May 5, 2021

The Honorable Patty Murray
Chair
Senate Health, Education, Labor
& Pensions Committee
United States Senate
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Senate Health, Education, Labor
& Pensions Committee
United States Senate
Washington, DC 20510

Re: Comments for the Record for the April 28, 2021 Hearing on Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders

Dear Chairwoman Patty Murray and Ranking Member Burr:

On behalf of national organizations representing consumers, family members, mental health and addiction professionals, advocates, payers and other stakeholders, we thank you for your ongoing leadership to address the rising demand for mental health and substance use disorder treatment and to advance telehealth both during the COVID-19 Public Health Emergency (PHE) and beyond.

As you are well aware, the flexibilities granted by the §1135 emergency telehealth waivers have provided critical stability for healthcare professionals, patients and families across the nation during this challenging time. In particular, telehealth access for mental health and substance use disorder treatment services have served as a lifeline for many Americans struggling with isolation, grief, future uncertainty, and other new stressors this past year. On August 14, 2020, the Centers for Disease Control and Prevention (CDC) reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics.[1] Of grave concern, the report indicated that *over 1 in 4 young adults had recently contemplated suicide*. Additional research revealed that *over 40 states saw a rise in opioid-related overdose deaths* since the start of the pandemic.[2] Overall, mental

[1] https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932-H.pdf?deliveryName=USCDC_921-DM35222

[2] https://www.ama-assn.org/system/files/2020-11/issue-brief-increases-in-opioid-related-overdose.pdf

health conditions were the top telehealth diagnoses in the nation in November 2020—signifying an almost 20% increase year over year, with no indication that this trend is reversing.

To that end, we applaud the Committee for holding this important hearing to examine policy considerations for mental health and substance use treatment and telehealth as the nation moves out of the COVID-19 Public Health Emergency. With a surge in demand for behavioral health services that are only expected to increase, our nation needs to apply every tool at our disposal to ensure that Americans have access to the mental health and substance use services they need. As such, our respective organizations offer the following recommendations to the Committee as Congress reviews next steps on telehealth**.**

I. Extend all telehealth flexibilities for mental health and substance use disorders at least one year beyond the end of the PHE to maintain access to care and better inform policymakers how to make permanent telehealth policies that increase equitable access to quality, evidence-based care

Telehealth helps to reduce the stigma around seeking mental health or substance use disorder treatment for those who want to seek care confidentially, and it makes access to services more available to those without childcare or transportation. Furthermore, audio-only telehealth, which has been a digital equalizer for those who lack access to broadband internet or video-enabled devices and for those who cannot utilize dual audio-video devices, is a critical flexibility. The ability to communicate between patients and behavioral health providers according to individuals' own needs is crucial to eliminating artificial barriers to care.

Extending these flexibilities for at least one year beyond the conclusion of the PHE will allow for additional time to evaluate questions associated with cost, utilization, efficacy, and compliance. *Taking this step is fully consistent with recent recommendations to the Congress from the Medicare Payment Advisory Committee, which asked for an extension of current telehealth flexibilities – including audio-only -- for up to two more years to gather more evidence about the impact of telehealth on access, quality, and cost, and for policymakers to use this evidence to inform any permanent changes.*[3] This additional time could provide more baseline data to address concerns, such as those relative to Congressional Budget Office (CBO) scoring, by allowing real world data rather than non-dynamic projections to guide policy decision making. Historical advancements have been

[3] Medicare Payment Advisory Commission, Report to Congress (March 15, 2021).

made in telehealth over the last year and consumer support for continuing these advancements remains strong, particularly for mental health and substance use disorder treatments. We therefore implore this Committee to take action – via seeking an extension of telehealth flexibilities at least one year beyond the PHE – to ensure that these immense gains in virtual care are not lost or discontinued abruptly.

II. Allow telephonic (audio only) services for mental health and substance use disorder services after the PHE concludes.

In 2019, the Federal Communications Commission (FCC) reported that between 21.3 and 42 million Americans lacked access to broadband. Many older adults and people with disabilities lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have access to them. Likewise, many in racial/ethnic and low-income communities lack access to broadband or video-enabled devices.

