November 1, 2021

United States Senate Finance Committee

Washington, DC 20510-6200

Re: Behavioral Health Care Request for Information

Dear Senators,

AdventHealth is pleased to provide comments in response to the Senate Finance Committee's Request for Information (RFI) on behavioral health care. Our faith-based system includes more than 50 hospital facilities located across nine states. AdventHealth provides inpatient, outpatient and emergency room care for over five million patients each year.

At AdventHealth, we are committed to providing whole-person care — caring for an individual in body, mind and spirit. This principle of whole-person care is anchored in more than 150 years of the Seventh-day Adventist church's tradition of health and healing. We continue to help the people in our care create a life of whole health by going beyond just treating a disease or what is broken and looking at the individual as a whole, including their mental health. This commitment is one of the reasons why we seek to address the behavioral health needs of the communities we serve.

To provide the Senate Finance Committee with sound recommendations, we consulted with behavioral health experts across our system and with experts of other Adventist-affiliated health systems that are part of the Adventist Health Policy Association (AHPA). We commend the Committee's initiative for addressing the behavioral health needs of our country and offer comments on the questions raised in the following areas:

- Strengthening the workforce
- Increasing integration, coordination and access to care
- Ensuring parity between behavioral and physical health care
- Furthering the use of telehealth
- Improving access for children and young people

Strengthen the Workforce

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

Provide Medicare reimbursement for Licensed Professional Counselors (LPCs) and peer support specialists. One of the most considerable challenges to access behavioral health services is the lack of adequate practitioners to meet the demand. The number of Medicare beneficiaries is over 54 million and is expected to rise to 80 million by 2030.[1] Studies show that approximately 26% of all Medicare beneficiaries experience some form of mental health disorder, including depression, anxiety, mild and major neurocognitive disorder and serious mental illness.[2] To meet the increasing demand and ensure timely access to care, we need to focus on growing the behavioral health workforce and use every tool, such as telehealth, to expand their reach. To accomplish this, the federal government should provide Medicare coverage of LPCs and peer support specialists. To date, LPCs and peer support specialists cannot be reimbursed by Medicare, despite having the education, training and practice rights equivalent to existing covered providers.

LPCs are licensed for independent practice in all 50 states and are covered by private-sector health plans. Peer support workers are defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "people who have been successful in the recovery process who help others experiencing similar situations."[3] They help build trust with the patient as they have themselves experienced a behavioral health issue. These workers have become an integral part of Medically Assisted Treatment (MAT) for Substance Use Disorders (SUD) and are currently reimbursed by the U.S. Department of Veteran's Affairs. They support fellow veterans dealing with mental health issues and help them navigate the VA health system. In addition, SAMHSA and the Health Resources and Services Administration (HRSA) launched the Behavioral Health Education and Training program in 2014, which supports training for 2,750 behavioral health paraprofessionals, including peer support specialists. SAMHSA has outlined the benefits of utilizing peer support specialists, which include reduced use of inpatient services and decreased hospitalizations.[4] If two different federal agencies have recognized the benefit of peer support

[1] The Next Generation of Medicare Beneficiaries. Medpac. 2015
[2] The Medicare Mental Health Coverage Gap. The Professional Counselor.
[3] Substance Abuse and Mental Health Services Administration (SAMHSA). Peer Support Workers.
[4] SAMHSA. Peers Supporting Recovery for Mental Health Conditions.

specialists in assisting individuals with behavioral health, we believe that the Medicare program should as well.

Examples of Legislation:

- (H.R. 8206/S. 2144) The Promoting Effective and Empowering Recovery Services (PEERS) in Medicare Act of 2021.
- (S. 870) The Improve Access to Mental Health Act of 2021.
- (H.R. 3550) The Primary and Behavioral Health Care Access Act of 2021.
- (S. 2226) The Native Behavioral Health Access Improvement Act of 2021.
- (S. 2112) The Enhance Access to Support Essential (EASE) Behavioral Health Services Act of 2021.

