recommendations to North Dakota policy makers?

The most common recommendation revolved around addressing the payment barrier or to increase Medicaid reimbursement. Other recommendations are related to patient education, technology grants, and health workforce.

- **Payment.** This was the most common recommendation with 16 of 19 respondents stressing the need to improve payment. They noted only Congress could address Medicare, but for state legislators it would be within their authority to increase Medicaid payments. As of August 2022, 21 states had enacted state policy changes to support Medicaid parity, five states had done so with specific conditions or caveats, and 24 states had not granted Medicaid parity (Manett, Phelps, and

Phillips, LLP, August 26, 2022). The issue, as framed by rural CAH CEOs and others interviewed, is payments or reimbursements for telehealth services are below both their fixed costs (which are the same for a face-to-face encounter as it is for a telehealth encounter) and below what is received for a standard face-to-face encounter. Fixed costs include salary/time for providers, equipment and supplies, setting up and testing the connection between sites, billing/office time, and other factors. Realizing that moving toward Medicaid parity (comparable to face-to-face) could challenge the state's appropriation process and budget, it has been suggested to explore a phased approach where not every provider group gains parity at the same time. Certain necessary providers to securing rural health access such as CAHs, Rural Health Clinics, and Federally Qualified Health Centers in rural areas could be in phase one. It was stressed in the interviews that increased payment is to hold rural providers harmless, not to as was said "make them rich" but to meet their cost threshold so they can adequately provide telehealth services. Many rural health facilities lack the margins to absorb lost revenue. However, they do understand the need to provide more telehealth (e.g. mental and behavioral health) and seek reliable, equitable reimbursement.

- **Patient Education.** The interviews commonly found that patients were less receptive of telehealth than standard face-to-face encounters. It was characterized as being seen by a provider in the doctor's office was normal, comfortable, optimal, and how they feel medicine should occur. Additionally, some are intimidated by technology and unsure in using it. Patient confidence and comfort were frequently cited. An intriguing policy recommendation was for the state to create a patient education fund, which could be a special targeted effort to support the education and training of rural citizens, particularly older patients, so as to assist them in gaining familiarity and confidence with some basic technology. The rural providers viewed this as a step beyond what hospitals or clinics could do; nevertheless, the state could support other entities (e.g., smaller, regionally-based community colleges) to provide direct one-to-one education.

- **Technology grants.** Of the three primary areas (payment, patient education, and technology grants), it was the latter that generated the least amount of policy focus. A few respondents did indicate that there was a need for state funding for technology. It should be noted though that there are numerous federal funding sources that rural providers could access: Distance Learning and Telemedicine Program Grants, Rural Veterans Health Access Program, Rural Health Care Telecommunications (Telecom) Program, and Rural eConnectivity Broadband Loan and Grant Program (ReConnect) to name a few. Additionally, as part of the previously discussed bipartisan Infrastructure Investment and Jobs Act (IIJA) of 2021, there are two new programs that can benefit North Dakota. One

is the Broadband Equity, Access, and Deployment (BEAD) program which is being heralded as a significant infusion of federal funds (over $42 billion) to help states and territories to increase broadband. This will have a significant impact in rural and tribal areas. The second is the Affordable Connectivity Program which will help lower income households pay for internet services and connected devices such as laptops and tablets. A number of federal income-based programs allow people to qualify for this internet service buy-down: SNAP, Medicaid, WIC, SSI, rental assistance, Veterans pension, tribal TANF, and more.

- **Workforce.** Respondents recognized the connection of a limited rural health workforce and barriers to providing more telehealth. While payment limitations and provider attitudes are seen as primary barriers, facility workforce issues almost always compound issues. It is difficult to adequately support telehealth when there are shortages for direct patient care and emergency department coverage. With reimbursement streams below cost, it is difficult to justify staff reallocations for services that add costs rather than generate revenue. It is difficult to build a market for telehealth when hospitals are struggling to maintain primary, core services. It is not simply a telehealth concern as it is systemic for all facets of a hospital and clinic system. Respondents see the need for increased state efforts to stabilize and ultimately to grow the rural health workforce supply. This can involve expanded loan and/or scholarship offerings to cover more slots and additional disciplines. Additionally, explore financial incentives that rural health facilities can use for not only recruitment but also retention. This could take the form of indirect compensation such as financial support for health workers needing day care services, local lodging, and travel costs.

For more information

Visit the CRH webpage for additional rural health publications and information.
https://ruralhealth.und.edu/publications

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