November 15, 2021

VIA ELECTRONIC MAIL

U.S. Senate Committee on Finance
304 Dirksen Senate Office Building
Washington, D.C.
mentalhealthcare@finance.senate.gov

Re: **Senate Finance Committee Behavioral Health RFI Response**

Dear Senate Committee on Finance,

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Senate Committee on Finance's RFI on behavioral health.

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the health care delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the health care industry – including providers, health plans, employers, and consumer/patient representatives – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by the Centers for Medicare and Medicaid Services and other public and private stakeholders, can increase the momentum of delivery system transformation.

The Task Force's detailed comments and recommendations are captured below. These recommendations – while organized according to the categories defined in the RFI – reflect the following cross-cutting themes:

- Making behavioral health care more accessible and affordable for all individuals is more critical than ever as we continue to experience the effects of the Public Health Emergency (PHE).
- Implementing behavioral health care equitably requires improving access to behavioral health services in underserved communities, recruiting, hiring, and training a more diverse workforce, and expanding telehealth post PHE.
- Improving behavioral health care requires integration into and coordination with physical health care, which will drive better outcomes.

***

I. Strengthening the Workforce

1. ***What policies would encourage greater behavioral health care provider participation in these federal programs (Medicare, Medicaid, CHIP and the ACA Marketplaces)?***

Several strategies can be employed to encourage greater behavioral health care provider participation in federal programs. First, reimbursement reform is necessary for mental health care providers to be paid on par with other medical services. Second, existing loan repayment programs – such as the National Health Services Corps Substance Use Disorder Workforce Loan Repayment Program - should be expanded to include crisis services (which allow individuals to receive care in the most community-integrated, least restrictive setting possible) as approved clinical sites eligible to receive loan forgiveness. The clinical and cost benefits of crisis services are detailed in question 5 below under the *Increasing Integration, Coordination, and Access to Care* section, further cementing their importance and relevance to being included in loan repayment programs to encourage greater provider participation. Further, graduate medical education (GME) funding should support training in these settings, be extended to cover peer training programs, and support educational programs that increase diversity in the workforce.

Beyond funding for training and education, there needs to be long-term stability, via dedicated funding, for behavioral health providers regardless of their practice location. Often, clinical crisis centers are left out of the value payment and reimbursement dialogue because they are not hospital-based. One way to address this recommendation is to establish billing codes for all provider levels and sites of service and drive for parity between behavioral health and physical health services.

Finally, clinical licensure should be easily transferrable across state lines to allow for a greater number of providers to participate in the workforce who otherwise would be unable to, thereby increasing access to care in underserved communities or health professional shortage areas. This is especially relevant as telehealth for behavioral health has grown during the pandemic along with individual's satisfaction with seeing providers virtually. Telehealth allows for providers to deliver care regardless of geographic location, but not if state licensure regulations create undue restrictions. Given the importance of the behavioral health care crisis, Congress should consider preempting state licensure law to allow for behavioral health care practitioners to practice across state lines. If this is not possible, Congress should designate certain regions of the country as behavioral health provider shortage areas and allow providers from other states to practice in those areas. For both proposals, it is imperative that there are guardrails in place to ensure that patient safety concerns and complaints are tracked and adequately addressed across state or regional lines.

These recommendations not only encourage greater participation of behavioral health care providers in federal programs but can also increase the diversity of providers and address issues of provider shortages in rural and underserved areas.

2. ***What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?***

A significant barrier discussed by the Task Force's membership is the lack of mental health providers in rural and underserved areas which prevents patients who live in these areas from accessing needed services. According to a NCBI study, although the rates of mental health needs are similar between rural and urban areas, adults residing in rural areas receive necessary treatment less often, and with providers that have less specialized training. In the past eighteen months of the Public Health Emergency (PHE), the expansion of reimbursement for telehealth for behavioral health services has provided an alternative option for individuals in underserved communities to receive needed care without the burden of travelling long distances to reach providers. Congress should expand the scope of telehealth policies to ensure rural and underserved areas are affording sufficient access to behavioral health services.