Ensure behavioral health providers are reimbursed adequately. In-network reimbursement rates for behavioral health office visits are lower than for medical or surgical office visits. Based on an analysis of commercial preferred provider organization commercial plans conducted by Milliman, as of 2017, primary care reimbursements were 23.8% higher than behavioral reimbursement.[5] Low reimbursement rates make it challenging for behavioral health professionals to sustain their practices. Disparities in reimbursements across specialties reduce access to psychiatric specialty care and are inconsistent with the goals of the Mental Health Parity and Addiction Equity Act.[6] Consequently, many underserved individuals cannot access behavioral health services. If reimbursement parity is achieved, more health care providers would be interested in participating in these federal programs. We therefore recommend that Congress amend the Mental Health Parity and Addiction Equity Act so that it includes reimbursement parity for behavioral health services. Without that change, we will continue experiencing behavioral health shortages.

Medicaid reimbursement for behavioral health services, particularly for outpatient services, is also inadequate. A study comparing Medicaid reimbursement rates for psychiatrists and primary care physicians found that psychiatrists were reimbursed less than primary care physicians for providing the same services to patients with mental health or SUD.[7] Since the Medicaid program is the single largest payer of mental health

[5] Addiction and Mental Health vs. Physical Health. Millman Research Report. 2019
[6] Mark TL, Parish W, Zarkin GA, Weber E. Comparison of Medicaid Reimbursements for Psychiatrists and Primary Care Physicians. Psychiatr Serv. 2020
[7] Tami L. Mark, Ph.D., M.B.A., William Parish, Ph.D., Gary A. Zarkin, Ph.D., Ellen Weber, J.D. Comparison of Medicaid Reimbursements for Psychiatrists and Primary Care Physicians. Psychiatric Online. 2020

services, we recommend increasing Medicaid reimbursement rates for mental and behavioral health services to Medicare levels or increasing the Federal Medical Assistance Percentage (FMAP) for mental and behavioral health services to 100%.

What policies would most effectively increase diversity in the behavioral health care workforce? What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?

AdventHealth commends Congress for seeking ways to diversify the behavioral health care workforce. There is a wide gender and racial gap in behavioral health professions. A large percentage of workers in the field are female and white. White and Asian psychiatrists dominate the field, while Hispanic and Black psychiatrists are underrepresented based on population size.[8] To encourage more diversity, we recommend that Congress:

- Provide loan forgiveness to individuals seeking behavioral health careers.
- Provide additional incentives, such as grant programs or scholarships, to individuals practicing in rural areas.
- Provide Medicare coverage for non-clinical workers, such as community health workers, peer support specialists and behavioral health navigators.
- Provide GME support to Allied Health Colleges and Universities to target educational opportunities for diverse populations.

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?

Restrictions for the reimbursement of medical and behavioral health visits provided within the same day inhibit collaboration and access to care. Currently, Medicare reimburses providers for medical and behavioral health visits provided within the same day, but many state Medicaid programs and commercial payers still do not. This segmentation of mental and physical health imposes an arbitrary barrier for patients to receive care in a timely manner. For example, a patient experiencing anxiety attacks

[8] Mental Health Technology Transfer Center Network. Characteristics of the Workforce

may visit the Emergency Department (ED) multiple times with shortness of breath and chest pain. Due to these symptoms, the patient would likely be placed under observation status as a preventive measure. If the attending provider called a behavioral health professional on the floor or via telehealth for a consultation, such visit may not be reimbursed. As a result, the provider may simply prescribe an anti-depressant without assessing the patient properly to determine the root of the issue. Failure to adequately treat the patient's anxiety could worsen the patient's medical symptoms, increasing ED utilization and leading to increased health care costs.

While a provider can refer a patient to see a behavioral health professional on a different day, this approach generally results in more missed appointments. This is even a bigger issue with economically disadvantage populations as many may not have reliable transportation or have the ability to take another day off from work. Additionally, the stigma associated with seeking behavioral health can deter patients from seeking care.

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?

