



**Alliance for Connected Care Statement for the Record**

**Hearing on “America’s Mental Health Crisis”**

**U.S. House Committee on Ways and Means**

**February 2, 2022**

Dear Chair Neal, Ranking Member Brady, and Members of the Committee:

The Alliance for Connected Care (“the Alliance”) welcomes the opportunity to provide input to the Committee hearing on “*America’s Mental Health Crisis.*” We applaud your continued leadership and critical role in enhancing 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 with mental health needs. Below we provide background information on telehealth’s impact on access to mental health care during COVID-19, and recommendations that we believe would significantly improve mental and behavioral health care access.

**Background On Telehealth’s Impact on Access to Mental Health Care During COVID-19**

The COVID-19 pandemic has further exacerbated existing mental and behavioral health care 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, 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 has recommended strengthening behavioral health EHR adoption through new health IT incentives.



The COVID-19 pandemic has resulted in drastic increases in telemedicine utilization, introducing millions of Americans to a new way to access health care. Data from the 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 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. The effects of the COVID-19 pandemic on patients seeking or avoiding care still need further peer-reviewed analysis, but these data suggest that telehealth substituted for in-person care without increasing utilization.

Policymakers should 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, including mental health 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 Advantage 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.

The experience during COVID-19 has pushed forward a revolution in consumer attitudes toward virtual care. Polling data from the [University of Michigan](#) showed that one in four older adults had used telemedicine during the first three months of the pandemic, compared to just 4 percent in 2019. The same poll showed that 64 percent of those surveyed in June 2020 were comfortable with using videoconferencing technology for any purpose, up from 53 percent in May 2019.

### **Recommendations to Expand Access to Mental Health Services Through Telehealth**

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 flexibilities have prevented further exacerbation of disparities in access to care. 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. Requiring an in-person visit can further barriers and delay behavioral health access, especially in areas where mental health services are already limited.



Below, we outline several recommendations and alternatives Congress might want to consider to expand access to mental health care across the country.

1. Permanently remove obstructive in-person requirements on mental health through telehealth. 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 for mental health 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. We strongly support *H.R. 4058. The Telemental Health Care Access Act*, which would repeal the in-person requirement for behavioral health services furnished via telehealth. This legislation is crucial to increasing access for Medicare beneficiaries needing behavioral health and substance use services.

2. Move to fully remove outdated originating site requirements on telehealth. The Alliance supports legislation to 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 mental 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.
3. Ensure Continued Access to Audio-Only Mental Health Care. 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.

4. Ensure Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics can furnish telehealth in Medicare and be reimbursed fairly for those services, despite unique payment characteristics and challenges for each. The Alliance strongly supports *The Protecting Rural Telehealth Access Act* (H.R.5425/S.1988) which has strong provisions for both rural providers and audio-only telehealth. The Alliance for Connected Care also strongly supports legislation introduced by Representatives Kildee and Wenstrup, the *Rural Behavioral Health Access Act* (H.R.2228), which would address specific telehealth changes to enable Critical Access Hospitals to take full advantage of telehealth to meet rural behavioral health needs.
5. Work with CMS 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.



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The Alliance greatly appreciates the Ways and Means Committee's leadership in working to improve access and outcomes for Americans with mental health needs. We look forward to working with you to develop and advance bipartisan legislation to enhance behavioral health care access for all Americans. If you have any questions or would like to hear from Alliance member experts on these topics, please do not hesitate to contact Chris Adamec at [cadamec@connectwithcare.org](mailto:cadamec@connectwithcare.org).

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac". The signature is fluid and cursive.

Krista Drobac  
Executive Director  
Alliance for Connected Care