At a more granular level, certain types of providers - such as Licensed Marriage and Family Therapists (LMFT) and Licensed Professional Counselors (LPC) - cannot bill for services under Medicare. When a system relies on billing for services for revenue, this becomes a work force issue as providers with a license but no ability to bill are unable to care for Medicare patients. One organization addressed this by setting up a triage tree to ensure the Medicare patients were only seen by a Licensed Clinical Social Workers (LCSW). While this did provide a logistical solution to the problem, it did not address the fact that these billing restrictions prevent a diverse range of providers seeing the patient and could impact patient access to care. Congress should authorize that LMFT and LPCs are permitted to directly bill for services provided to Medicare patients.

3. ***What policies would most effectively increase diversity in the behavioral health care workforce?***

One of our members participates in a "workforce partners" initiative where health care provider networks, hospitals, and systems come together to partner with academic institutions to open more slots in health care related trainings and programs. This allows local staff currently working in health care that have been unsuccessful in entering a program (*e.g.*, because of high costs to entry, lack of time, or lack of opportunity) the opportunity to pursue higher education. Similarly, pipeline initiatives can be funded in elementary and high schools to introduce local students to health care by way of internships or summer programs, which then encourages said students to enter the health care world post-graduation. Congress should encourage and fund these initiatives.

Peers, or individuals with their own lived experience of behavioral health challenges, are an often-overlooked segment of the population that greatly contribute to behavioral health care teams. Given their lived experiences, peers can be especially suited to engage with individuals in crisis or provide mentorship over a longer period. While many state Medicaid programs reimburse for peer support services, Medicare and private plans typically do not. One of our members, Cambia, did cover this in their commercial market, however, it took time to develop the correct payment methodology. This is an area for which Congress should direct additional study with the aim of encouraging coverage and payment by Medicare and private plans.

4. ***What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?***

As mentioned in response to question 1, reimbursement reform is a critical lever to increasing availability of behavioral health providers in underserved areas. Lack of reimbursement parity between behavioral health care providers and physical health care providers has a chilling effect on providers who might be interested in practicing in a rural or otherwise underserved area. A key policy solution at Congress' disposal is to better enforce current parity laws (*i.e.*, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)), and passing new legislation that goes further to ensure parity (refer to question 1 in the *Ensuring Parity* section for more information). Congress should also publicly promote the existence of current loan forgiveness programs targeted at behavioral health providers in rural and underserved areas, as well as expand these loan programs to reach a larger and more diverse behavioral health care workforce.

5. ***Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?***

The Health Information Technology for Economic and Clinical Health Act (HITECH) passed in 2009 promotes and expands the adoption of health information technology, with a specific focus on the use of electronic health records by healthcare providers. However, as discussed in the most recent MACPAC meeting, the HITECH program struggles to make an impact in the behavioral health space. The incentive program offered in HITECH does not completely offset the costs for behavioral health providers. Behavioral health providers are already often less likely to invest in the hardware, software, and training necessary for EHR adoption because of narrower operating margins. The lower participation in EHRs leads to lower participation in Health Information Exchanges (HIE). Further, the incentives in the program do not extend to other behavioral health workers – such as psychologists and social workers in psychiatric hospitals - working within behavioral systems. As this program sunsets at the end of 2021, Congress should focus on addressing these issues while concurrently developing a new program to incentivize behavioral health providers to implement EHRs and participate in data exchange for the purpose of more effective care coordination for patients with behavioral and physical health needs.

While integrating behavioral health providers into EHR systems is one issue, there are also issues around data sharing and compliance under 42 CFR Part 2 that lead to lack of care coordination and communication. Congress should revisit policies related to 42 CFR Part 2 to see how they can be made more inclusive of sharing data, while still protecting patient confidentiality.