Encourage Medicaid programs to provide reimbursement for collaborative care models integrating behavioral health and primary care. This could be done by providing guidance to the states about these models and the billing codes currently available within Medicare and the VA to reimburse for collaborative care. Collaborative care is an evidenced-based approach that involves the delivery of integrated care through a multi-disciplinary team, including a primary care physician, a care manager and a behavioral health professional. Given that the preponderance of psychiatric medications is prescribed in the primary care setting, upwards of 79%, the addition of a psychiatric consultant in this model expands the scope of patients that the PCP is able to manage. According to several studies, 45% of those dying by suicide saw their primary care physician in the month before their death. Only 20% saw a mental health professional

in the preceding month.[9] That is why many health systems, including AdventHealth, have invested in integrating behavioral health within primary care, where providers have a greater opportunity to address suicidal ideation or any signs of depression before is too late.

Currently, both Medicare and the VA provide reimbursement for collaborative care between behavioral health and primary care providers; however, most Medicaid programs do not. This makes it more difficult for patients to receive behavioral health services as part of their primary care visit, since those services would not be reimbursed. Mental illness is more than twice as prevalent among Medicaid beneficiaries as it is in the general population and roughly 49% of Medicaid beneficiaries with disabilities have a mental illness.[10] That is why we believe it is crucial for Medicaid programs to adopt collaborative care models that promote the provision of whole-person care. Medicaid could adopt the same CPT codes that were adopted by Medicare (CPT codes 99492, 99493, 99496). This would empower primary care providers to treat patients wholistically as opposed to only treating those symptoms that are physically visible.

Investing in collaborative care models has the benefit of improving patient outcomes and also reducing health care costs. Several studies have demonstrated that collaborative care is cost effective compared to care without integration. For example, the Improving Mood Promoting Access to Collaborative Treatment (IMPACT) trial enrolled 1,800 depressed older primary care patients into a randomized control trial of a collaborative care management program for depression. The trial found that an initial investment in collaborative care of $522 in year one returned a net cost savings of $3,363 over the first four years or a return on investment of $6.50 per dollar spent. The net savings associated with this initial investment approximate $5,200 per program participant over four years or $1,300 per year.[11] Compared to patients receiving care without integration, patients enrolled in the IMPACT program also experienced improvement in their depression over 12 months, had less physical pain, better social and physical functioning and improved overall quality of life.

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[9] McDowell, A. K., Lineberry, T. W., & Bostwick, J. M. Practical Suicide-Risk Management for the Busy Primary Care Physician. *Mayo Clinic Proceedings*. 2011
[10] Kronick R et al., The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions, Center for Health Care Strategies. 2009.
[11] The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. 2013

What are other policies that could increase access to behavioral health care?

Revise the Controlled Substances Act (CSA) to eliminate the requirement for practitioners to apply for an X waiver to prescribe Buprenorphine, used for SUD treatment. Access to drugs like Buprenorphine can make the difference between life and death for individuals suffering from SUD. Currently, Buprenorphine is prescribed as part of a person's Medically Assisted Treatment (MAT), which is an evidenced-based approach for treating SUD that includes counseling and other behavioral health therapies. The difference between Naloxone and Buprenorphine is that while Naloxone can be used only to reverse overdoses, Buprenorphine is used continuously as part of a person's SUD treatment.

Prescribing Buprenorphine for SUD treatment requires prescribers to complete an approved training, attest to their referral capacity and submit an application to the federal government. Following approval, a waiver license number is issued that begins with an "X." X-waivered prescribers face heightened scrutiny by federal and state law enforcement officials, including periodic audits that are intended to minimize diversion and misuse.[12] Ironically, Buprenorphine's X-waiver only applies when it is prescribed to treat SUD, not pain. Therefore, a medication that is critical to reducing deaths from the opioid epidemic is regulated more tightly than medications largely responsible for creating the epidemic. The notion that individuals can be prescribed medications that can lead to dependency issues, but the drugs needed to cure them require a waiver is failure of policy that needs to be addressed.

Ensuring Parity Between Behavioral and Physical Health Care

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?

