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November 1, 2021

Chairman Ron Wyden
Ranking Member Mike Crapo
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: AHIP Response to the Senate Finance Committee Bipartisan Request for Information

Submitted via email to mentalhealthcare@finance.senate.gov.

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of AHIP[1], thank you for the opportunity to respond to your Request for Information (RFI) on data-driven policy proposals designed to improve access to behavioral health care services for individuals enrolled in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplaces. AHIP strongly shares your commitment to ensuring access to quality, affordable behavioral health care, including both mental health (MH) care and treatment for substance use disorders (SUD) in the context of whole-person care. We look forward to working with you to advance these goals.

Health insurance providers engage in a wide variety of activities and programs designed to improve behavioral health care access, quality, and value for the populations they serve. Our member companies implement policies that protect patient safety, emphasize evidence-based care, drive better health outcomes, and support quality reporting. In addition to offering behavioral health benefits on par with medical and surgical benefits in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), health insurance providers are pioneering innovative programs designed to improve the behavioral health of their members. The industry is raising patient awareness of the importance and availability of behavioral health care, while working to reduce stigma, integrate behavioral and medical/surgical care, encourage collaborations with providers, and proactively identify behavioral health needs for members.

COVID-19 has exacerbated a loneliness crisis in America, which is why health insurance providers have been providing resources to help people avoid isolation and loneliness during a time of extraordinary social distancing. AHIP has also partnered with Psych Hub, a COVID-19

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Mental Health Resource Hub coalition created to address the need for quality and engaging online education on timely and essential topics, including mental health, substance use, and suicide prevention. In addition, health insurance providers have been leaders in supporting access to telehealth, inclusive of tele-behavioral health services, the need for which has been accelerated by the pandemic.

Based on the collective experience of our member health insurance providers, we offer input on a number of the specific questions and areas you pose in your RFI. Investment in these areas can have a wide-ranging impact and go a long way toward improving our current system of behavioral health care. For example, behavioral health integration into primary care not only promotes timely access and whole-person care but, in removing the traditional siloes between medical and behavioral care, integration also reduces stigma and increases equity. Similarly, in addition to helping to address access issues and workforce shortages by increasing efficiency in patient visits, telehealth helps promote equity by providing access to available technology, thereby making behavioral health services more widely and conveniently accessible.

In addition, there is extensive work being done at the state level in many of these areas. As you develop policies to redesign the way behavioral health care is delivered in the U.S., we encourage you to coordinate with state efforts and leverage the progress that is already being made to address many of these same issues at the state and local levels.

Thank you again for the opportunity to provide input. We appreciate your commitment to developing a national strategy that will lead to a modernized behavioral health system that aims to improve outcomes and provide value for all stakeholders. We look forward to working with you in this effort.

Sincerely,

Elizabeth Goodman, JD, MSW, DrPH
Executive Vice President, Government Affairs and Innovation

Strengthening Workforce

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

There is no question that we need more behavioral health clinicians to meet the growing demand for services. For example, one estimate projects that by 2030, there will be a 20 percent decrease in the supply of adult psychiatrists. Shortages in clinician supply are also projected for addiction counselors. Policies that provide incentives for individuals to enter the behavioral health field and participate in federal programs could include:

- Increasing funding for loan repayment programs for providers who enter the behavioral health field;
- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include behavioral health care professions;
- Increasing the number of graduate medical education (GME) slots allotted to behavioral health providers; and
- Expanding the behavioral health provider types covered under Medicare, such as certified peer support specialists, licensed professional counselors, and licensed mental health counselors.

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

There have been longstanding challenges to accessing behavioral health care that pre-date COVID and have been exacerbated by the increased need resulting from social isolation, fear and uncertainty, economic factors, and other challenges resulting from the pandemic. There is a well-documented national shortage of behavioral health providers which can be more acute in certain geographies such as rural areas and in the aftermath of emergencies. There is also relatively low participation of behavioral health providers in health insurance plan provider networks even among the current supply of providers and in comparison with other specialties.