6. ***What public policies would most effectively reduce burnout among behavioral health providers?***

The COVID-19 pandemic has exacerbated many feelings of burnout among all health care providers. Congress should invest in research to understand the factors that contribute to, and detract from, well-being and resiliency among the behavioral health workforce. This research should not only look at the factors that are specific to the PHE but also to the general issues that

affect provider satisfaction or lack thereof. Passing S. 4349, the Dr. Lorna Breen Health Care Provider Act, can serve as a valuable starting point for this work. The bill establishes several grant programs and requires HHS to take actions to improve mental and behavioral health and prevent burnout among health care providers.

Finally, value-based care delivered via alternative payment models, specifically population-based capitated payments, can allow physicians to manage their patients' care plans with greater flexibility as they receive an upfront payment for all services related to their patient. While this payment structure does not solve issues of burnout, it does take some strain off and allows the physician to treat their patients as they see best with value-based outcomes as the central driver for patients.

II. Increasing Integration, Coordination, and Access to Care

1. ***What are the best practices for integrating behavioral health with primary care? what federal payment policies would best support care integration?***

Congress should revise HIPAA policies to promote better communication for continuity of care with primary care and addiction treatment providers. Behavioral health providers should be able to communicate diagnostic and prescription information to other treatment providers – with appropriate patient consent – without the fear of violating confidentiality. Another strategy to integrate behavioral health into primary care is to dually train more physicians in both physical and behavioral health. If this is not possible, at a minimum, there should be increased training for mental health and substance use disorders in graduate medical education programs.

Further, as referenced in the previous question, global budgets and capitated payments can be powerful levers to incentivize providers to coordinate care in a way that effectively integrates behavioral health with primary care.

2. ***What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services?***

Due to the pandemic, CMS lowered the deductible threshold for consumers that participate in high deductible health plans, allowing consumers to have lower-out-pocket for telehealth services received. However, the legislation enacting this change is scheduled to sunset at the end of 2021. Two recent bills (HB 5541 and SB 1704) work to extend these provisions: the Primary and Virtual Care Affordability Act, HB 5541, extends the safe harbor flexibilities for two years (through the end of 2023) for both telehealth and primary care. The Telehealth Expansion Act of 2021, SB 1704, allows for the safe harbors to extend permanently for telehealth. The Task Force supports both bills and encourages Congress to pass them to improve patient access to affordable behavioral health care.

3. ***What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?***

In a 2017 comment letter, the Task Force encouraged CMMI to coordinate with SAMHSA to increase flexibility and modernize patient data sharing requirements; the Task Force continues

to echo these comments here to amplify their importance. The Task Force also supports the inclusion of consent policy best practices in future behavioral health models, including an examination of the limitations presented by the 42 CFR Part 2 provisions on the ability for providers to engage in the recommended data sharing approaches and provide high quality treatment and care coordination that addresses all patient health needs. Suggestions from the most recent September MACPAC meeting include creating a consent mechanism program that can be incorporated into existing EHRs. One panelist from New Jersey Medicaid Enterprise Systems shared his organization's program that allows SUD beneficiaries to provide consent on which providers and what information can be shared with other providers in the organization. To incentivize providers to use this program, they received additional funding for participating.

4. ***What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities?***

Broadly speaking, Congress should increase health care coverage and access for those in rural and underserved communities. It is impossible to offer equitable care when many Americans are uninsured or cannot access their health care easily even when they have coverage.

Alternative payment models offer ways to address accessibility and equity in care provided. The current fee-for-service system is ill-equipped to properly serve disadvantaged and underserved populations. A value-based payment and care delivery infrastructure that incentivizes the health care system to focus on whole-person care, encourages collaboration to address the social drivers of health, and holds payers and providers accountable for quality and cost outcomes is critical to advancing the Administration's health equity policy objectives. Investment in payment reforms that support population health – such as the Medicare Shared Savings Program, Medicare Advantage, and efforts to test new payment and care delivery reforms from the Center for Medicare and Medicaid Innovation (CMMI) demonstrations – is critical to creating a modernized payment and care delivery system that equitably serves individuals from all populations. It is also critical that the models coming out of CMMI include resources for providers who serve underserved populations so that they can afford to participate in the models. By incentivizing providers from underserved areas participating in these models, it brings all the benefits mentioned above to underserved populations.