Amend the Employee Retirement Income Security Act (ERISA) to give the Department of Labor (DOL) the authority to levy Civil Monetary Penalties (CMPs) against health insurers not complying with mental health parity requirements. To address the behavioral health crisis in America, ERISA must have the ability to levy CMPs against health insurers that are not in

[12] Fiscella K, Wakeman SE, Beletsky L. Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder: X the X Waiver. JAMA Psychiatry.

compliance with mental health parity requirements set by the Mental Health Parity and Addiction Equity Act of 2008. Holding payers and plans responsible for ensuring mental health parity is crucial in cementing behavioral health as an integral part of physical health care. This policy was included within the House Education and Labor Committee (HELP) budget reconciliation language, section 21005. President Obama's Mental Health and Substance Use Disorders Parity Task Force strongly recommended providing this authority, as did President Trump's Commission on Combating Drug Addiction and the Opioid Crisis.[13][14]
The recently passed Consolidated Appropriations Act of 2021 requires group health plans and issuers to complete an analysis explaining whether the factors used for mental health coverage differ from limits imposed for medical and surgical benefits. While this was a positive step by Congress to improve transparency, support for allowing the Department of Labor to levy CMPs is needed to promote accountability and strengthen enforcement.

Require that all insurance plans cover FDA-approved medications for SUD treatment without restrictions. Section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requires Medicaid programs to cover all drugs and biologicals approved or licensed by the FDA to treat opioid use disorders, along with related counseling services and behavioral therapies.[15] However, this law did *not* prohibit the use of coverage limitations, such as prior-authorization. Due to this issue, we continue to face many hurdles when trying to secure medications for the treatment of SUD. Prior-authorization requirements for treatments and medications that have been deemed clinically necessary for the treatment of SUD create unnecessary barriers for patients and providers. Unfortunately, these discriminatory exclusion practices are common. The federal government recently clarified that discriminatory coverage of the SUD medication methadone for OUD treatment might be illegal.[16] While this clarification demonstrates that we are heading in the right direction, it also shows that a large portion of FDA-approved medication is beholden to discriminatory practices by payers and plans. Therefore, we recommend that Congress enact legislation requiring all insurance plans, including Medicaid, to cover FDA-approved medications for SUD without the need for prior-authorization.

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[13] Final Report of The Mental Health & Substance Use Disorder Parity Task Force. October 2016
[14] Recommendation 35 of The President's Commission on Combating Drug Addiction and the Opioid Crisis. November 2017.
[15] Centers for Medicare and Medicaid Services. Mandatory Medicaid State Plan Coverage of Medication Assisted Treatment.

Eliminate the 190-day Medicare lifetime coverage limit for inpatient psychiatric stays. Congress should remove the 190-day Medicare lifetime coverage limit for inpatient psychiatric stays. We believe that a timeframe cannot stipulate recovery from mental health issues and SUD. Moreover, Medicare currently does not impose any lifetime coverage limits for other diseases. The 190-day arbitrary cap is problematic for patients being treated in psychiatric hospitals as they may easily exceed the 190 days if they have a chronic mental illness. Additionally, removing individuals from care because they have exhausted their allotted time can negate any progress made and further delay or prevent recovery. Removing the Medicare lifetime coverage limit will expand access for the most seriously ill, help improve continuity of care and equalize Medicare's behavioral health coverage with those of other diseases.

Example of Legislation:

The Medicare Mental Health Inpatient Equity Act, which would eliminate the 190-day Medicare cap. *(No number has been assigned yet)*

Remove the Medicaid Institutions for Mental Diseases (IMD) exclusion to increase Medicaid-funded inpatient bed capacity. The IMD was created in 1965 to ensure that states maintained primary responsibility for funding inpatient psychiatric services rather than the federal government. It prohibits federal reimbursement to states for adult Medicaid patients receiving mental health services or SUD treatment in psychiatric or substance abuse treatment facilities with more than 16 beds. The IMD exclusion is the only part of the Medicaid program that does not pay for medically necessary care simply because of the type of illness, significantly reducing capacity and access to life-saving care. The exclusion is discriminatory, outdated and has a real-life impact on people's access to needed inpatient treatment. While the IMD attempted to shift the financial responsibility of care to the states, there are no mechanisms to ensure that states will comply in a manner that satisfies the behavioral health needs of the public. Recently, states were given the option to cover short-term stays in psychiatric hospitals by applying for a waiver from the federal government. While this option shows progress, we need to permanently remove the IMD exclusion to ensure equal access across the country.[17]

[17] Medicaid IMD Exclusion. NAMI.

