



ALLIANCE for
CONNECTED CARE

November 5, 2021

The Honorable Ron Wyden
Chairman
Senate Finance Committee
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Finance Committee
United States Senate
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The Alliance for Connected Care appreciates the opportunity to provide input into the development of bipartisan legislation to enhance behavioral health care for all Americans. We look forward to working with you to improve access and outcomes for Americans with mental health needs and substance use disorders.

The Alliance is dedicated to improving access to care through the reduction of policy, legal and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of 40 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

We believe telehealth has the potential to broaden access to care and improve patient engagement, particularly for those suffering from behavioral health and substance use disorders. Below we provide recommendations that we believe would significantly improve behavioral health care.

Strengthening the Workforce

For digital health technologies to truly transform the way Americans access innovative treatments and cures, we must reduce barriers to accessing that care. Many of these barriers are remnants of a time in which telehealth did not have the advanced capabilities available today.

What policies would encourage greater behavioral health care provider participation in these federal programs? What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?

1. Remove distant site provider list restrictions to allow all Medicare providers who deliver telehealth-appropriate services to provide those services to beneficiaries through telehealth when clinically appropriate and covered by Medicare. The Alliance supports the Telehealth Modernization Act, as it is the most robust telehealth legislation introduced by Congress. The legislation would provide the HHS Secretary authority to expand the types of health care providers that can offer telehealth services and the types of services that can be reimbursed under Medicare. As described in further detail below, workforce shortages span across the specialty types and have especially afflicted the behavioral health workforce. The Alliance supports greater expansion under Medicare for coverage of behavioral health practitioners including mental health



counselors and marriage and family therapists. The Mental Health Access Improvement Act, introduced by Senators Barrasso and Stabenow is model legislation for expanding our nation's mental health professionals.

2. Call on DEA to immediately promulgate the Special Telemedicine Registration regulation. We appreciate the White House's early commitment to move forward this year with the telemedicine special registration for prescribing controlled substances. Special registration for telemedicine was originally called for by Congress in the Ryan Haight Act of 2008. In 2018, in response to concerns about the ongoing and escalating opioid epidemic the [SUPPORT for Patients and Communities Act](#) included a provision requiring the Attorney General, in consultation with the Secretary of Health and Human Services, to within one year promulgate final regulations related to a Special Registration for Telemedicine. It has now been three years since the SUPPORT Act was signed into law without any appreciable progress from the DEA signaling movement on a rulemaking process. The Alliance has [recently led two letters](#), one from the Alliance and its members and another signed by over 80 organizations on this issue urging DEA to immediately move forward with the telemedicine special registration process required by federal law.
3. Move to address provider enrollment concerns and facilitate actions to reduce provider burdens. During the COVID-19 public health emergency, CMS moved to allow practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. Unfortunately, this policy is set to expire at the conclusion of the PHE. The current enrollment structure is outdated and does not support providers' new operational and privacy concerns faced in a digital age. Furthermore, we encourage thoughtful consideration of the implications of telehealth on providers – not just patients. All of the conveniences that telehealth provides for patients, are also afforded to providers. First, care can be delivered dynamically and in many settings. A provider may not be just at their office, they can be at home, or at an off-site clinic, etc., and there are operational issues with how to list all of those various addresses. In addition, all providers (whether 0%, 51%, or 100% virtual care) are associated with a clinic that has a primary address. The associated address for that clinic represent the “operational structure.” Therefore, the infrastructure has little to do with where the provider is located physically during the virtual visits. Second, in addition to operational concerns, providers have personal privacy concerns with submitting their personal home addresses. Providers face a multitude of barriers and burdens deterring them from participating in federal programs, including additional requirements for billing, lower reimbursement, and handling a population with higher comorbidities and psychosocial factors for the provider to navigate in treatment. Those dually eligible for Medicaid and Medicare are nearly [three times more likely](#) to be diagnosed with a serious mental illness, and the prevalence of co-occurring physical and behavioral health conditions were [more common](#) among patients with Medicare than among patients in other payer categories. **Given that CMS declined to address the provider enrollment issue under rulemaking, we urge examination of these concerns and adoption of appropriate changes as described herein. Furthermore, we urge Congress to consider provider burdens in any future Congressional action.**



Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?