Additionally, there is strong evidence to support the efficacy of telephonic behavioral health services. A review of 13 studies found reduced symptoms of anxiety and depression when therapy was conducted via telephone.[4] Patients have also benefited from receiving various interventions over the telephone, such as combined tele-pharmacotherapy and tele-cognitive-behavioral therapy (tele-CBT),[5] tele-CBT alone[6, 7, 8], receiving short-term tele-CBT in primary care settings,[9] and tele-bibliotherapy for older

[4] Coughtrey, A. E., & Pistrang, N. (2018). The effectiveness of telephone-delivered psychological therapies for depression and anxiety: A systematic review. *Journal of Telemedicine and Telecare, 24*(2), 65–74. https://doi.org/10.1177/1357633X16686547

[5] Ludman, E. J., Simon, G. E., Tutty, S., & Von Korff, M. (2007). A randomized trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *Journal of Consulting and Clinical Psychology, 75*(2), 257-266. https://doi.org/10.1037/0022-006X.75.2.257

[6] Mohr, D. C., Hart, S. L., Julian, L., Catledge, C., Honos-Webb, L., Vella, L., Tasch, E. T. (2005). Telephone-administered psychotherapy for depression. *Archives of General Psychiatry, 62,* 1007-1014. https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1108409

[7] Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014). Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology, 82*(2), 349-354. https://psycnet.apa.org/fulltext/2014-02032-001.html

[8] Stiles-Shields, C., Corden, M. E., Kwasny, S., Schueller, M., & Mohr, D. C. (2015). Predictors of outcome for telephone and face-to-face administered cognitive behavioral therapy for depression. *Psychological Medicine, 45*(15), 3205-3215. https://doi.org/10.1017/S0033291715001208

[9] Watzke, B., Haller, E., Steinmann, M., Heddaeus, D., Härter, M., König, H.-H., Wegscheider, K., & Rosemann, T. (2017). Effectiveness and cost-effectiveness of telephone-based cognitive-behavioural therapy in primary care: study protocol of TIDe – telephone intervention for depression. *BMC Psychiatry, 17*(263). https://doi.org/10.1186/s12888-017-1429-5

adults with anxiety.[10] Veterans with comorbid psychological distress and combat-related mild traumatic brain injury have also benefited significantly from receiving telephone-problem solving therapy (Tele-PST).[11] After receiving tele-PST, veterans reported improved quality of sleep and reduction of symptoms of depression and PTSD.

Given the significant increase in demand for behavioral health services and the significant role of audio-only as a digital equalizer, we recommend continuing this flexibility for the provision of mental health and substance use disorder services for at least one year beyond the PHE. During this time, regulators may evaluate data to better understand which modalities may be considered for audio-only on a permanent basis.

III. Remove the in-person requirement for telemental health services

While we applaud inclusion of the telemental health services in the end-of-year COVID relief package, we urge Congress to remove the in-person requirement it established. Imposing service restrictions on telehealth access through arbitrary in-person requirements undermines the flexibility and access afforded by telehealth and other virtual care modalities. Additionally, as many providers around the nation have created virtual front doors for their services, they have also started serving larger geographic areas. As such, this new requirement, which would go into place after the PHE concludes, would place an unnecessary burden on consumers and providers alike.

IV. Continue payment parity for telehealth services

As more providers transitioned to telehealth, payers are starting to evaluate cutting rates, often making the case that delivering care for telehealth is less expensive. This is simply not the case for behavioral health providers that provide both in-person and telehealth services. First, it assumes that behavioral health rates were already actuarially sound. However, because the Mental Health Parity & Addiction Equity Act has not been enforced since its inception over ten years ago, in many cases rates are already below the actuarial costs of delivering care and coverage of behavioral health services is limited.[12,]

