American Hospital Association™
Advancing Health in America

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The Honorable Ron Wyden
Chairman
United States Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
United States Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for your leadership in developing approaches to better meet the nation's behavioral health care needs. The AHA is pleased to respond to your request for information that will advance these efforts.

The AHA believes that physical and mental health care are inextricably linked, and we share your view that everyone deserves access to quality behavioral health care. We look forward to working with you to advance legislation to that end. Our responses to your questions follow.

Strengthening Workforce

What policies would encourage greater behavioral health care provider participation in these federal programs?

Traditional fee-for-service payment systems, including Medicare, have inadequately reimbursed providers across the behavioral health service continuum. Fee-for-service payment structures rarely reimburse for important elements of behavioral health care, such as coordinating care across providers and settings, or for non-face-to-face care management, including referrals and case management. Low reimbursement rates for behavioral health services also negatively impact access to care.

Current reimbursement levels also reflect an undervaluing of behavioral health services, which may require more evaluation and time than certain medical services. For example, schizophrenia, unlike anemia, cannot be identified with a blood test, nor can x-rays be used to reveal depression as they would broken bones. In addition, separate

funding streams and benefit structures for psychiatric and substance use disorders create barriers and limit integration. This is particularly true for the Medicaid program – the largest payer of behavioral health care, with nearly one-quarter of adult Medicaid and CHIP beneficiaries receiving mental health or substance use disorder services – where payment levels and models vary from state to state.

To address this issue, Congress should:

- bolster enforcement of existing parity laws, which we address below, including focusing on non-quantitative treatment limitations, such as blanket preauthorization requirements, fail-first protocols, likelihood of improvement requirements, along with other statutes; and,

- increase low Medicare payment rates for behavioral health services in a budget-neutral fashion.

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

Severe shortages of behavioral health providers and beds severely hinder patient access to care. In addition, insurers' continued violations of mental health and substance use disorder parity laws and other administrative roadblocks, which we explore later in this document, prevent patients from receiving needed care. Even before the COVID-19 public health emergency, the demand for behavioral health services was rising. In 2019, an estimated 52 million U.S. adults were reported to have a mental, behavioral, or emotional disorder. Meanwhile, 20 million people aged 12 or older were reported to have a substance use disorder. The prevalence of behavioral health issues and their interactions with physical health have in recent years increased demand on hospitals and health systems across the continuum of care. The stresses of the COVID-19 pandemic have compounded these concerns: one in three adults reported symptoms of an anxiety disorder in 2020, compared with one in 12 in 2019.

Unfortunately, the nation is ill-prepared to respond to these needs, due to severe shortages in the behavioral health workforce. More than 100 million Americans live in areas that have shortages of psychiatrists, as designated by the Health Resources and Services Administration (HRSA). HRSA projects shortages of psychiatrists and addiction counselors to persist through 2030. For hospitals and health systems, the pandemic exacerbated existing behavioral health challenges, with many hospitals forced to decrease the size of their behavioral health workforce due to budgetary pressures.

Additionally, the number of psychiatric beds has steadily decreased over the past few decades. The number of state-funded psychiatric beds per capita has declined by 97% between 1955 and 2016. The paucity of available beds has resulted in a sharp increase in the number of ED visits for behavioral health care services. According to the Agency for Health Care Research and Quality, between 2006 and 2014, the number of ED visits related to behavioral health diagnoses rose by 44% and visits related to suicidal ideation rose by 414%. Our members report that the practice of boarding –or keeping patients in an acute-care setting or ED while they await the availability of a psychiatric treatment bed – has increased significantly in recent years, with pediatric patients enduring the longest waiting times.

To address these shortages, Congress should:

- bolster student loan forgiveness programs to support training for behavioral health professionals at all levels;

- promote efforts to reduce variability of scope-of-practice laws and support changes that drive integration of care teams; and

- lift the cap on Medicare-funded residency slots to enhance access to care and help America's hospitals better meet the needs of the communities they serve. In the Consolidated Appropriations Act, 2021, Congress created 1,000 new residency slots. Now is the time to build on that foundation and help alleviate the nation's critical physician shortage.

To increase the number of providers available specifically to address the nation's substance use disorder crisis, Congress should also enact the Opioid Workforce Act of 2021 (S. 1438), which would add 1,000 Medicare-funded slots in approved residency programs in addiction medicine, addiction psychiatry and pain medicine.

