Partnership to Advance Virtual Care

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The Honorable Ron Wyden
Chairman, U.S. Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member, U.S. Senate Committee on Finance
239 Dirksen Senate Building
Washington, D.C. 20510

Submitted Electronically

Re: Response to U.S. Senate Committee on Finance Request for Information (RFI) Regarding Bipartisan Behavioral Health Care Legislation

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the Partnership to Advance Virtual Care (the Partnership), I write to thank you and the Committee for your continuing work to enhance access to quality mental health care services and substance use disorder services (behavioral health care services) for patients across the country. As noted in your Request for Information (RFI), the COVID-19 public health emergency (PHE) has exacerbated the already unmet behavioral health care needs of far too many Americans. We strongly agree that patients must be able to access high-quality behavioral health care when they need it.

Our Partnership is composed of health systems, health IT vendors, chronic care specialists, behavioral health providers, and primary care stakeholders that are leading innovation in telehealth care delivery. We appreciate the opportunity to provide our input as you and the Committee develop legislative proposals to address America's need for greater behavioral health care accessibility.

Our comments focus primarily on your questions regarding access to care and furthering the use of telehealth for behavioral health care services. Specifically, we request that any legislative package protect Medicare beneficiaries' access to mental and other telehealth care services. By repealing Medicare's in-person requirement for certain mental telehealth care services, and by removing Medicare's originating site and geographic restrictions, Congress has the opportunity to remove harmful and arbitrary barriers to care for America's seniors, including those living with disabilities and chronic conditions. Our detailed comments follow.

The Increasing Need for Behavioral Telehealth Care Services

The COVID-19 PHE has vastly accelerated the revolution in telehealth care delivery. During the pandemic, enhanced flexibilities and access to telehealth services, including behavioral health care services, served as a lifeline to patients across the country. The pandemic and the resulting economic recession have negatively affected many Americans' mental health, and created new barriers for those already suffering from mental illness and substance use disorders.

About four in ten U.S. adults reported symptoms of anxiety or depressive disorder during the pandemic, compared to one in ten adults who reported these symptoms in 2019.[1] This increased mental distress is occurring against the backdrop of already high rates of mental illness and substance use that existed prior to the PHE.[2] Patients living with chronic conditions have unique mental and behavioral health care needs. As an example, dialysis patients suffer from high rates of depression and anxiety.[3] Maintaining access to high-quality telehealth services can vastly improve care for vulnerable populations.

According to the Health Resources and Services Administration (HRSA), roughly 37% of the U.S. population lives in a mental health professional shortage area.[4] As America's mental health continues to deteriorate, there are simply not enough mental health professionals to address increasing behavioral health needs. As the country recovers and rebuilds from the pandemic, it is critical that we make behavioral health care services more available and accessible, and that we make the advances in behavioral telehealth care delivery a permanent part of our health care system.

Medicare's In-Person Requirement Is a Harmful and Arbitrary Barrier to Mental Telehealth Care

The COVID-19 pandemic has had a particularly devastating impact on the mental wellbeing of America's seniors and those living with disabilities.[5] Enhanced access to mental telehealth services during the pandemic improved the lives of many Medicare patients across the country. To protect and improve the mental health of Medicare beneficiaries, we urge Congress to repeal the "in-person requirement" for telehealth treatment of certain mental health conditions.

Medicare generally only allows patients in specific, qualifying locations to access telehealth services. These geographic and originating site restrictions are extremely limiting: only two out of every 100 Medicare beneficiaries reside in counties eligible to

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[1] The Kaiser Family Foundation, *The Implications of COVID-19 for Mental Health and Substance Use* (Feb. 10, 2021), available here.
[2] *Id*.
[3] *See* Mark Unruh, Renal and Urology News, *Chronic Kidney Disease: Depression in Chronic Kidney Disease*, available here.
[4] USAFacts, *Over one-third of Americans live in areas lacking mental health professionals* (updated July 14, 2021), available here.
[5] The Kaiser Family Foundation, *One in Four Older Adults Report Anxiety or Depression Amid the COVID-19 Pandemic* (Oct. 2020), available here.

receive telehealth services under the restrictions.[6] During the PHE, waiver of these restrictions greatly expanded Medicare beneficiaries' access to behavioral and other telehealth services at a critical time.

Congress sought to codify expanded access to mental telehealth services, post-PHE, for Medicare beneficiaries in the Consolidated Appropriations Act, 2021 (CAA) in December 2020. The CAA permits Medicare beneficiaries to access telehealth treatment for a broader range of mental health conditions from a broader range of qualifying locations, including the beneficiary's home.[7] However, while this provision of the CAA expanded access to mental telehealth treatment, in theory, a subsequent provision severely limits Medicare beneficiaries' access to this care in practice.