Furthering the Use of Telehealth

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

Since Congress relaxed the restrictions on telehealth, we have been able to increase access to behavioral health services. This has allowed our clinicians to better manage patients' symptoms and conduct follow-up care. As a result, we have seen improved patient satisfaction and patient outcomes.

Telehealth removes barriers to behavioral health treatment and encourages continuity of care. Seeking treatment for behavioral health needs can be a daunting and stress-inducing experience. For many, there is still a negative stigma associated with seeking treatment for behavioral health needs. This stigma can prevent many from seeking help from in-office care settings. This is where telehealth plays an essential role in providing individuals with access to care from the comfort of their home, reducing stress and anxiety, and encouraging better continuity of care. Additionally, telehealth can increase access for individuals in behavioral health professional shortage areas and rural areas. It allows patients in areas with limited availability to expand their provider searches beyond local areas because travel time is eliminated.

Telehealth is also a windfall for behavioral health shortages. As we have covered throughout this RFI, there are alarming discrepancies in behavioral health care needs and service availability. The COVID-19 pandemic has only worsened this behavioral health crisis with a recent poll showing that 85% of respondents claimed that their wellbeing has declined since the start of the pandemic and 55% stating mental health as the biggest factor.[18] However, access to treatment remains a problem with only 27% of the nation's mental health needs being met with existing capacity.

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

[18] What COVID-19 has done to our well-being. Harvard Business Review. 2021

the same services?

Medicare should not make a distinction between coverage and payment for audio-only and audio-visual forms of telehealth. Both modalities have demonstrated their effectiveness and reliability in addressing the needs of individuals. Audio-only is a valuable tool that increases care access to individuals who do not have adequate broadband or technological know-how. Individuals experiencing poverty in the U.S. have very low rates of internet access (59%) and digital literacy (53%) despite many owning a cellular telephone (71%).[19] Many seniors also have technology illiteracy, which inhibits the use of audio-video communication. Lack of audio-only coverage could therefore significantly impact seniors, economically disadvantage populations and individuals living in areas with limited broadband.

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?

Judgment calls on whether a service should be rendered via audio-only or not should be left to the provider's discretion or clinical decision-making. Establishing parameters for when certain health services should require a visual component would be arbitrary and fail to recognize other barriers to utilizing video, such as a patient having unreliable internet or simply not feeling comfortable using video. To address any concerns about patient safety and health care quality, quality measures could be adopted that apply to all behavioral health services, regardless of the modality used. Supporting quality metrics that are recognized by the National Quality Forum (NQF) will help ensure that any metrics adopted are valid and reliable. The NQF is an independent, nonpartisan organization tasked with devising a national strategy to set quality improvement and reporting standards.

Should Congress make permanent the COVID-19 flexibilities for providing telehealth

[19] Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders. SAMHSA. 2021

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?

Making *all* the COVID-19 telehealth flexibilities for behavioral health permanent will increase access to care and help mitigate current clinician shortages. Reinstating the telehealth restrictions that existed prior to the pandemic would be a missed opportunity to expand the reach of behavioral health professionals. We believe that telehealth services should be treated as any other services covered by Medicare, with HHS using the same mechanisms it currently has to prevent fraud and abuse. As mentioned above, the use of quality metrics would help ensure that any services provided via telehealth improve the health of Medicare patients.

We also recommend that Congress eliminate the Medicare requirement for an in-person visit to take place before a telehealth service is provided for mental health services.