Additionally, Congress should increase funding for HRSA's Title VII and VIII programs, including the health professions program, the National Health Service Corps, and the nursing workforce development program, which includes loan programs for nursing faculty. Congress also should consider expanding the loan program for allied professionals. Moreover, Congress should direct support for community college education to high priority shortage areas in the health care workforce.

Finally, congressional action should be taken to reform the Medicaid Institutions for Mental Diseases exclusion and repeal the 190-day lifetime limitation on inpatient psychiatric days in a freestanding psychiatric institution.

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

Congress should establish scholarship programs for the behavioral health workforce that are similar to the Pathway to Practice Training Program included in the Build Back Better Act; such scholarship programs encourage members of underrepresented groups to pursue health careers.

Congress should also increase support for existing federal programs that promote and help increase diversity among the behavioral health care workforce, such as the National Health Services Corps (NHSC) Loan Repayment Program and NHSC Scholarships, the NHSC Substance Use Disorder Loan Repayment Program, the Health Resources and Services Administration Primary Care Loans program, and the National Institute on Minority Health and Health Disparities loan repayment program for researchers.

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

Investments in the behavioral health needs of rural and underserved areas will help stymie the wave of unmet demand for these critical services – which has been exacerbated by the COVID-19 pandemic – and improve America's overall health. Because evidence shows that providers tend to remain in the areas where they train to practice medicine, we recommend increasing behavioral health training slots in rural and underserved areas, including offerings of Medicare bonus payments and loan forgiveness to behavioral health providers who practice in underserved communities. To increase the number of providers available to treat substance use disorders, the AHA supports the Opioid Workforce Act of 2021 (S.1438), which would add 1,000 Medicare-funded training positions in approved residency programs in addiction medicine, addiction psychiatry or pain medicine.

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?

Congress should build on progress made to date in efforts to modernize the Stark Law and Anti-kickback Statute regulations that better protect arrangements that promote value-based care.

Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?

The AHA supports streamlining licensing and credentialing for federal programs, and promoting interstate licensure compact agreements for physicians and allied health

professionals.

What public policies would most effectively reduce burnout among behavioral health practitioners?

Federal support is required to address rising clinician burnout, which has been accelerated by the COVID-19 pandemic. A recent National Academy of Medicine report suggests that between 35% and 54% of U.S. nurses and physicians have symptoms of burnout, which is characterized as high emotional exhaustion, high depersonalization and a low sense of personal accomplishment from work. Hospitals and health systems are deploying a range of programs and interventions to assist their workforce, and federal support is needed.

Congress should help reduce the administrative burden on providers. Every day, hospitals and health systems confront the daunting task of complying with a growing number of federal regulations. Federal regulation is largely intended to ensure that health care patients receive safe, high-quality care. In recent years, however, clinical staff must devote more time to regulatory compliance, detracting from patient care.

Some of these rules do not improve care; all of them raise costs. Patients are affected because less time is available with their caregivers; they also face unnecessary hurdles to receiving care that are caused by such regulations. As a result, the growing regulatory morass is fueling higher health care costs. A reduction in administrative burden will enable health care workers to focus on patients rather than paperwork; resources can be reinvested into improving care and health, while reducing costs. This includes psychiatry-specific staffing, treatment planning and related regulatory burdens developed in the period between 1970 and 1990 that do not exist in other specialty areas. Additionally, Congress should support efforts to eliminate duplicative and unnecessary quality reporting requirements while simplifying CMS' survey-and-certification process.

Further, Congress should provide additional funding to support national research and demonstration programs related to clinician well-being. The AHA urges Congress to enact the Lorna Breen Health Care Provider Protection Act, which would direct resources to reduce and prevent health care professionals' suicides, burnout and behavioral health disorders. The legislation would authorize grants to health care providers to establish programs that offer behavioral health services for front-line workers, and require the Department of Health and Human Services to study and develop recommendations on strategies to address provider burnout and facilitate resiliency. Additionally, the bill would direct the Centers for Disease Control and Prevention to launch a campaign encouraging health care workers to seek assistance when needed.

Increasing Integration, Coordination, and Access to Care

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

Behavioral health is linked to patients' physical health, and both behavioral and physical health conditions are present in many hospitalized patients. To address this growing challenge, hospitals and health systems around the country are adopting integration.