---

[10] Brenes, G. A., McCall, W. V., Williamson, J. D., & Stanley, M. A. (2010). Feasibility and acceptability of bibliotherapy and telephone sessions for the treatment of late-life anxiety disorders. *Clinical Gerontologist, 33*(1), 62-68. https://doi.org/10.1080/07317110903344968

[11] Bell, K. R., Fann, J. R., Brockway, J. A., Cole, W. R., Bush, N. E., Dikmen, S., Hart, T., Lang, A. J., Grant, G., Gahm, G., Reger, M. A., De Lore, J. S., Machamer, J., Ernstrom, K., Raman, R., Jain, S., Stein, M. B., & Temkin, N. (2017). Telephone problem solving for service members with mild traumatic brain injury: a randomized, clinical trial. *Journal of Neurotrauma, 34*, 313-321. https://doi.org/10.1089/neu.2016.4444

[12] https://www.naatp.org/sites/naatp.org/files/MillimanReport11-20-19.pdf

[13] Second, proposing rate cuts for telehealth assumes that telehealth delivery for providers

operating a hybrid (in-person and digital) service environment is less costly than the delivery of in-person care. However, this is also inaccurate as many providers continue to maintain much of their brick and mortar overhead while also seeking to invest in telehealth platforms, hire more tech support staff, and make overall and continuing IT investments. These additional costs do not have a reimbursement mechanism and overlay current operating costs. As such, we recommend that telehealth - for mental health and substance use disorder services - continue to be reimbursed on par with in-person services.

In conclusion, even with today's telehealth emergency waivers, providers around the nation are struggling to meet the growing need for services at a time when many payers are already beginning to decrease rates for telehealth encounters. These combined effects – limited workforce, rate cuts, and an already underfunded system coupled with predictions that demand for behavioral health services will only increase – signals the clear need for urgent and immediate action. Through passing legislation that extends the telebehavioral health flexibilities, including audio-only services, beyond the PHE, removes the in-person requirement for telemental health services, and secures telebehavioral health parity – we can provide additional tools to increase access, break down stigma, and advance health equity.

We thank the Committee for its ongoing attention to addressing the mental health and substance use disorder crisis in our country, as well as for its consideration of the critical role that telehealth access can play for our nation both during and, importantly, beyond the PHE. Should you have any questions, or we can be of further assistance, please reach out to Laurel Stine (lstine@apa.org), Lauren Conaboy (Lauren.conaboy@centerstone.org), and Elizabeth Cullen (elizabeth.cullen@jewishfederations.org).

Sincerely,

American Art Therapy Association
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychoanalysis in Clinical Social Work
American Association of Child and Adolescent Psychiatry
American Association of Nurse Anesthetists

[13] https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/

American Association of Suicidology
American Association on Health and Disability
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Psychiatric Association
American Psychological Association
Anxiety and Depression Association of America
Association for Ambulatory Behavioral Healthcare
Association for Behavioral & Cognitive Therapies
Centerstone
Center for Law and Social Policy
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
College of Psychiatric and Neurologic Pharmacists (CPNP)
Confederation of Independent Psychoanalytic Societies
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
Education Development Center
Global Alliance for Behavioral Health and Social Justice
The Jed Foundation
The Jewish Federations of North America
International OCD Foundation
International Society for Psychiatric-Mental Health Nurses
Mental Health America
NAADAC, The Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of County Behavioral Health & Developmental Disability Directors
National Association of Pediatric Nurse Practitioners
National Association for Rural Mental Health
National Association of Social Workers
National Association of State Mental Health Program Directors
National Board for Certified Counselors
National Council for Behavioral Health
National Federation of Families for Children's Mental Health
National League for Nursing
National Register of Health Service Psychologists
Network of Jewish Human Service Agencies
Postpartum Support International
Psychotherapy Action Network (PsiAN)
REDC Consortium

RI International, Inc.
Schizophrenia & Psychosis Action Alliance

SMART Recovery
The American Counseling Association
The Kennedy Forum
The Michael J. Fox Foundation for Parkinson's Research
The National Alliance to Advance Adolescent Health
The Trevor Project
Well Being Trust
Wounded Warrior Project