4. We urge Congress to consider addressing antiquated licensure laws that impede access to care. Telehealth and remote patient monitoring are important tools for bringing innovative services and treatments to those with the least access to it. According to the latest [USAFacts report](#), an estimated 122 million Americans, or 37 percent of the population, are living in mental health professional shortage areas. Furthermore, the Census Bureau reported that [30 percent of American adults had symptoms consistent with an anxiety or depression diagnosis](#) as of May 24, 2021. Provider shortages are [associated](#) with delayed health care usage, reduced continuity of care, higher health care costs, worse prognoses, less adherence to care plans, and increased travel. In addition to being a tool to address barriers, telehealth services play an important role in supplementing and strengthening clinician networks available to patients. Telehealth can be leveraged to strengthen the delivery system by providing highly specialized services in areas where clinicians with these skills are not available to consumers.

State lines create artificial barriers to the delivery of care – complicating access for patients and creating additional burden on clinicians. These lines sometimes split major urban areas and hamper the ability of telemedicine providers to fill in gaps in the delivery system and provide high-value care directly to consumers in rural or underserved areas. Current efforts to expand interstate licensure have been insufficient to meet the needs of patients and the clinicians seeking to better serve them. One of the most effective utilizers of telehealth networks to support the delivery of care across state lines, the U.S. Department of Veterans Affairs, supported 900,000 veterans through telemedicine visits in fiscal year 2019 – a majority of which were for mental health care. The program demonstrated growth of 17 percent over the prior fiscal year.

As an example of a licensure framework that works well to expand access to care, the [Nurse Licensure Compact](#) (NLC) is considered the gold standard of existing licensure compacts, as it has true licensure portability as a key feature of the compact. This means nurses in one of the 38 states that have adopted the compact can practice in other participating NLC states, both in person or via telenursing, without having to obtain additional licenses in each state. The NLC also increases access to care while maintaining public protection at the state level and facilitating the exchange of information. This compact has helped remove the burdensome expense for organizations that employ nurses and may share the cost of having to purchase and maintain multiple licenses. In a recent report, the OIG also [highlighted](#) the NLC as an example of a licensure compact that helps to ease the administrative burden of obtaining multiple licenses and helps achieve licensure reciprocity.

As our entire ecosystem works to address inequities, **we urge Congress to consider addressing antiquated licensure laws that impede access to care**, and the value of cross-state care in providing greater access to health care and specialty medicine, addressing provider shortages in rural and medically underserved communities, improving follow-up and continuity of care, and providing patients with more choice in the providers they wish to see. Throughout the pandemic, states waived certain aspects of state licensure requirements to facilitate greater access to care



for patients. Doing so allowed licensed medical professionals more flexibility to treat patients in other states when there were pressing needs or specialized expertise not available where they lived, or to maintain continuity of care for patients when an in-person visit was not possible. These flexibilities enabled college students that had to return home during the pandemic, for example, to continue seeing their on-campus provider via telehealth even when in their home state. This resulted in less disruptions in routine care, particularly for students being seen for mental and behavioral health issues. It also enabled children and adolescents with rare diseases or who are immunocompromised to see their specialists who reside in another state virtually, in order to maintain continuity of care without risking exposure to COVID-19 from an in-person visit.

Increasing Integration, Coordination and Access to Care

What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?

The COVID-19 pandemic has further exacerbated existing behavioral health and substance abuse disorder challenges. Recent data from the Centers for Disease Control and Prevention (CDC) indicate rising drug overdose deaths, and increasing incidence of anxiety and depression. Drug overdose deaths reached a [peak](#) after the pandemic hit, and symptoms of anxiety and/or depression in adults have [quadrupled](#). Workforce shortages and exacerbating behavioral health and substance abuse disorders demands an urgent solution. Telehealth and digital health technologies can be used to facilitate greater integration of care. For example, as discussed above, telehealth can help to mitigate provider workforce shortages and provide greater access to health care services, especially in regions and populations that lack access. Furthermore, telehealth technology supports greater integration within a health system. For example, provider-to-provider or e-consults can facilitate rapid exchange of information between a primary care provider and a specialist.

Additionally, efforts to further integrate clinical health information systems to capture more behavioral health services would be a meaningful improvement to care. As you know, MACPAC is currently exploring additional solutions to address low EHR adoption among behavioral health providers and have recommended strengthening behavioral health EHR adoption through new health IT incentives.