For many hospitals and health systems, the ability to integrate behavioral health services into the daily operations of their affiliated primary care practices is essential. That means supporting their affiliated primary care physicians (PCPs) with evidence-based, standardized behavioral health screening and assessment tools to use at each patient visit; PCPs must be taught to effectively use those tools and apply the information produced by screenings. In addition, hospitals and health systems are establishing a continuum of services to which patients can be referred for further evaluation and treatment. When behavioral health competencies are not physically available on-site, PCPs, particularly those in geographic markets with few psychiatrists or other behavioral health specialists, may be able to access consultations via telehealth technologies. Remote specialists can consult virtually with PCPs about patients or connect directly with the patients virtually. Other hospitals and health systems are opening behavioral health urgent care centers. Some centers are stand-alone, while others are adjacent to, or co-located with, existing urgent care centers.

To further promote integration, Congress should support the development of primary care medical home models and other bundled payment models that explicitly include behavioral health providers.

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

During the COVID-19 pandemic, it has been even more critical to share patient information and coordinate care. Such care coordination aids in the recovery of millions of individuals who are facing COVID-19-related stress and anxiety. Care coordination is particularly essential as mental health conditions, substance use, and chronic medical conditions are often co-morbid. As one example, the American Heart Association has reported that patients hospitalized from heart attacks are three times as likely as the general population to develop depression.

To drive better health outcomes and deliver on value-based care, it is imperative that all hospitals and health systems have the ability to communicate electronically with psychiatric inpatient hospitals and outpatient behavioral health providers. However, to date, behavioral health has not been included in federal health information technology initiatives, making it challenging to provide coordinated care. Many behavioral health

providers are using electronic health records, but the field is implementing this technology at a lower rate than other providers. Much of the infrastructure available from major electronic medical records and the technological improvements have not been realized in mental health, as those providers were excluded from participation in the HITECH Act.

The federal government should provide financial assistance to help psychiatric hospitals and behavioral health providers use electronic health records optimally. In addition, the federal government should help ensure that major medical/surgical hospital EMR vendors build out robust behavioral health platforms.

Additionally, we applaud Congress for amending CFR 42 Part 2 to better align with HIPAA, and we urge you to encourage the administration to promulgate the final rule implementing this alignment as soon as possible.

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

A 2018 study published in JAMA Open Network found that nearly 30% of patients who visited a hospital emergency department (ED) had at least one behavioral health diagnosis. Also, the more severe the initial behavioral health diagnosis, the more frequently the same patient visited the ED the next year. Consequently, integration of physical and behavioral health services in the ED can provide added value to the patients, providers and health care systems. That means making behavioral health clinicians available in the ED for patients' assessments, evaluations and initiation of, or referral to treatment, regardless of the reason for admission. Behavioral health clinicians can either personally assess and evaluate the patient, or consult with the ED physician who assessed the patient.

Congress can promote routine behavioral assessments for patients admitted to the hospital for a physical illness or injury as a part of his or her treatment plan. In addition to performing a history and physical, checking patients' vital signs or dispensing medications, a clinician can incorporate into the patients' inpatient care behavioral health questions, examinations, tests and treatments.

For example, at Cedars-Sinai Medical Center, Los Angeles, 95% of patients admitted to the hospital receive screening and evaluation for depression. Currently, CMS covers Medicare beneficiaries' annual screenings for depression in primary care settings; Congress could provide, through Medicare and Medicaid, coverage for similar screenings in specialty settings, such as orthopedics and oncology.

To help prevent SUD relapse, Congress can provide additional support for programs that fund hospital efforts to initiate medication assisted treatment (MAT) in EDs. The

2018 SUPPORT Act requires Medicaid programs to cover MAT from October 2020 through September 2025, and it expands certain providers' ability to treat up to 100 patients in the first year of receiving a waiver. However, access to these programs remains limited. Congress should make permanent the SUPPORT Act's MAT provisions and expand grant funding included in the 2018 law for hospitals and other entities to enable the development of protocols on discharging patients from the ED who have overdosed on opioids, including providing MAT; connecting patients with peer-support specialists; and supporting referrals to community-based treatment.

