June 16, 2022

The Honorable Ron Wyden
Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Ben Cardin
509 Hart Senate Office Building
Washington, DC 20510

The Honorable John Thune
511 Dirksen Senate Office Building
Washington, DC 20510

RE: ATA Action Comments on Discussion Draft of Telehealth Policies for Mental Health Care Initiative

Dear Chairman Wyden, Ranking Member Crapo, Senator Cardin, and Senator Thune:

On behalf of ATA Action, the American Telemedicine Association's affiliated trade association focused on advocacy, thank you for releasing a discussion draft for telehealth policies as a part of the Senate Finance Committee's ongoing work to improve mental health care.

As you and your staff are well aware, the impacts of the pandemic have touched just about every American. Nationwide we're seeing alarming increases in rates of anxiety, depression, and substance use disorders. During this uncertain time - telehealth flexibilities - like the ability to serve a patient in their home and provide audio-only services - have been an effective lifeline for many individuals and families. We know that even as the pandemic subsides, the mental health needs of our communities are not going to lessen. As a result, there is clear urgency for decisive policy solutions that will enable mental and behavioral health providers to deliver care when and where consumers need it most.

We applaud this discussion draft first and foremost for removing the in-person requirement for Medicare telemental health services, currently slated to go into effect 151 days after the COVID-19 public health emergency (PHE) expires[1]. ATA Action strongly opposes in-person requirements and believes putting service restrictions on telehealth access through arbitrary in-person requirements undercuts the very tenets around flexibility and access afforded by telehealth and other virtual care modalities[2]. There is no clinical evidence for an arbitrary in-person requirement before a patient can access telehealth services. In fact, evidence has demonstrated that telemental services like telepsychology are just as effective as in-person visits.[3] Additionally, requirements such as these could negatively impact those in underserved communities who may not be able to procure an in-person exam due to provider shortages, work, lack of childcare, and/or other resources. Furthermore, Section 123's

[1] Pub.L. 116–260
[2] ATA-Overview-of-In-Person-Requirements-1.pdf (americantelemed.org)
[3] Clinically Based Policy Decisions: In-Person Requirements for Telehealth Create Unnecessary Barriers (psychiatrictimes.com)

mandate for an in-person visit applies only to mental health treatment, whereas Medicare beneficiaries seeking other medical services via telehealth are not subject to this requirement.
However, we would like to offer feedback on a few areas of the bill where we have questions and concerns.

1. Requirement to connect patients to in-person care

While we agree with the concept that not all services are appropriate via telehealth for all patients and we appreciate the Committee's effort to replace the current in-person requirement with a less onerous "guardrail" to ensure that patients maintain that option, the new requirement as currently drafted in section 1(a)(III) is not workable and in practice would essentially maintain an in-person requirement.

In the new section, a provider must attest on a telehealth claim that the individual receiving telehealth is capable of and consents to the use of telehealth, that the use of telehealth is appropriate for the service, and that the provider could *"(aa) furnish a service in person to the eligible telehealth individual on the same day that, or within a reasonable period of time after (as determined appropriate by the Secretary), such telehealth service would be furnished; or (bb) refer the eligible telehealth individual to another physician or practitioner with whom the referring physician or practitioner has an arrangement to furnish in-person services to such individual on the same day, that or within a reasonable period of time after (as determined appropriate by the Secretary), such telehealth service would be furnished"*.

When a patient is receiving services via a telehealth visit, it is highly unlikely to impossible that any provider offering that service would be available to provide the same services to that patient on the same day. This of course is impossible for telehealth providers that do not offer in-person services, so under the language those providers must comply with the second option of referring a patient to another provider. It is also unreasonable for providers that *do* offer in-person services as it is still unusual to be able to obtain a same-day appointment in most practices. Also, the provider must first start the visit via telehealth in order to ascertain that telehealth is not appropriate for this patient or service (as also indicated by the fact that this is an attestation on a claim, or a visit that has occurred), so it would be unlikely that a provider would have a gap in their schedule for two visits with the same patient on the same day.