Implementing value-based payment models also allows for easier reimbursement of telehealth, peer networks, and the use of community health workers as providers typically have the discretion to use care teams best suited to the patient's needs. Reimbursing for peer networks and community health workers improves the chance that individuals will be served by someone who looks like them from their community, which will result in a higher likelihood of receiving culturally congruent care. While this alone will not solve all inequities in health care, taking steps to improve access to telehealth, peer networks, and community health workers are all a step in the right direction.

5. ***How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?***

Task Force member Connections Health Solutions offers behavioral health care through an innovative model that offers an alternative to Emergency Departments (EDs) and jails for

individuals experiencing mental health and substance use emergencies. This model originated in Arizona and is sometimes known as "Crisis Now." Crisis Now creates a team of service providers to provide care in the least restrictive setting that meets the needs of an individual going through a crisis, with the goal of preventing avoidable jail, ED, and hospital time. These less restrictive settings (such as in-person crisis management, crisis lines, and mobile crisis vans) are also less costly. The Regional Behavioral Health Authority (RBHA) serves as the 'accountable entity' via its role as the managed Medicaid payer and regulator for the crisis system. The RBHA is financed via braided funding from a variety of sources (e.g., Medicaid, SAMHSA block grants, state and local funds) and is held accountable for both clinical and fiscal outcomes. The RBHA contracts with multiple service providers to create the crisis continuum and set expectations for system performance that align with overarching system goals.

Connections Health Solutions has now opened multiple crisis centers in the United States, with the largest in Maricopa County, AZ. A $100 million investment in crisis care resulted in savings in psychiatric inpatient spending, ED costs, and ED psychiatric boarding hours. In their Maricopa County center, more than 75% of contracts are geographically capitated and value based, allowing providers to treat patients holistically.

Crisis intervention models are beneficial all around. Therefore, Congress should require states to develop a crisis delivery system that supports program design, development, implementation, and continuous quality improvement efforts modeled after the National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit – SAMHSA released in early 2020.

6. ***How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?***

The first step to connecting people to non-clinical services is screening patients for social needs and having a set of standardized codes that can be used to track these needs. Upon this foundation, health systems should build a system that allows seamless bi-directional communication with relevant community resources that is designed to allow providers to refer patients, and to know if patients are accessing the referral services. For example, Trinity Health, a Task Force member, launched their Community Resource Directory powered by Aunt Bertha in Spring of 2020. Aunt Bertha is an online portal for providers, patients, and community members to anonymously search for free or reduced-cost social services, and it also provides a platform for providers to refer patients directly to a social service organization and receive confirmation as part of a closed loop referral. The Task Force recommends that Congress incentivize the inclusion of programs like this within EHRs to ensure patients have access to the necessary social services.

However, it should be noted that even in examples where a system such as Aunt Bertha exists, there are barriers to using the EMR program to its highest capacity. Namely, there is a lack of health care professionals (such as social workers or community health workers) trained to screen patients for social needs and appropriately refer them to community-based organizations (with all necessary follow-ups). Congress should seek to fund public and private entities to implement and train staff on use of infrastructure (including data systems) that support better

coordination and alignment between community organizations, public health entities, and health organizations.

III. Ensuring Parity

1. ***How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?***

The Task Force supports the Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Act) being fully extended to Medicare and all of Medicaid, as well as TRICARE. While the Federal Parity Act extends to nearly all commercial plans and Medicaid Managed Care Plans, Congress has yet to extend Federal Parity Act protections to tens of millions of Americans in health insurance coverage plans administered directly by states and the federal government.