Furthering the Use of Telehealth

As observed during the COVID-19 pandemic, public health emergency flexibilities have resulted in drastic increases in telemedicine utilization, introducing millions of Americans to a new way to access health care. Data from the Centers for Disease Control and Prevention (CDC) finds that during the period of June 26 – November 6, 2020, 30.2 percent of weekly health center visits occurred via telehealth. In addition, preliminary [data](#) from the Centers for Medicare & Medicaid Services (CMS) show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the public health emergency (PHE). Finally, an HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicare fee-for-service (FFS) telehealth [report](#) found that from mid-March through early July, more than 10.1 million traditional Medicare beneficiaries used telehealth, including nearly 50 percent of primary care visits conducted via telehealth in April vs. less than 1 percent before the COVID-19 pandemic.



In addition to providing a lifeline to continuity of care, it is important to note that the net number of Medicare FFS primary care in-person and telehealth visits combined remained below pre-pandemic levels. As in-person care began to resume in May, telehealth visits dropped to 30 percent but there was still no net visit increase. We infer this and other data showing that as in-person visits increased, telehealth visits decreased, demonstrating a substitution effect.

How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care? How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?

Policymakers should also consider telehealth’s ability to increase efficiencies and improve access where barriers to care exist. COVID-19 has dramatically heightened awareness of existing health disparities and made the call to address these longstanding issues more urgent. Transportation is just one example of a barrier to care that telehealth can alleviate. Transportation barriers are regularly [cited](#) as barriers to access, particularly for low-income or under/uninsured populations – leading to missed appointments, delayed care, and poor health outcomes. In a [2018 proposed rule](#), CMS estimated that telemedicine is saving Medicare patients \$60 million in travel time, with a projected estimate of \$100 million by 2024 and \$170 million by 2029. CMS also noted that these estimates tend to underestimate the impacts of telemedicine. Higher projections estimate \$540 million in savings by 2029.

1. Move to replace outdated originating site and geographic requirements on telehealth. The Alliance strongly supports legislation that would eliminate the originating site construct completely – rather than just adding the “home.” Section 1834(m) of the Social Security Act has long been a barrier to expanding Medicare beneficiaries’ access to telemedicine due to stringent originating site and geographic location restrictions. Evidence has shown that telemedicine is not only necessary in rural and underserved areas, but also in urban and suburban communities where health care may not be accessible, convenient, or affordable. Furthermore, Medicare/Medicaid populations traditionally face significant transportation barriers such as affordability and physical impairments, making it more difficult to get to an in-person location. While requiring specific sites of care for telehealth may have made sense when technology was new and unreliable, the commercial market today is effectively deploying telehealth nationwide. There is no reason for our most vulnerable populations to have less access to care.
2. Ensure Federally Qualified Health Centers, Rural Health Clinics and Critical Access Hospitals can furnish telehealth in Medicare and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each. It is important to note that Critical Access Hospitals (CAHs) are sometimes omitted from this list, but are a crucial component of a health care system’s ability to reach all Medicare beneficiaries. As such, they must be able to directly bill for telehealth services as they do for in-person services.
3. Additionally, the Alliance and its members strongly believe that an in-person requirement, as Congress created in the Consolidated Appropriations Act, 2021 (P.L. 116-260) is never the right guardrail for a telehealth service, and would further exacerbate a two-tiered access system, where some have access while others do not. We explain the disruption in access to care caused by in-person requirements in further detail below. **We strongly urge the Senate Finance**



Committee to take up the [Telemental Health Care Access Act of 2021](#) (H.R. 2061/H.R. 4058) which would address the in-person requirements previously placed on behavioral telehealth.

How should audio-only forms of telehealth for mental and behavioral health services be covered and paid for under Medicare, relative to audio-visual forms of telehealth for the same services? Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental health and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

The Alliance supports efforts to provide access to care that are clinically appropriate and modality-agnostic. To that end, Congress must continue coverage for audio-only services beyond the COVID-19 public health emergency for several reasons. The Alliance believes that audio-only telehealth has been a critical tool for many clinicians and patients during COVID-19, especially when considering providing equitable access to care for patients facing broadband access, affordability, comfortability, digital literacy and other barriers. While we believe that audio-video communication is the preferred modality for most telehealth, we strongly support continued flexibility for audio-only – when clinically appropriate as determined by the provider and when meeting the need or request of the patient. Generally, audio-only has been more frequently clinically appropriate for behavioral health services than some other services.

Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?

The Alliance believes Congress could make permanent many of the COVID-19 flexibilities that have effectively expanded access to telehealth across the nation. Many of these are addressed in our comments above as efforts to prevent further exacerbation of disparities in access to care. Below we outline several additional recommendations and offer several alternatives Congress may want to consider to protect against fraud, waste and abuse.

Permanently remove obstructive in-person requirements. The SUPPORT Act expanded Medicare coverage of telehealth services in the home for beneficiaries with substance use disorders. Then, at the end of December 2020, the Consolidated Appropriations Act, 2021 further expanded Medicare payment beyond substance use disorder treatment to include mental health disorders and waived the geographic restrictions typically placed on telehealth services. However, the expanded flexibility only applies when the physician or practitioner furnishes an item or service in-person, without the use of telehealth, within 6 months prior to the first time the physician or practitioner furnishes a telehealth service to the beneficiary.

The Alliance and its members strongly believe that an in-person requirement, as Congress created in the Consolidated Appropriations Act, 2021 (P.L. 116-260) is never the right guardrail for a telehealth service. Requiring an in-person visit constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. It does not



constrain those using telehealth for convenience. This creates a perversion of the Medicare payment system by reducing access for those who need it most, while allowing access for others. We cannot create a guardrail that is an access barrier between patients and their clinicians – it will lead to harm the most vulnerable and access-constrained Medicare beneficiaries. Senators Cassidy, Smith, Cardin and Thune introduced the Telemental Health Care Access Act which would repeal the in-person requirement for behavioral health services furnished via telehealth signed into law as part of the Consolidated Appropriations Act. This legislation is crucial to increasing access for Medicare beneficiaries needing behavioral health and substance use services.

We also find that nearly all of the fraud Congress may seek to prevent is fraud that mirrors activities currently occurring during in-person care. These concerns include fraudulent Medicare enrollment, false claims, fake patients, and durable medical equipment (DME) prescribing. All of these issues are problems for the Medicare program – and should be addressed as Medicare fraud problems. They are not new problems for telehealth services. Therefore, an in-person requirement would hinder legitimate telehealth providers while doing very little to stop fraudulent actors. Instead of creating barriers to services for Medicare beneficiaries, Congress must empower CMS to address fraudulent actors.

We are pleased to note that on February 26, 2021, OIG Principal Deputy Inspector General Grimm issued [a statement](#) to this effect – differentiating between fraud perpetrated through virtual tools and telehealth fraud.

“We are aware of concerns raised regarding enforcement actions related to “telefraud” schemes, and it is important to distinguish those schemes from telehealth fraud. In the last few years, OIG has conducted several large investigations of fraud schemes that inappropriately leveraged the reach of telemarketing schemes in combination with unscrupulous doctors conducting sham remote visits to increase the size and scale of the perpetrator’s criminal operations. In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. We will continue to vigilantly pursue these “telefraud” schemes and monitor the evolution of scams that may relate to telehealth.”

Recommendations

With the understanding the Congress may still want to pursue additional guardrails against fraud, waste, and abuse as part of permanent telehealth legislation, we offer the following alternatives. Please note that many of these are simple regulatory changes, and could be issued as recommendations to CMS.

- Enhance the ability of HHS to fight fraud in Medicare through new resources and capacity
 - Provide additional funding for OIG to strengthen existing fraud, waste, and abuse mechanisms that have already been proven successful in fighting fraud perpetrated through virtual tools. The House Ways and Means minority staff has proposed workable text to this effect that we support.
 - We also support the development of OIG telehealth compliance guidance to healthcare organizations to help prevent and mitigate unintentional mistakes related to Medicare telehealth billing.