Moreover, although the current public health emergency has done much to reduce stigma, lingering stigma associated with behavioral health continue to make some patients less willing to seek behavioral health care or only receive care out-of-network where they can pay out-of-pocket without accessing their behavioral health benefits.

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

It is important to have diverse provider networks that reflect communities served so that individuals can find providers that meet their preferences and needs to receive culturally

competent and patient-centered care. This not only includes provider and practitioner demographic diversity but also diversity of staff and care team members who have varied living experiences to build empathic relationships with patients.

To increase diversity in the behavioral health workforce, it is important to expand loan repayment and scholarship programs that help incentivize diverse providers to enter the health care field and serve in underserved areas (such as National Health Service Corps or Nurse Corps). Individuals also need a way to know the demographic diversity of behavioral health providers available to them to find someone that they feel comfortable seeing for care. It is therefore important to collect provider demographic data (on a voluntary basis) in a streamlined manner and securely stored in national or state databases to serve as "single sources of truth". Potential data collection vehicles for provider demographic data include state medical licensure boards or the CMS National Provider and Plan Enumeration System (NPPES).

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

Scholarships for medical students can encourage graduating providers to practice in underserved areas, especially with a focus on high-need clinical areas like behavioral health. Sufficient opportunities and support for clinicians to receive the supervision hours necessary for licensure as behavioral health providers is also critical. Financial incentives, such as bonus payments, can encourage more providers to practice in rural and underserved communities. Health insurance providers, additionally, have invested in rural practices, introduced loan repayment programs, and have awarded scholarships for incoming students to encourage practice in rural areas after graduation. Visa waivers should be available for foreign providers committed to serving in rural, underserved areas. And the National Health Service Corps encourages providers to practice in rural areas. In addition to offering incentives to attract behavioral health providers to work in underserved rural communities, the federal government should consider tax incentives for health insurance providers and other private companies to facilitate the adoption of private investments to encourage providers to practice in rural and underserved communities.

To support those already in practice, insurance providers promote the use of telehealth and other virtual care modalities to extend the reach of behavioral health care. And to support clinicians, insurance providers are actively promoting Project ECHO, which uses hub-and-spoke models to allow rural providers to interact with specialists at larger tertiary care hospitals or other facilities to consult about patients with complex needs. This innovative communication channel expands patient access to specialty care and overcomes geographic limitations of traditional health care services and a lack of specialists in some areas. We encourage Congress and other federal stakeholders to support programs that increase rural behavioral health provider-to-provider connections, like Project ECHO. The federal

government should continue to provide funding for the expansion of broadband access into rural and underserved areas.

Through these actions, federal policies can recruit and support behavioral health providers in rural communities.

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?

Several challenges contribute to the lack of access to care coordination and/or communication between and among providers. For example:

- We await federal HIPAA regulations to improve care coordination and access for individuals to obtain health services, including behavioral health care, recognizing that certain restrictions exist over sharing SUD information under the federal confidentiality requirements. States, too, may have their own restrictions for information sharing from behavioral health providers without patient consent.
- Additionally, many primary care physicians do not have relationships with behavioral health providers and rely on plan provider networks for referrals. Building these relationships and collaborations can improve patient access and outcomes.
- Despite Medicare's update to the physician fee schedule policies to improve payment for psychiatric collaborative care and care management services, provider adoption of the Collaborative Care Model (CoCM) and use of the associated codes have been relatively low. Start-up costs, complexity, and the need for technical assistance are often cited as barriers to more widespread adoption. Moreover, many state Medicaid programs do not reimburse for the collaborative care codes, further challenging broader adoption and use.
- Another barrier to greater communication between behavioral health professionals and other providers in the health care system is the current exclusion of behavioral health clinicians from the Electronic Health Record (EHR) Incentive Program. Inclusion of behavioral health providers in this program would incentivize greater adoption of EHRs among behavioral health clinicians and promote greater ability for them to share information electronically among providers caring for the same patient.
- Finally, it is important to highlight challenges faced by individuals in need of or currently receiving treatment for a mental illness or SUD who are transitioning between types of coverage, such as those re-entering society following involvement with the justice system.