For telehealth treatment of the expanded range of mental health conditions and treatment locations, the CAA also imposes an in-person requirement. For Medicare beneficiaries to receive telehealth treatment for the expanded range of mental health conditions, such as anxiety and depression, from the expanded list of qualifying sites (including the patient's home), the beneficiary must have an in-person visit with their health care provider within the six months prior to the telehealth treatment.[8]

There is no compelling clinical reason to legislatively mandate an in-person visit for all Medicare patients for the expanded range of eligible mental health services. Whether a patient requires an in-person visit prior to commencing their mental telehealth treatment should be left to the clinical judgment of her health care provider. The nature of mental and behavioral health care services does not require in-person assessments with legislated frequency. In cases where an in-person visit would be warranted, providers can exercise their clinical judgment.

The Negative Consequences of the In-Person Requirement

The in-person requirement will have several unintended negative consequences. First, the requirement will force many existing provider-patient relationships to terminate simply because the provider does not have a physical office location. Mental telehealth care delivery is increasingly provided via virtual-only practice models. During the pandemic, many Medicare beneficiaries have accessed care via virtual-only practices to meet their mental health needs. Without a physical office location, these providers will *de facto* be unable to meet the in-person requirement, resulting in treatment disruptions for their patients. These harmful disruptions will not be the result of inferior care quality; they will be the result of unnecessary barriers to care.

The in-person requirement will also discourage behavioral health providers, who often do not have brick-and-mortar offices, from enrolling in Medicare. This disincentive for enrollment comes at a time when the demand for behavioral health treatment has

[6] CMS Master Beneficiary Summary File, 2019.
[7] Before the PHE, telehealth treatment for substance abuse disorders (and co-occurring mental health disorders) was already exempted from the Medicare originating site and geographic restrictions. In other words, Medicare beneficiaries seeking treatment for substance abuse (and co-occurring) disorders could already access mental telehealth treatment regardless of their location.
[8] The CAA also allows the Secretary of Health and Human Services to impose additional in-person visit requirements.

significantly increased. Not only will the in-person requirement disrupt existing care relationships, it will also reduce the number of providers enrolled to provide much-needed and in-demand behavioral and mental health care services, in turn reducing beneficiary access and exacerbating the existing shortage of mental health care professionals.

The in-person requirement will also unnecessarily drive up volume. The requirement mandates an in-person visit prior to telehealth treatment, regardless of whether the visit is truly clinically necessary. Congress has worked hard to develop value based care models in Medicare. Legislative requirements like the in-person requirement needlessly increase volume and undercut progress in the value based care movement. The in-person requirement will also shift costs to state Medicaid programs that cover telemental health without an in-person requirement for dual eligibles.

The in-person requirement will increase administrative burden on providers, who will have to track compliance rather than focusing on care. Providers who have been providing mental telehealth care services to Medicare patients during the pandemic will now have to invest time in understanding when the in-person requirements apply. Instead of focusing on patient care, providers will have to devote more time and energy to ensuring that patients meet the requirement. The requirement imposes an additional layer of patient management with no clinical value.

Most importantly, the in-person requirement unnecessarily restricts Medicare beneficiaries' access to telehealth treatment for mental health conditions. For example, if a Medicare beneficiary seeks treatment from their home via telehealth for depression, that beneficiary will have to satisfy the in-person requirement. The beneficiary will have to go to her provider's physical office location for an in-person visit in the six-month time period before her telehealth treatment begins. Attending these in-person visits will be inconvenient for some beneficiaries; it will be next-to-impossible for others. In short, the in-person requirement is a physical barrier to care that will prevent many Medicare beneficiaries from getting the mental health care they need and deserve.

Repealing the in-person requirement would simply bring telehealth treatment for the expanded range of mental health conditions in line with how Congress has already addressed access to services for substance abuse disorders. As with telehealth treatment for substance abuse disorders, Congress should allow Medicare beneficiaries to have unimpeded access to telehealth services for additional mental health conditions, such as anxiety and depression.

Congress Should Protect Medicare Beneficiaries' Access to Telehealth Care

The PHE accelerated the revolution in telehealth care delivery. Telehealth care services should continue to be leveraged to enhance patient experiences, improve health outcomes, improve health equity, and reduce health care costs. To solidify these advances, Congress should enable Medicare beneficiaries to access telehealth care, including mental and behavioral health care services, from the broadest possible range

of locations. To achieve this goal, Congress should repeal the originating site and geographic restrictions in traditional Medicare.

Absent the waivers put in place during the PHE, Medicare generally only allows beneficiaries in specific, qualifying locations to access telehealth services. These geographic and originating site restrictions are extremely limiting: only two out of every 100 Medicare beneficiaries reside in counties eligible to receive telehealth services under the restrictions.[9] Given the growth and advances in telehealth care delivery during the pandemic, patients and providers have come to rely on telehealth modalities to deliver high-quality care. Simply put, these restrictions are a relic of a pre-pandemic health care delivery system, and should be removed as unnecessary barriers to care.