Currently, Medicare only reimburses telehealth services if provided to a patient living on a rural area. Telehealth is not covered if the patient is receiving the service from their home or in an urban area. Because of the nationwide shortages of behavioral health professionals, Congress eliminated this restriction through the Consolidated Appropriations Act of 2021. However, the law also made it mandatory for an in-person visit to take place prior to the telehealth service for behavioral health.

In our opinion, this requirement only adds another barrier to seeking care. Once you have a patient come through the door, it is easier to retain that patient. What is much harder is to get that patient to come in for the first time. Telehealth facilitates that; it makes it easier for the person to have that first contact with a behavioral health professional. The in-person requirement also fails to recognize the stigma associated with seeking mental health services. It is easier for a person experiencing depression or any other behavioral issues to call the first available behavioral health professional in the middle of the night than to make the decision to get into a car and drive to the closest office, which in the case of behavioral health services could be many miles away from home. Due to these reasons, we ask that Congress eliminate this in-person requirement for mental health services provided via telehealth.

What barriers exist to accessing telehealth services, especially with respect to

availability and use of technology required to provide or receive such services?

Access to high-quality and affordable broadband. To ensure that care provided via telehealth is high-quality and cost-effective, Congress should address inequalities in internet access and high-speed broadband. For example, access to quality internet access can cost 10 times more in rural areas compared to urban areas. Only 1.4% of urban households lack access to broadband internet, while approximately 27% of rural households lack access to proper broadband.[20] Additionally, the U.S. ranks 28th in the world for having one of the highest average prices for internet connection at an average of $60. Germany, South Korea and Israel all have an average price under $30. Subsequently, roughly one in five U.S. households living on less than $30,000 a year do not have internet.[21] Furthermore, there are wide discrepancies between Black and Hispanic populations' access to home broadband and ownership of a home computer when compared to White counterparts. To ensure that *all* individuals have access to telehealth services, Congress should further invest in broadband infrastructure.

Improving Access for Children and Young People

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

As mentioned earlier, low reimbursement rates are a major deterrent for seeking a career in behavioral health, including for those wanting to specialize in children. The inability to bill for primary care and behavioral health visits within the same day is also seen among many state Medicaid programs and commercial insurance. Changing these reimbursement policies at the federal level would allow more children to be screened for behavioral health issues and access those services in a timely manner as part of their regular wellness visits. In addition to addressing these issues, we recommend that Congress:

Increase funding and grant opportunities for children's behavioral health services. Suicide is the 3rd leading cause of death in youth ages 10 – 14. Additionally, 50% of all lifetime cases of mental illness begin by age 14.[22] Unfortunately, only about 20% of children with mental,

[20] Rural American's Battle for Faster Internet. AARP. 2020
[21] The Scandalous Cost of Internet in America. Milken Institute Review. 2021
[22] Mental Health Facts: Children & Teens: NAMI

emotional or behavioral disorders receive care from a specialized mental health care provider.[23] Ensuring children can receive behavioral health treatment is vital to preventing a lifelong affliction that could lead to chronic conditions and increased health care costs. Unfortunately, many of the behavioral health centers in the U.S. do not treat adolescents. For example, in 2018, there were nearly 12,000 specialty mental health treatment facilities in the United States. Roughly half (55%) of facilities reported accepting youth age 12 or younger and participating in Medicaid, and slightly more facilities (59%) reported accepting youth age 13–17 and participating in Medicaid. However, many of these facilities did not offer tailored programming for adolescents.[24] To remedy this, Congress should ensure that there are grants dedicated to addressing the needs of children and adolescents or ensure that a percentage of grant funding is directed towards bolstering pediatric care capacity.

Examples of Legislation:

- (H.R. 4943) - The Children's Mental Health Infrastructure Act of 2021, would provide $2 billion a year for five years for grants to children's hospitals for increasing their capacity to provide pediatric mental health services.
- (H.R. 4944) - The Helping Kids Cope Act of 2021, would provide $500 million a year for five years to support grants to children's hospitals and other providers to support pediatric behavioral health care integration and coordination.