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

Inequities in access to quality behavioral health care and in outcomes are well-documented for people of color. For example, one study found that 48% of white adults with mental illness received services in 2015; however, only 31% of Black and Latino adults with mental illness and only 22% of Asian-American adults with mental illness received services that year. Additionally, Native Americans and Alaska Natives have lower rates of use of mental health services and elevated suicide rates as compared with white adults.

Numerous factors contribute to disparities in behavioral health care access and treatment, including difficulty finding and paying for care because of lack of insurance or underinsurance; a dearth of culturally competent providers; and inadequate supply of safety net providers. However, other factors have to do with long-standing and cultural differences toward behavioral health conditions, including issues with stigma about mental illness or distrust of the health care system.

To address these inequities, Congress should:

- direct the Government Accountability Office to study barriers to access to behavioral health care for underrepresented populations in Medicare, Medicaid, CHIP and enrollees in ACA marketplace plans;
- support programs to increase the number of providers of color, such as the Pathways to Practice Training Program;
- increase reimbursement rates to promote access in underserved communities;
- promote cultural and structural competency training in residency programs and through continuing education;
- fund programs that address the social factors that influence mental health; and,
- authorize and fund federal campaigns to raise awareness of the mental health challenges facing people of color, dispel stigma, and encourage them to seek care.

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

The AHA supports efforts to scale up best practices identified by current successful crisis intervention models, such as CAHOOTS in Oregon, and to create national guidelines for more appropriate levels of care in lieu of disconnected locality-by-locality approaches that exist now.

Mental health crisis call centers offer support to individuals and connection to additional services. Starting in July 2022, people around the country will be able to dial 9-8-8 to receive help during mental health crises. In order for this system to be effective, however, the national crisis system of care must be bolstered. We encourage Congress to support this system by providing funds for:

- staffing and training for crisis call centers;
- mobile crisis response teams staffed by non-law enforcement professionals skilled in de-escalation; and
- crisis stabilization programs that offer safe, short-term care settings while people wait to be connected with more-intensive facilities, such as hospitals, for their care.

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

The AHA recognizes that in many communities, even if quality care is available, certain social factors often prevent individuals from being able to access health care or achieve health goals.

We have identified three general paths for providers to facilitate connections to non-clinical services and supports:

- ***Screening and information***: Providers can systematically screen patients for health-related social needs and discuss with patients their potential impact on their health
- ***Navigation:*** Providers can offer navigation services to assist patients in accessing community services
- ***Alignment:*** Providers can partner with community stakeholders to align local services more closely with patients' needs

Ensuring Parity

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?

Our member hospitals and health systems have reported that certain payers, including Medicare Advantage (MA) and Medicaid Managed Care plans, use business practices that threaten patient access to care and inappropriately deny or delay reimbursement to providers, and apply them disproportionately to behavioral health services.

To address these issues, Congress can:

- set standards for services requiring prior authorization, with most services to be considered automatically authorized with no further action required;

- require the HHS Office of the Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) to collect, analyze and make public data from MA and Medicaid Managed Care plans on prior authorization and payment, including timeliness, denial rates, appeal rates and outcomes;

- direct CMS and its Office of the Inspector General to routinely audit health plans;

- require CMS to develop a public reporting system to alert beneficiaries to plans that have experienced issues maintaining adequate provider networks for behavioral health services;

- establish a consumer-facing health plan “report card” to help educate consumers on health plan performance;

- create a mechanism for providers to report complaints to regulators; and

- give CMS authority to take action against plans found to have high rates of inappropriate denials or delays. Congress could include these types of violations in the section of the law related to intermediate sanctions.

How can Congress ensure that plans comply with the standard set by Wit? Are there other payer practices that restrict access to care, and how can Congress address them?

Insurance plans have stated that non-quantitative treatment limitations (NQTLs) are challenging to operationalize and apply, as they appear to be subjective, but Wit and related complaints settled in Walsh v. UBH provided clear examples of parity violations regarding NQTLs. Specifically, courts found it to be a violation of the MHPAEA to set reimbursement rates at a discount for non-physician mental health providers but not for non-physician medical/surgical providers without justification; to apply any NQTL approach to the majority of behavioral health benefits but to only a limited set of medical/surgical benefits; provide inadequately detailed documentation on NQTLs in beneficiary disclosures; and to determine medical necessity based on guidelines inconsistent with standard practices of care.