- Strengthen the *Public-Private Partnership for Health Care Waste, Fraud and Abuse Detection* created by the Consolidated Appropriations Act of 2021 (Section 1128C(a) of the Social Security Act (42 U.S.C. 1320a-7c(a)). This public-private partnership must be empowered with experts with experience in virtual care delivery and payment.
 - After – (6)(E)(i)(II) add *“(III) The executive board shall include no less than 3 individuals with significant expertise delivering and managing the delivery of virtual care, including practitioners, medical directors and individuals with oversight of telehealth programs, and virtual care experts with experience in corporate fraud prevention.*
- Work with CMS to develop restrictions on the solicitation of Medicare Fee-For-Service telehealth services. It is our understanding that one of the primary ways in which fraudulent actors exploit virtual services is by calling Medicare beneficiaries to solicit their interested in high-value DME products. We believe a restriction on marketing, as currently exists for DME, would significantly hinder situations in which DME fraud actors exploit telehealth services to drive DME sales. As long as there was a significant allowance for legitimate marketing practices, we do not believe this restriction would hinder legitimate telehealth providers.
- Encourage CMS to advantage of the enhanced data capabilities present in most telehealth platforms. Technology platforms that provide telehealth are often capable of automatically recording times, dates, patient information, prescribing, and other documentation details which can be used to enhance compliance and are not necessarily available in brick-and-mortars. These technologies should allow for the greater use of audits and other forms of retroactive monitoring approaches on providers. As long as data capture requirements are very clear, and that compliance with any requirements do not impose a significant regulatory burden they could be a compliance tool. (Please note that very small-providers should likely be exempted from these burdens.)

What legislative strategies could be used to ensure that care provided via telehealth is high-quality and cost-effective?

- The Alliance supports the [Evaluating Disparities and Outcomes of Telehealth \(EDOT\) During the COVID-19 Emergency Act of 2021](#). The bill would study what has happened during the pandemic and how we can improve telehealth for minority communities. Specifically, it would require HHS to study the impact of telehealth on utilization, cost, fraud, privacy, and equitable access within the Medicare and Medicaid programs during the COVID-19 emergency. Furthermore, it would direct the Medicare report to include a description of expenditures and savings, and any instances of fraud identified by the HHS Secretary acting through the Office of the Inspector General.

What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?

1. Congress should invest in efforts that support the deployment of broadband for all Americans, including those living in rural areas, on Tribal lands and to our nation’s schools and health care



providers. The Alliance for Connected Care has been supportive of calling for additional FCC funding to help health care providers and others provide telemedicine. In June, Representatives Spanberger (D-VA), co-leads Johnson (R-SD), Matsui (D-CA) and Curtis (R-UT) – plus 31 bipartisan members of Congress sent a [letter](#) to House and Senate leaders emphasizing the demand in their districts for reliable telehealth services during the COVID-19 pandemic and the need to strengthen the FCC’s COVID-19 Telehealth Program.

We applaud Congress’ and the FTC’s continued efforts to close the digital divide and ensure health care providers have the appropriate tools to take care of their patients in an ever-evolving virtual world. The COVID-19 Telehealth Program and Connected Care Pilot Program have remarkably increased telehealth adoption among health care providers and health centers serving those in need. Health care providers in each state, territory, and the District of Columbia have received funding.

Furthermore, digital equity is vitally important to ensure equity in access to services, particularly with regard to telehealth services. The Digital Equity Act of 2021, included in the Infrastructure Investment and Jobs Act awaiting passage proposes \$2.75 billion to in new dedicated funding to address gaps in digital literacy and digital skills, particularly among low-income communities, improve the online accessibility of social services for individuals with disabilities, and to more accurately measure broadband access and adoption in rural communities.

2. Congress should pass the bipartisan, bicameral Data Mapping to Save Moms’ Live Act. The Data Mapping to Save Moms’ Lives Act (S. 198) would use data mapping to identify areas of the country where poor maternal health rates overlap with a lack of broadband access, to better deploy telehealth services there. The United States is one of the only countries in the developed world with a rising maternal mortality rate. The problem is especially prevalent in rural communities and amongst women of color who continue to experience disproportionately high rates of maternal and infant mortality. This bill will give our nation one more tool to combat the devastating rising maternal mortality rate in this Country. We urge Congress to pass the Data Mapping to Save Moms’ Live Act in future legislation.

Thank you for your consideration. We look forward to working with you on this important effort. Please contact Crystal Wallace at 301-742-5240 or crystal.wallace@connectwithcare.org with any questions.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac".

Krista Drobac
Executive Director
Alliance for Connected Care