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

Telehealth and other digital tools can be effective in helping to increase efficiencies and reduce burnout among behavioral health practitioners, because these tools allow patients to connect with

a wider network of providers than may be accessible in their geographic region. For example, there are areas of the country where there may only be one behavioral health provider available for significant numbers of people who is responsible for the needs of all patients in surrounding communities. By introducing or expanding access via virtual care, providers in other areas can connect with patients, alleviating some of the patient visits from the provider who is physically based in that community. Telehealth and digital tools can help the community-based provider to be more efficient in practice by assisting with triage and follow-up and allowing patients with lower-acuity to use virtual care, freeing up capacity for people with more serious behavioral health issues.

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?

In an integrated care model, often providers – medical and behavioral health – work in the same medical setting or group practice, or if not a common site, collaborate on care plans, clinical pathways and guidelines, procedures, and information systems. This close collaboration promotes coordinated follow-up to improve both medical and behavioral outcomes for the patient.

The Center for Integrated Health Solutions, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), has developed a standard framework for levels of integrated healthcare, on which the Center for Health Care Strategies has based its continuum of behavioral health integration models. This integration continuum includes models that emphasize coordinated care through screening and consultation, to those that supplement that care coordination with care management and co-location, to those that are more fully integrated at the health home or system-level.

Along this continuum, there are several best practices for integrating behavioral health with primary care and the range of models underscores the importance of flexibility and recognition that provider practices are at varying stages of readiness in their ability to integrate behavioral health care. A few of these best practices include:

- CoCM: The Collaborative Care Model (CoCM) of integration includes care management support for patients receiving behavioral health treatment and psychiatric consultation.
- Expanded and/or Integrated Care Management: This approach relies on behavioral health and medical care managers coordinating and communicate across co-morbid conditions and a special focus on care management specific to behavioral health conditions.
- Value-Based Purchasing (VBP) and Alternative Payment Models (APMs): This approach uses value-based payments to encourage providers to integrate care.

All of these approaches rely on team-based care that includes primary care providers using validated behavioral health screen and assessment tools to identify patients in need of services, referral/consultation arrangements and partnerships with behavioral health specialists, care management by health care professionals trained to coordinate care across behavioral and medical conditions, education and training resources to support providers, and quality measurement to assess effectiveness.

There are several changes to payment policies that could promote greater care integration. The Committee should consider the following options:

- Funding for start-up costs and/or technical assistance to help providers implement collaborative care and other models that coordinate and integrate physical and behavioral health. For example, legislation like H.R. 5218, the Collaborate in an Orderly and Cohesive Manner (COCM) Act, which would not only provide primary care practices with start-up funds and technical assistance to adopt the model but would also fund research to build the evidence base for other models of integrated behavioral health care, is an important step in moving toward greater adoption of integration models. Additionally, policymakers could explore leveraging CMMI alternative payment models to support primary care practices that implement the CoCM or other evidence-based integration strategies.
- Expanding the behavioral health provider types covered under Medicare to include providers who can deliver services within integrated care settings, such as certified peer support specialists, licensed professional counselors, and licensed mental health counselors.
- Use of state Medicaid waivers to fund primary and behavioral health integration and state Medicaid reimbursement of the CoCM codes.
- Expanding the current Certified Community Behavioral Health Clinics (CCBHC) demonstration and/or making the CCBHC enhanced Medicaid reimbursements permanent. The CCBHC demonstration is designed to improve community behavioral health services, including through advancing integration of behavioral health with physical health care, and building on this existing demonstration could address workforce capacity and community and state infrastructure needs, in addition to promoting delivery integration.