To ensure that plans comply with these standards, Congress should:

- establish thresholds for "appropriate" use of the application of NQTLs in order to target potential bad actors for increased scrutiny;

- direct the Department of Labor to use the findings in these cases to develop and disseminate guidance for health plans and require audits of health plans practices based on this guidance; and

- require the exclusive application of streamlined and consistent eligibility criteria based on clinical evidence for admission authorization specific to behavioral health, including a standardized list of documentation necessary to demonstrate medical necessity. Under such a requirement, a plan would not be allowed to ask for documentation other than what is listed.

Other payer practices that restrict access to care include overly broad use of prior authorization, automatic denials (most of which are overturned upon appeal), inappropriate delays of approvals, and insufficient provider networks.

To address these practices, Congress should:

- require standardized formats for prior authorization requests (with standard fields for required clinical information) and responses (requiring detailed rationale for denial);

- require the application of standardized claim review processes and deadlines, for example: communication protocols (e.g., use of fax machines instead of electronic transfer protocols only in rare instances); responses within 24 hours for urgent situations and 48 hours for non-urgent situations, regardless of business

hours;

- require action taken by agencies such as the Department of Labor or CMS against plans found to have high rates of denials or delays that are overturned on appeal or and plans that are in violation of their prompt-pay contract terms; and

- establish penalties for plans found to have excessively high rates of prior authorization and payment delays and denials. Penalties could include civil and monetary penalties and additional compensation for providers.

Are there structural barriers, such as the size of the provider network, travel time to a provider, and time to an appointment, that impede access to the BH care system?

Hospitals and health systems report struggling to find placements for individuals with behavioral health care needs, which forces these individuals to spend unnecessary time in a general acute care hospital, often boarding in the emergency department. This is often due to inadequate provider networks, which are allowed to persist because plans provide to regulators often-inaccurate information about their networks and oversight of these networks is limited.

To address these issues, Congress should:

- require standard protocols for administrative branch agency staff to use in evaluating the adequacy of networks and solicit stakeholder input on the development of those protocols;

- require administrative branch agencies to develop more specific network adequacy standards to ensure availability of behavioral health services using a process that allows for stakeholder input;

- increase the frequency of network review to annual; and

- require the development of a public reporting system to alert beneficiaries to plans that have experienced issues maintaining adequate provider networks.

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

Prior authorization and other benefit management requirements and processes vary widely, even among different health plan products offered by the same issuers, creating dangerous delays in care delivery. Because many mental health services are more time-based than physical health services, with fewer quantitative ways to measure outcomes, these processes take a disproportionate toll on behavioral health services. For example:

- variation in authorization request submission processes (including the means, i.e. verbal, electronic and fax, as well as criteria, necessary documentation and involvement of third-party vendors);

- application of prior authorization for services for which the clinical standards of care are well established;

- variation in, and plan modification of, clinical guidelines used to determine medical necessity;

- unreasonable requests for documentation; and,

- inappropriate delays in decisions, such as returning requests multiple times because of supposed insufficient information, or not responding outside of traditional office hours

How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicare FFS programs impact access to care and patient health?

Traditional Medicare, Medicare FFS programs and Medicaid each include policies that inherently treat behavioral health services differently than medical/surgical services in terms of remuneration; these policies should be repealed, including:

- **The Institutions for Mental Disease (IMD) exclusion**. This exclusion prohibits the use of federal Medicaid financing for care provided in mental health and SUD residential treatment facilities larger than 16 beds to patients ages 21 to 64. The exclusion is one of the few examples of Medicaid law prohibiting the use of federal financial participation for medically necessary care furnished by licensed medical professionals to enrollees, based on the health care setting providing the services. The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act loosened this prohibition by granting state Medicaid programs the option to receive federal matching payments for SUD treatment provided in certain IMDs

for up to 30 days over a 12-month period, and this provision is set to expire in 2023. To alleviate the dire shortage of inpatient psychiatric beds, Congress should permanently repeal the IMD exclusion for both SUD and mental health treatment.

- **The 190-day lifetime limit for inpatient psychiatric hospital care for Medicare beneficiaries.** No other Medicare specialty inpatient hospital service has this type of arbitrary cap on benefits. Not only does this restriction limit access to care for many patients with chronic mental illness who will exceed 190 days of inpatient treatment, but also it contributes to the stigma and discrimination against patients with mental illness. Currently, Medicare covers only 190 days of inpatient care in a psychiatric hospital in a person's lifetime. This 190-day limit unfairly creates a barrier to accessing care for beneficiaries who have a chronic mental illness. To remedy this discriminatory policy, Congress should enact the bipartisan Medicare Mental Health Inpatient Equity Act, (S. 3061), introduced by Senators Susan Collins, R-Maine, and Tina Smith, D-Minn.