Ensure that all payers have adequate network coverage of behavioral health professionals specializing in children and adolescents. Disparities in out-of-network utilization for office visits are greater for children than for adults. A study conducted by Milliman of commercial insurance claims found that a behavioral health care office visit for a child was 10.1 times more likely to be an out-of-network provider than a primary care office visit — more than twice the disparity seen for adults.[25] This issue not only limits access to care, it also increases patients' out-of-pocket costs. Stronger network adequacy standards and oversight are needed across all payers. These standards should include specific requirements that health plans demonstrate they contract with an appropriate number of trained mental health professionals specializing in child and adolescent behavioral health.

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[23] E. O'Connell, T. Boat, & K. E. Warner Eds. National Research Council and Institute of Medicine. Washington, DC. The National Academic Press. 2009
[24] Access to Behavioral Health Services for Children and Adolescents. MACPAC. 2021
[25] Addiction and Mental Health vs. Physical Health. Millman Research Report. 2019

Expand access to behavioral health services through School-Based Health Centers (SBHC). Policies that promote SBHCs would help increase children's access to behavioral health treatment. SBHCs provide a full range of services to students and their families, including primary medical care, nutrition education, hearing screenings and behavioral health care. According to a study conducted by the U.S. Department of Health and Human Services (HHS), adolescents are more comfortable accessing health care services through school-based clinics.[26] At present, only 2% of schools have on-site SBHC and 10% have access to off-site facilities.[27] Funding for SBHCs has traditionally come from a patchwork of revenue streams. Many centers are funded by traditional school financing sources such as local property taxes and formula-driven state revenue allocations to local school districts. Federal funding comes from various federal discretionary grants for school-based care, from Medicaid payments for certain services provided to students in special education and through Federally Qualified Health Centers (FQHC) sponsorship. We believe it would be beneficial to identify more sustainable funding sources.

Example of Legislation:
(H.R. 4944) - The Helping Kids Cope Act of 2021, supports flexible funding for communities to support a range of child and adolescent centered and community-based services. While this legislation does not provide permanent funding for SBHCs, which would be the ideal policy, it does invest in community-based services.

Expand the use of telehealth services in the scholastic setting. Given the lack of sufficient behavioral health professionals, reimbursing for telehealth services provided to children and adolescents in school has the potential to significantly improve access to care. Research shows that students with access to care through telehealth at school show improved health and education outcomes.[28] Several research studies show, for example, a relationship between access to care through telehealth at school and improved outcomes for asthmatic students, such as increasing the number of symptom-free days. Telehealth can also eliminate well-documented access barriers for children, including long distances to providers and lack of transportation.

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[26] Five Steps to Health in America. Adventist Health Policy Association. 2015
[27] Access to Behavioral Health Services for Children and Adolescents. MACPAC. 2021
[28] Love H, Panchal N, Schlitt J, Behr C, Soleimanpour S. The Use of Telehealth in School-Based Health Centers. Glob Pediatr Health. 2019

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

Having a multi-disciplinary care team that includes non-clinical professionals is essential to the success of any behavioral health program. That is because in order to care for an individual wholistically, care needs to go well beyond medication management or physical care. For example, families of children with behavioral health issues also need non-clinical support and resources, such as access to healthy food or assistance navigating the health care system. Non-clinical professionals can act as a liaison between the patient, community-based organizations and the health system. Additionally, these professionals can play a role in advancing health equity because they generally share and understand the person's language, cultural practices and spiritual beliefs. In the case of peer support specialists, they also share similar life experiences and challenges that help cultivate trust and openness. In our experience, integrating non-clinical workers into health care teams has proven to be a successful strategy to provide culturally-competent care and improve health care outcomes.

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? **Appropriate resources should be set aside for these programs to have behavioral health care embedded in these systems**. This care will go a long way in decreasing the reliance of children on these systems.

Conclusion

AdventHealth welcomes the opportunity to further discuss any of the recommendations provided. If you have any questions or would like further information, please do not hesitate to contact Susana Molina, Director of Public Policy, at Susana.MolinaRamos@Adventhealth.com.

Sincerely,

Michael E. Griffin
Senior Vice President, Advocacy and Public Policy