Maintaining broad access to telehealth services would greatly benefit the Medicare population, particularly those patients who suffer from chronic conditions. As an example, allowing an ESRD patient's dialysis clinic to serve as an originating site for other types of care, such as mental and behavioral health, would benefit patients by increasing access and convenience, reducing out of pocket costs for transportation, and improve care and patient engagement for minority and rural populations. Given the importance of maintaining access we urge you to prioritize modernizing the originating site and geographic restrictions.

Congress Should Extend and Make Permanent Certain Telehealth Flexibilities that Increase Access to Mental Health Services

The COVID-19 pandemic greatly accelerated the adoption of telehealth care delivery in the United States, including the delivery of behavioral health services. Advances in telehealth have made health care more accessible and equitable, and we believe that these advances should remain part of our health care system after the pandemic ends.

The Medicare population will greatly benefit from making enhanced access to mental and behavioral telehealth services a permanent part of our health care delivery system. Medicare's in-person requirement for mental telehealth services, and Medicare's originating site and geographic restrictions for other telehealth services, are harmful barriers to health care access and equity. Congress should protect Medicare beneficiaries' access to telehealth care by removing the in-person requirement for mental health care services and by enabling beneficiaries to access telehealth services from the broadest possible range of locations.

In addition, those who have employment-based health coverage are also at risk of losing access to important telehealth services without action from Congress. Section 3701 of the CARES Act created a safe harbor allowing those with Health Savings Account (HSA)-eligible High Deductible Health Plans (HDHPs) to have telehealth services covered on a first-dollar basis, which has meant that millions of Americans with employment-based coverage have had access to telehealth services during the pandemic. Without further congressional action, Section 3701 will expire on December

[9] CMS Master Beneficiary Summary File, 2019.

31, 2021, as the provision is not tied to the extension of the PHE. Congress should extend this safe harbor at least through 2023, to ensure continued access to important telehealth services—including behavioral and mental health services.

Further, Congress should add telehealth and remote care services as an ERISA-excepted benefit when paid entirely by the employer or other plan sponsor. A June 2020 FAQ on COVID-19 health coverage issues[10] included temporary relief from most group market reforms to employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan. This temporary relief has proven to be beneficial as a short-term fix, but a permanent solution is required to ensure long-term benefits of telehealth services can be accessed—across the spectrum of Americans in need—once the PHE ends.

Congress Should Streamline the Medicaid Provider Enrollment Process to Improve Access to Behavioral Health Services

We also respectfully encourage Congress to modernize the Medicaid provider enrollment process by amending Section 5005 of the original 21st Century Cures Act, to allow auto-enrollment of providers into Medicaid if they are already credentialed by a participating Medicaid Managed Care Organization. Under Section 5005, all Medicaid providers must be enrolled directly with the state Medicaid agency. Unfortunately, this requirement did not consider the role that advances in virtual care plays in improving access to critical health care services such as behavioral health. In addition, it places an administrative burden and discourages Medicaid participation from providers operating in multiple states, as Medicaid provider enrollment requirements, processes, and timelines vary by state. Further, some state Medicaid programs require providers to be physically located in the state, in addition to holding an appropriate license, to provide services to Medicaid beneficiaries. We support further Medicaid provider enrollment modernization, and request that you prohibit Medicaid programs from requiring a physical in-state presence or address for the purposes of provider enrollment.

Urgency Needed in Finalizing the DEA Telemedicine Special Registration

Responsible prescribing patterns must be a priority for all providers, regardless of whether they are seeing patients in-person or virtually. Importantly, the Drug Enforcement Administration (DEA) has waived requirements during the COVID-19 PHE; however, the agency will need to promulgate and finalize the telemedicine special registration rule allowed under the Ryan Haight Act to ensure providers can continue to treat and prescribe controlled substances to patients post-pandemic.

The continued delays in rulemaking from the DEA and the lack of a finalized telemedicine special registration rule has had an impact of the provision of mental health treatments to patients. On October 24, 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was signed into law and mandated that that no later than one year

[10] https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf

after enactment, the Attorney General, in consultation with the HHS Secretary, promulgate final regulations establishing a special registration for telemedicine and the procedure for obtaining the registration. The DEA has yet to issue an interim final rule.

Congress should ensure that the DEA promulgates the special registration rule and establish clear rules of the road, which would allow DEA-registered practitioners to prescribe controlled substances, such as certain kinds of medication-assisted treatment, without an in-person medical evaluation.

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We welcome the opportunity to discuss these important issues with you and the Committee further, and to continue to work together to ensure that all patients maintain access to high-quality health services.

Respectfully,

Mara McDermott
Executive Director
Partnership to Advance Virtual Care