Expanding Telehealth

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?

The COVID-19 pandemic is the first time that policymakers and stakeholders have access to such extensive data about the use of telehealth services. We expect forthcoming data to show quality and cost-effectiveness from telehealth services is on par with in-person behavioral health services, and we look forward to the opportunity to examine the data.

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

Congress should ensure that multiple modalities are covered so that persons without access to broadband can receive needed services. We emphasize that any expansion of telehealth should be implemented with the explicit goal of advancing health equity and reducing health disparities. We are mindful that even though our recommendations would expand access to care for millions of patients, challenges may remain for communities of color. As such, telehealth must be employed with supporting policies, such as improved access to broadband and end-user devices, to reach underserved patient populations.

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

Our members have reported that while in-person services declined during the COVID-19 pandemic, the availability of telehealth services increased access. Many providers reported a significant reduction in canceled or missed appointments because barriers such as difficulty securing transportation were eliminated. Some providers also reported that patients felt more comfortable receiving services from their homes, and providers were able to better assess the patients when interacting with them in their home environment.

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 telehealth for the same services?

When clinically appropriate, audio-only services should be considered as telehealth services and should be covered and paid for in the same manner as audio-visual telehealth services. Lack of connectivity via high-speed internet remains a rate-limiting factor for health care providers and patients to engage in telehealth and other virtual care services in many communities. Even where broadband infrastructure may exist, poor quality, combined with high costs and lack of digital devices, such as smart phones, tablets and computers, make real-time voice-video connections unreliable at best and unavailable at worst. For patients in these communities, particularly those accessing behavioral health services, audio-only services have opened a lifeline to care during the pandemic. We applaud Congress for investing in our nation's broadband infrastructure. At the same time, ensuring connectivity, affordability and access to devices will require sustained investment and proactive efforts over many years to make telehealth via high-speed internet a reality in *every* community.

Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

Clinicians should have the authority to decide the most appropriate way to deliver services to each patient, depending on the patient's diagnosis, condition and other factors.

How should Medicare pay for the practice expense portion of Medicare's telehealth payment for mental and behavioral health services? Should the practice expense resources needed for telehealth forms of these services be

independently measured, or should Medicare rely on the practice expense values used for in-person forms of Medicare payment for the services?

To best support providers' ability to deliver high-quality care and improved patient outcomes, there must be a thorough and complete accounting of the costs involved in providing virtual visits, along with consideration for how such expenses relate to the need to maintain capacity for in-person services. Hospital staff and providers must take a significant number of additional steps to execute a virtual visit, compared with what is required for an in-person visit. For example, before the virtual visit takes place, the hospital must first equip providers with the necessary hardware, such as laptops and webcams, and acquire professional licenses for the chosen virtual platform, such as Zoom. If the hospital staff is at home, hospitals may also purchase additional software to protect the privacy of personal phone numbers and redirect staff to focus exclusively on helping providers and patients execute virtual visits.

Next, other dedicated staff work to set patients up on Zoom or another platform; communicate with patients before the visit to complete pre-registration; obtain and then manually record patients' verbal consent to telehealth; and provide several pre-visit points of communication to ensure patients have the correct link for their telehealth visit. For in-person care, many of these functions can occur at the same time as the visit when the patient interacts with registration staff while waiting for a provider. However, via phone and video, these functions must be completed in advance of the visit, requiring significant manpower. This process is even more complicated for a service such as group therapy, which involves more than one patient.

When the time of the virtual visit arrives, clinical staff admit a patient from a virtual waiting room or call the patient if they do not present to the waiting room. The clinical staff then completes an intake process and notifies the provider that he or she can enter the virtual visit. If any consent or release forms are required, the clinical staff obtain verbal authorization and note that in the patient's documentation, a two-step process that, when completed in person, requires only the single step of a patient signature. At the end of the visit, whereas with an in-person visit a provider would normally send a patient to check-out to schedule any follow-up visits, the provider in the virtual environment must conduct this follow-up planning him or herself because there is no way to do a warm handoff on that provider's license to a staff, as the provider needs the license for the next patient. And, finally, once the visit is over, hospital staff must send patients their visit summaries via a patient portal or via mail for patients not on the portal; when in person, this step consists of simply handing the patient their summary sheet.