That leaves the second option, that the provider have the ability to refer the patient to another provider with whom the referring provider *has an arrangement* to furnish in-person services *on the same day*. The requirement that the referring provider have an arranagement with the in-person provider is both vague and concerning. In fact, Stark and Anti-Kickback laws discourage providers from having such referral relationships, and much more guidance would be necessary to clarify how providers could have an arrangement without implicating those laws. Additionally, it is unclear the level of responsibility the referring provider is intended to have – somewhere along the range from providing the patient with a list of potential in-person clinicians to actually securing the same day appointment for the patient. Lastly, there are different scenarios in which a patient may need to be referred after initiating a telehealth visit. If their issue is emergent, they should be referred to an emergency room. If their issue requires a specialist or different specialty than the provider they are speaking with, they should be referred to a specialist. The last scenario is if the provider themself is appropriate to deliver the service but the service dictates an in-person visit. It would be very difficult or impossible for a telehealth provider to maintain relationships with providers in all such options. Additionally, this arrangement requirement is not

imposed upon in person visits for whom a specialist referral is needed. Lastly, the same concerns about the availability of same-day appointments as described above applies here as well.

2. Requirement to coordinate with primary care

Further the aforementioned section of the draft bill requires that the telehealth provider attest to documenting the visit in the medical record that *"the mental health telehealth services are appropriately coordinated with other services recommended by the primary care physician or practitioner for the overall treatment of such individual*."

While we appreciate the goal of care coordination and electronic health record integration, these are goals that are not yet reality and cannot be achieved simply by imposing one-side requirements upon telehealth providers. Many telehealth providers either keep their own electronic health record or are integrated into the record of the health system or provider with whom they are a part or partner with. However, across our health care system, there is no automatic connection or easy way of sharing the electronic health record data from a visit with one provider to another provider's system, whether in person or via telehealth. This is especially true for mental health as mental health records, particularly therapy notes and substance use disorder records, have historically had more stringent protections and segmentation from information about the patient's physical health.

In some cases, the telehealth provider is in fact the patient's primary care provider. Short of that, the telehealth provider has no way of knowing who the patient's primary care provider is – if they have one at all – aside from self-reporting by the patient, which is not always available or accurate. Attempts should be made by both telehealth and in-person providers to coordinate care across the patient's whole health, but this requirement as written is not feasible to achieve.

3. CMS communication regarding telehealth and interstate licensure requirements

It is our understanding that the provision in Section 8 of the bill is intended to clarify that if a provider is licensed in a state that is part of an interstate licensure compact, that they are considered licensed for the purposes of Medicare and Medicaid. While we appreciate the effort to clarify providers' licensure and authority to practice, CMS has already issued guidance on this matter that was updated on September 16, 2021.[4] Our concern is that this provision as drafted may add confusion to the existing CMS guidance. As you know, the Interstate Medical Licensure Compact facilitates states issuing valid and full licenses to physicians seeking them in other participating states, so this provision would largely not have an impact on physician licensure or the process used to verify physician licenses. Other professions, such as physical therapy, that have a compact offering a multistate privilege to practice model have benefitted from the existing CMS guidance. We agree that it would be helpful for CMS to provide updates to MACs on which states have enacted and implemented interstate compacts for the purposes of license portability.

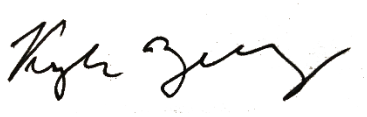
Furthermore, we are concerned that the use of the term "valid and full licenses" at this time may complicate the future inclusion of other privilege to practice models, such as state-approved telehealth

[4] MLN Matters SE20008. Medicare Clarifies Recognition of Interstate License Compact Pathways https://www.cms.gov/files/document/se20008.pdf

registries, as meeting CMS licensure requirements. Given that there are now many different pathways for providers to obtain a privilege to practice in a jurisdiction outside of their primary state of licensure, including interstate compacts, telehealth registries, and licensing waivers, we believe placing the term "valid and full licenses" in statute at this time could complicate efforts to get these various state-approved models recognized as meeting CMS licensure requirements. We would support broadening this section's language to make it more inclusive of the many innovative models that states are utilizing to allow providers licensed in other states to practice telehealth within their boundaries. We propose amending Section 8 to read, "…the interstate license compact pathway *or other forms of authorization to practice recognized by a State*…," in order to give CMS the authority to recognize these newer state licensing models.

We appreciate your leadership advancing policies to address mental and behavioral health and believe telehealth will play a key role in that effort. If you have any questions or would like to discuss our recommendations further, please contact Kyle Zebley, Executive Director, kzebley@ataaction.org.

Kind regards,



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