January 19, 2021

The Honorable Joseph R. Biden, Jr.
c/o
Ms. Chiquita Brooks-LaSure
Team Lead
HHS Agency Review
Team Biden-Harris Transition
1401 Constitution Avenue, NW
Washington, DC, 20230

RE: Tele-Behavioral Health Priorities & Recommendations for the First 100 Days

---

To Whom It May Concern:

The Mental Health Liaison Group (MHLG)– a coalition of national organizations representing consumers, family members, mental health and addiction providers, advocates, payers and other stakeholders committed to strengthening Americans' access to mental health and addiction care– urge the Biden-Harris Administration to take the following steps in its first 100 days to ensure continued Medicare coverage of essential mental health and substance use disorder (SUD) treatment provided through telehealth in Medicare. Specifically, we urge the Biden-Harris Administration to immediately extend all §1135 emergency tele-behavioral health waivers through 2021, including for audio-only services and for payment parity with in-person care, to ensure that this innovative delivery modality remains available well beyond the end of the Public Health Emergency (PHE).

We believe these steps are vital to ensuring that Americans in need of mental health and SUD treatment services are able to access care when and where they need it most amidst this unprecedented crisis and beyond. The demand for access to quality mental health and SUD care services has been increasing for many years, and unfortunately the COVID-19 pandemic has only exacerbated this substantial need, a trend that is likely to continue for some period of time after the public health emergency officially comes to an end.

**Introduction**

On August 14, 2020, the Centers for Disease Control and Prevention (CDC) reported that recent rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. 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. Moreover, although some increase

in mental illness is consistent with prior research on reactions to traumatic experiences, such as major natural disasters, the current rise in mental illness attributable to the pandemic is far greater than expected. Another marker of increasing distress is evident in the surge of calls coming into mental distress hotlines, such as the Disaster Distress Helpline, a sub-network of the National Suicide Prevention Lifeline that offers emotional support to people in need after natural and human-caused disasters. The Distress Helpline saw an 890% spike in call volume in April 2020 compared with April 2019. In line with this data, mental health and SUD treatment providers around the nation have reported a significant increase in the demand for services as more consumers reach out for urgently needed care. To complicate matters for this growing population in need of behavioral health services, the behavioral health workforce and behavioral health safety net was under resourced and strained for workers even before the pandemic.

To address the existing and emerging mental health access crisis, we call upon the Biden-Harris Administration to take the following actions in its first 100 days:

**MHLG urges the Administration to immediately extend all emergency tele-behavioral health waivers through 2021, including for a broad range of mental and behavioral health services furnished through audio-only telehealth and extending to intensive outpatient and partial hospitalization program levels of care as well.**

The flexibilities granted by §1135 Public Health Emergency telehealth waivers during the pandemic have proved to be a critical lifeline for millions of Americans struggling with mental illness and substance use disorders and the providers who care for them. Without these telehealth waivers, many providers report that they would have had to shutter their operations and/or permanently close programs. Telehealth helps to reduce the stigma around seeking mental health or substance use disorder treatment for those who want to seek care confidentially, reduces community spread of COVID-19, and makes access to services more available to those without childcare or transportation.

These telehealth waivers, however, currently are linked to the public health emergency declaration and therefore only extend for 90 days at a time. Yet, a growing body of evidence suggests that the impact of COVID-19 on people's mental health will extend well beyond the public health emergency. Moreover, behavioral health providers need to move beyond emergency 90-day planning windows to have more certainty as to how care will be delivered to assess budget, workflows, and staffing needs for infrastructure like call centers and tech support. MHLG therefore recommends that the Biden-Harris Administration immediately provide a longer-term extension for these emergency telehealth waivers that will last through 2021. A longer-term extension gives providers an operational planning

runway and allows Congress to further study questions around cost and quality to determine which waivers should be made permanent.

Furthermore, we urge that this extension must also include 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. For example, 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 them. Likewise, many in racial/ethnic and low-income communities lack access to broadband or video-enabled devices. In 2019, the Federal Communications Commission (FCC) reported that between 21.3 and 42 million Americans lack access to broadband. The ability to communicate between patients and behavioral health providers according to individuals' own needs is crucial to eliminating artificial barriers to care.

Accordingly, MHLG recommends that the telehealth waivers for Medicare be extended through 2021, including for audio-only and for a broad range of tele-behavioral health services. This simple action would not only give frontline providers – and the patients we serve – regulatory certainty and stability, but also it would create much needed flexibility as the number of consumers requesting services continues to climb and providers struggle to deliver these urgently needed services. **MHLG further believes that the Centers for Medicare and Medicaid Services (CMS) has the authority to proceed with this change in Medicare policy – without specific direction from or action by Congress – under Section 1834m of the Social Security Act.**

**MHLG urges the Biden-Harris Administration to ensure that telehealth is covered at parity with in-person services.**

As more providers transitioned to telehealth, payers (Medicare, Medicaid, and commercial) 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. 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. 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; this is also inaccurate. The additional context below illustrates why costs for telehealth should be on par with in-person delivery modalities:

- **In creating new workflows for tele-behavioral health, there are new associated costs that include:**

    - Tech support teams: The establishment of connectivity support staff to help consumers who need assistance in getting connected via a video-audio platform. Offices such as primary care offices already have built in reimbursement for health care practitioners that do the initial evaluation with the patient, such as a nurse or a medical assistant. In most cases, however, behavioral health providers – such as therapists, case managers, and oftentimes even psychiatrists – do not have that billing option. Thus, this cost is an add-on cost, with no direct reimbursement, but is essential to ensure that clients are able to receive timely care.
    - New, interoperable software: Telehealth software, which is critical for auditing telehealth appointments (thus addressing fraud concerns) and meeting interoperability requirements with existing Electronic Health Record (EHR) systems, can add significant costs. These costs are significant and currently not reimbursed. Moreover, most behavioral health providers were carved out of the $30 billion investment (HITECH Act, passed as part of the American Recovery and Reinvestment Act of 2009, P.L. 111-5) given to hospitals and other healthcare entities to roll out EHRs in the past. As a result, the behavioral health system, which operates on razor thin margins if any margin at all, has been left to cobble together the resources to stand up EHR systems with minimal resources or capital to invest. Additional investments in telehealth infrastructure add further financial burden onto the already strained system.
    - Brick and mortar costs: Office space is still needed for patients who need to be in the office for lab work, as well as for consumers who have barriers with technology and/or may not be appropriate for telehealth for clinical reasons.
    - New infrastructure build outs: More call center and administrative staff support are needed as the demands for services increase and more Americans seek to access virtual care.
    - Workforce barriers: Lastly, as demand increases, the behavioral health workforce is shrinking. Prior to the pandemic, the behavioral health sector already was experiencing significant workforce shortages in some parts of the country. However, given that behavioral health is a female dominated workforce and that an increasing number of women are leaving the workforce to help with

caretaking, the behavioral workforce is increasingly strained. Telehealth enables providers to most efficiently utilize their limited workforce to meet the growing demand.
- With a surge in demand for services, that is only expected to increase, our nation needs to apply every tool at our disposal to ensure that Americans have access to behavioral health services.

- **In terms of quality, initial data indicates that the delivery of telehealth produces results that are on par with in-person treatment, here are a few examples that have emerged:**

  - Treatment of depression and anxiety via telehealth on par with in-person: There is evidence showing that providing mental health services over the telephone is equally as effective as face-to-face visits for patients with depression and anxiety. A review of 13 studies found reduced symptoms of anxiety and depression when therapy was conducted via telephone. Patients have also benefited from receiving various interventions over the telephone, such as combined tele-pharmacotherapy and tele-cognitive-behavioral therapy (tele-CBT), tele-CBT alone, receiving short-term tele-CBT in primary care setting, and tele-bibliotherapy for older adults with anxiety. Veterans with comorbid psychological distress and combat-related mild traumatic brain injury have also benefited significantly from receiving telephone-problem solving therapy (Tele-PST). After receiving tele-PST, veterans reported improved quality of sleep and reduction of symptoms of depression and PTSD.
  - SUD treatment demonstrated better outcomes with telehealth: Initial findings indicated that a cohort of clients receiving telehealth medication assisted treatment (MAT) experienced a 9% reduction in average days using any substance, a 29% reduction in average days depressed or anxious, and a 9% increase in treatment satisfaction at six months *relative to face-to-face clients*. A research study also demonstrated no significant differences in treatment outcomes between face-to-face and telepsychiatry MAT for individuals with opioid use disorder. Patient satisfaction is high among patients using telemedicine for SUD and rural Medicaid patients fully utilizing telemedicine services. For individuals who use illicit substances, such as opioids and cocaine, abstinence rates were higher in those who received telephone therapy services through an "Interactive Voice Response" system versus usual care.

- Treatment of co-occurring physical health conditions also benefited from tele-mental health: Individuals with HIV who received tele-interpersonal psychotherapy for depression saw a reduction in depressive symptoms. Individuals with epilepsy who received tele-mindfulness-based cognitive therapy found that it significantly reduced depressive symptoms.

In conclusion, even with today's telehealth emergency waivers, providers around the nation are struggling to meet the growing need at a time when many commercial and some Medicaid payers are already beginning to decrease rates for telehealth encounters. These combined effects–increased demand for services, limited workforce, Medicare, Medicaid and commercial 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.

We implore the incoming Administration to take immediate action to proactively address these issues. Should you have any questions, or we can be of further assistance, please reach out to Lauren Conaboy (lauren.conaboy@centerstone.org), Laurel Stine (lstine@apa.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 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
Centerstone
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
College of Psychiatric and Neurologic Pharmacists (CPNP)
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 Association of County Behavioral Health & Developmental Disability Directors
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Behavioral Health
National Federation of Families for Children's Mental Health
National Register of Health Service Psychologists
Postpartum Support International
Psychotherapy Action Network (PsiAN)
REDC Consortium
RI International, Inc.
Schizophrenia and Related Disorders Alliance of America
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

CC: The Honorable Xavier Becerra
Dr. Yngvild Olsen