Without sufficient funding to cover these numerous additional steps, it will be difficult-to-impossible for hospitals and health systems to provide telehealth at the level at which patients are requesting. The goal of expanding telehealth should be integrated care across modalities to achieve the most appropriate and efficient care for patients.

Therefore, the AHA recommends the creation of a practice expense value for telehealth services that is unique to those services, taking into account their intensity and complexity as well as the costs of the necessary infrastructure and labor described above. This would generate a payment for telehealth that reflects the inputs for delivering this service, removing the need for artificial reductions to telehealth payment simply because it is a different modality of care.

Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?

The increased use of telehealth since the start of the PHE is producing high-quality outcomes for patients, enhancing patient experience, and protecting access for individuals susceptible to COVID-19 infection. With the appropriate statutory and regulatory framework, this beneficial shift in care delivery could continue to improve patient experiences and outcomes and deliver health system efficiencies beyond the pandemic. The AHA urges Congress and the Administration to consider making permanent these flexibilities.

Telehealth policies should work together to maintain access for patients by connecting them to vital health care services and their personal providers through videoconferencing, remote monitoring, electronic consults and wireless communications. We support the following: elimination of the 1834(m) geographic and originating site restriction; coverage and reimbursement for audio-only services; expanding the list of providers and facilities eligible to deliver and bill for telehealth services, including rural health clinics and federally qualified health centers; a national approach to licensure so that providers can safely provide virtual care across state lines; and, adequate reimbursement for the substantial costs of establishing and maintaining a telehealth infrastructure, among others. Congress should expand the list of eligible practitioners that are authorized to provide telehealth services, coordinate licensure across state lines, as permitted by the TREAT Act (S. 168), which would allow the interstate provision of telehealth services during, and until 180 days after, the COVID-19 emergency.

What legislative strategies could be used to ensure that care provided via telehealth is high quality and cost-effective?

Congress should consult with the provider community to develop appropriate quality measures for telehealth services.

What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?

The primary barriers are: the unavailability of broadband for providers and patients in rural and some non-rural localities; lack of access to end-user equipment for patients; and the need to conduct training for facility staff.

Improving Access for Children and Young People

How should shortages of providers specializing in children's behavioral health care be addressed?

Congress should establish scholarships and bolster existing loan forgiveness programs to encourage providers to specialize in children's behavioral health care. Congress should also examine payment rates to ensure that reimbursement structures pay providers fairly for the services rendered.

How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?

These individuals can work with providers to improve outreach and awareness, offer cost-effective services and broaden access to care. They might also be linked to health care systems for backup, supervision and support.

Are there different considerations for care integration for children's health needs compared to adults' health needs?

As providers work to integrate behavioral health care for children, major factors to consider are developmental challenges and delays, including issues related to autism, speech and sexual reaction. These factors influence how behavioral conditions present and are best treated, as well as which non-medical services children might need to realize improvement, such as speech-language pathology and case management involving a child's family and support system.

Another major consideration is the influence of, and interaction with, other entities, including the child's family members, school, and the judicial system. For children, any treatment or screening procedures will almost certainly overlap with other institutional protocols.

How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?

Congress should ensure that at-risk children and adolescents are eligible for and have access to early screening for behavioral health conditions to prevent, if at all possible, the need for them to be involved in the child welfare or juvenile justice systems. The input and involvement of parents, foster parents, the foster care system, and schools are essential in ensuring optimal, culturally sensitive behavioral health care. In addition, close coordination is necessary with programs that support individuals' social needs and provide meaningful health care coverage upon transition from the child welfare or juvenile justice system. This includes partnerships with crisis intervention organizations that can respond to school-based issues.

What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?

The AHA urges Congress to provide consistency from state-to-state for originating site eligibility for Medicaid and CHIP to ensure that providers can receive payment for services.

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We thank you again for the opportunity to respond to your questions and look forward to working with you to improve behavioral health care for all Americans. If you have any questions, please contact Priscilla A. Ross, AHA's senior associate director of federal relations, at pross@aha.org or 202-626-2677.

Sincerely,

/s/

Lisa Kidder Hrobsky
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