2. ***To what extent do payment rates or other payments practices (e.g. timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?***

There are several issues that concern our members regarding how current payment rates and other payment practices are affecting access to mental health care:

- The Institutions for Mental Disease (IMD) exclusion in the mental health parity legislation prohibits the use of federal Medicaid financing for care provided to most patients in mental health substance use disorder and residential treatment facilities larger than 16 beds. While states were given the option to cover short-term stays in psychiatric hospitals through a waiver, the IMD exclusion needs to be removed permanently.
- The 190-day psychiatric inpatient lifetime limit for acute care also should be removed. In addition, current reimbursement for acute inpatient psychiatric care is insufficient and does not cover the cost of care; reimbursement reform is needed to ensure an adequate network of behavioral health services and providers.
- Co-payments can create a significant financial barrier to receiving needed care, particularly when a patient requires ongoing care. For example, partial hospitalization, intensive outpatient programs, and other episodic treatments often require multiple visits over a relatively short period of time, which leads to a substantial amount of patient spend on co-payments while not allowing for flexibility for caregivers to determine the scope and extent of services needed for particular patients.

3. ***How could Congress improve mental health parity in Medicare and Medicaid? How would extending mental health parity principles to traditional Medicaid and Medicare fee-for-service programs impact access to care and patient health?***

Congress should adopt mental health parity within CMS by setting the standards of care for behavioral health on par with physical health. Behavioral health conditions – both chronic and acute – should be treated at the same standard as other medical conditions. In both cases, the level of care should not be established based upon an arbitrary cap on the number of services furnished. Adoption of value-based care systems that promote parity while affording flexibility for clinicians to care for individual patients is a better base-line design.

With this adoption of mental health parity, Medicare and Medicaid managed care organizations and state public health agencies should audit plans for compliance with mental health parity. The California State Department of Managed Health Care has created a tool that serves this purpose. Auditing needs to be done across the board to include ERISA, HMO, and PPO plans as well as Medicare and Medicaid.

A current model from the Centers for Medicare and Medicaid Innovation (CMMI) provides a good step in the right direction for parity of behavioral health treatment facilities. The Emergency Triage, Treat, and Transport (ET3) model provides parity Medicare reimbursement for EMS to transport to "alternative" destinations instead of the ED, which includes crisis facilities. Lessons learned from this model should be noted and used to determine future models of behavioral health care in Medicare, as well as inform policy in the private health care sector.

IV. Expanding Telehealth

1. ***How do the quality and cost-effectiveness of telehealth for behavioral health care services compare to in-person care, including with respect to care continuity?***

Anecdotally, Task Force members have shared that the quality and cost-effectiveness of telehealth for behavioral health care is on par with in-person care. Especially during COVID-19, individuals preferred receiving behavioral health care virtually as it required taking less time off work and offered both some level of safety (related to contracting COVID) as well as privacy for patients who felt more comfortable receiving telehealth behavioral health visits in their own home.

2. ***How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?***

While telehealth has been praised for its expansion during COVID and its ability to meet patients with care where they are comfortable, concerns remain about equitable access to telehealth for all individuals. Those with no or unreliable access to broadband, such as lower-income communities or rural areas, will face inequitable access to telehealth services. In late 2020, the Task Force wrote a commentary, Health Equity in Telehealth, to address these concerns. The commentary highlights six areas to focus on when creating telehealth policy, which can be applied to telehealth for behavioral health care:

- **Implementation and Evaluation**: Patients from diverse backgrounds, and with a range of technology access and tech experiences, should be engaged in the design of virtual care tools.
- **Quality Measurement Approaches**: All health care providers and organizations should move toward collecting and stratifying patient data based on indicators of inequitable patient care to assess potential disparities in patient outcomes, utilization, and experience based on social factors.
- **Routine Collection and Use of Patient Generated Health Data**: As a complement to robust quality measurement, the collection and use of patient generated health data (PGHD) should be a routine component of telehealth care delivery.

