HEALTH CARE FOR THE HOMELESS TESTIMONY
IN SUPPORT OF
SB 393 – MARYLAND MEDICAL ASSISTANCE PROGRAM AND HEALTH INSURANCE - COVERAGE AND REIMBURSEMENT OF TELEHEALTH SERVICES

Senate Finance Committee
January 27, 2021

Health Care for the Homeless strongly supports SB 393, which would make permanent a number of telehealth expansions that have existed under the public health emergency. Among the changes enumerated in the bill are, for Medicaid, effectively removing originating and distant site provisions so both the provider and patient may be off-site for a clinical setting, and requiring reimbursement for audio-only services. Telehealth has been a lifeline for Marylanders as they access mental health (MH) and substance use disorder (SUD) care during the pandemic. Telehealth coverage must be expanded permanently in private and public insurance to help address the skyrocketing need for MH and SUD care as result of COVID-19 and as Maryland recovers from the pandemic.

Audio-only telehealth is lifesaving

Telehealth has immensely increased access to care for people experiencing homeless. While this increased access occurred during the public health emergency, the benefits are so concrete that we strongly believe increasing access to telehealth permanently is critical. **Make no mistake: the ability to provide phone-only services to our clients is lifesaving**. While we support the bill in its entirety, we would like to focus our testimony on the most vital aspects of the bill: maintaining access to audio-only services.

A collection of case studies based on interviews with staff at 17 Health Care for the Homeless programs throughout the country about their experience implementing telehealth demonstrates why increasing access to telehealth permanently is beneficial. Cases specific to Health Care for the Homeless in Maryland are highlighted below.

Contrary to prior belief, telehealth, particularly audio-only telehealth, works well for people experiencing homelessness. With our client population, we have generally found that phones are ubiquitous and inexpensive. Conversely, high speed internet access and video screens are exceedingly inaccessible. Allowing patients to receive services via audio-only telephones can make up for the lack of broadband access in many parts of the State and the lack of affordable internet and computer technology among lower-income families.

Currently 60% of our visits are through telehealth and 97% of those telehealth visits are phone only. Since implementing audio-only telehealth, we found our missed appointment

rate, which was previously around 30%, fell in the first two months of use to 10%.[1] We widely attribute this to the fact that we are meeting our clients where they are and breaking down barriers to care, such as an onerous public transportation system. Importantly, keeping our clients connected to care is pivotal, especially during the pandemic when overdose, suicide and depression rates have increased.[2] Telehealth has been essential to delivering MH and SUD services during the pandemic, and utilization for behavioral health care has far exceeded utilization for other health conditions.

Some clients experiencing homelessness report that telehealth feels safer and more accessible. Policies related to reimbursements and ongoing ability to conduct audio-only visits are likely to determine the ongoing use of telehealth. In other words, phone-only telehealth is the only type of telehealth accessible to the vast majority of our clients. If the ability to conduct phone-only visits goes away, so will our ability to provide any level of lifesaving telehealth care.

Audio-only telehealth is just a tool to deliver health care; all clinical standards and expectations still apply.

We believe there are widespread misconceptions about audio-only telehealth. At its core, audio is just another tool for delivering the same type of and level health care. No clinical or medical requirements, regulations, or standards have changed under audio-only telehealth. We provide the same quality therapeutic and medical services as we always have – whether in person, on video or by phone. The requirements to meet billable standards are robust and nothing about the way we practice is relaxed just because they are over the phone. As highlighted in the examples below, checking in with clients by phone on various issues is a valuable service but not always a *billable* service. There continues to be a distinct set of criteria for a service to be billable. The distinctions between what is a billable phone telehealth visit versus a non-billable phone call are exemplified below.

We urge a favorable report on Senate Bill 393.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. We work to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. We deliver integrated medical care, mental health services, state-certified addiction treatment, dental care, social services, and housing support services for over 10,000 Marylanders annually at sites in Baltimore City, and in Harford, and Baltimore Counties. For more information, visit www.hchmd.org.

[1] While our missed appointment rate has increased slightly to slightly over 15%. However, this rate represents nearly half of our pre-telehealth missed appointment rate.

[2] For instance, the number of overdose deaths from drugs and alcohol in Maryland increased 12% in the first three quarters of 2020 compared to the same time period in 2019. *See* https://beforeitstoolate.maryland.gov/opioid-operational-command-center-department-of-health-release-opioid-and-intoxication-fatality-data-for-third-quarter-of-2020/.