- **Technology for Vulnerable Communities**: Policymakers should prioritize increased and affordable broadband access for all and invest in hands-on training to improve technology literacy for patients and providers, along with access to necessary non-English language/translation services.
- **Access to Care**: The use of virtual care needs to be the patient's choice and should reinforce a trusted provider-patient relationship. Telehealth visits should be coordinated with and be complementary to in-person care.
- **Coverage and Reimbursement for Telehealth**: The regulatory and reimbursement environment should be conducive to reimbursing telehealth services in a way that allows this method of care delivery to be integrated as a regular feature for patients, and not create unnecessary barriers for patients to access that care.

Although not in the original Task Force commentary, Congress should set standards around measuring and understanding utilization of telehealth as a means to inform future policymaking. Payers have shared that it is difficult to know how to reimburse when they do not have accurate utilization data. The Task Force encourages Congress to set standards around collecting utilization data.

3. ***How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?***

The Consolidated Appropriations Act of 2021 (CAA) amends section 1834(m) of the Social Security Act to allow the patient's home as a permissible originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective on or after the end of the PHE. The expanded scope of Medicare telehealth reimbursement provides a huge benefit to the patient. Not only does this address stigma of receiving mental health services by providing the patient with a more comfortable, private, and attentive space in which to receive mental health care, it also allows those who may struggle to find a mental health facility within travel range – such as those in rural areas, or areas with few providers - with the opportunity to engage in counseling services via telehealth. While we are happy to see the lifting of geographic restrictions (as per the CY 2022 Medicare Physician Fee Schedule Final Rule) we urge Congress to focus on the requirement for subsequent in-person visits required to continue to use mental health telehealth services as detailed in question 5 below.

4. ***How should audio-only forms of telehealth for mental and behavioral health services be covered and paid for under Medicare, relative to audio-visual forms of the health for the same services?***

In previous communication to CMS, the Task Force encouraged Medicare reimbursement for services delivered via both audio/video synchronous technology and audio-only technology at the same rate to promote equitable access to telehealth services. The Task Force continues to encourage payment parity in this area. Receiving audio-only care is superior to not receiving care when needed, and therefore should be reimbursed appropriately including ensuring that diagnoses found via audio-only telehealth are accounted for in risk adjustment methodologies.

5. ***Should Congress make permanent the COVID-19 flexibilities for provider telehealth services for behavioral health care? if so, which services? What safeguards should be included for beneficiaries and taxpayers?***

Congress should make permanent the COVID-19 reimbursement flexibilities for provider telehealth services for behavioral health care following the end of the PHE. However, in making certain changes permanent, the Task Force has significant concerns with the proposed six-month in-person visit a requirement for all subsequent telehealth services, both video and audio-only. We believe the six-month period is arbitrary and should be eliminated for both video and audio-only telehealth services, as it could contribute to disparities in health care access and outcomes by preventing those who cannot travel to an in-person appointment (because of their job, a rural location, lack of childcare, etc.) from receiving needed telehealth services. Section 1834(m)(7)(B)(i)(I) of the CAA gives the Secretary of the Department of Health and Human Services the discretion to specify the times or intervals for which a subsequent in-person requirement is required. The CY 2022 Medicare Physician Fee Schedule Final Rule set these subsequent in-person required visits at 12-month intervals. The Task Force continues to echo a recommendation made previously to CMS, which is to remove the in-person visit provision completely for subsequent in-person visits.

In looking at safeguards for behavioral health offered over telehealth, Congress should look to the outliers to identify the bad actors, instead of creating safeguards that impact all of telehealth and therefore limit access to care for patients.

V. Improving access for children and young people

The Task Force supports Congressional funding and focus on greater research in improving access to behavioral health services for children in young people. It is especially important to research the impact of COVID-19 on children's health, as the pandemic has greatly impacted schooling and development for children. The Task Force also realizes the importance of children having access behavioral health care in schools; Congress should increase and incentivize access to school-based programs that offer licensed therapists and providers.

*****

The Task Force appreciates the opportunity to respond to this RFI. Please contact HCTTF Associate Anna Kemmerer (anna.kemmerer@hcttf.org) or me (jeff.micklos@hcttf.org) with questions related to this statement.

Sincerely,

Jeff Micklos