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

As we work toward an interoperable health system, limitations on information sharing based on federal and/or State requirements that restrict information flows will need to be identified and understood. For example, as behavioral health information is often subject to more stringent privacy protections and patient consent requirements, analyses could be performed to evaluate if or how these requirements have an intended (e.g., individuals restrict information about their prescribed medications or used substances) or unintended (e.g., an adverse medication reaction results) effect on overall care.

In addition, policymakers should explore opportunities to remove statutory access barriers to care, such as Medicaid's Institution for Mental Diseases (IMD) exclusion, which prohibits most Medicaid reimbursement for adults under the age of 65 in residential behavioral health facilities with more than 16 beds. Reform of the IMD exclusion will help improve access to evidence-based treatment in an appropriate setting when medically necessary.

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

As mentioned previously, loan repayment or scholarship programs (such as National Health Service Corps and Nurse Corps) are important policies and programs that help incentivize people of diverse backgrounds to enter the behavioral health field and serve throughout the country, including in underserved areas. Visa waivers are also available for foreign practitioners committed to serving in underserved areas. Having diverse behavioral health providers that reflect communities is important to promote equitable quality care for minority populations so that they can find providers that meet their preferences and needs to receive culturally competent and patient-centered care.

However, given the growing shortages of behavioral health providers, more work is needed to recruit and retain behavioral health practitioners in rural communities. Existing programs should be expanded to include more regions and to recruit more behavioral health practitioners. Additional federal, state, and private financial investment can increase the number of providers available in designated health professional shortage areas, which could help rural states reduce provider shortages. Policymakers should consider providing tax incentives to health insurance providers and other private companies to facilitate the adoption of such financial investments. The federal government should expand loan repayment programs to further expand the capacity to deliver behavioral health care in underserved communities.

Telehealth and virtual care can also be powerful tools in addressing patient access, offering greater opportunity for people in both underserved rural or urban areas can access high-quality providers and specialty care. Telehealth has the power to close geographic distances and can eliminate other disparities faced by urban populations. Telehealth can be a valuable tool in breaking down issues of stigma, by allowing people to access care in the most convenient, private locations.

Health plans, additionally, are working to address some of the challenges associated with the "digital divide," by providing smartphones, WiFi, and education to improve technological literacy to expand access to virtual care, and support efforts to increase access to affordable broadband in rural and other underserved areas. Policymakers must take action to ensure that access to telehealth is maximized for all populations, by ensuring that health plans have the flexibility to design benefits and develop networks to best serve the needs of their members.

Enhanced training of behavioral health providers on cultural competency, cultural humility, unconscious bias, and anti-racism that leads to actionability, and accountability to their patients can also help promote patient access to equitable, quality care by imparting empathy, respect, and understanding between patients and their behavioral health providers. This training can help ensure that patients are treated with respect and compassion regardless of racial or demographic harmony between providers and patients.

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

Behavioral health is impacted by many non-clinical factors, ranging from interpersonal and family relationships to socioeconomic circumstances to traumatic events, among others. It is critically important for people with behavioral health needs to be connected with non-clinical services and supports to address the root causes of poor mental health in order to enhance or maintain emotional wellbeing.

To effectively do this, health plans and providers have accelerated efforts to collect standardized data on people's socioeconomic needs. Health plans collect this data using their care managers and community health workers, as part of their Health Risk Assessments, when someone contacts the customer service line, and through other direct outreach methods such as surveys, among other methods. Providers collect this information either before the clinical visit through the patient portal or during the clinical visit such as in the waiting room or in conversation with a provider or non-clinical health worker.

In many cases, health plans offer their own programs and services that mitigate non-clinical needs identified by the health plan or their providers, ranging from grocery store debit cards to exercise classes to social connectedness programs that address isolation and loneliness, among many others.

Health plans also have also invested in community resource and referral platforms and share those platforms with their provider networks and community partners so that any entity can identify resources in the community that can mitigate non-clinical needs and are convenient for the individual to access and make referrals to those key services.

Challenges in connecting people to non-clinical services include:

- Gaps in standard codes related to socioeconomic risk factors: it is hard to share, aggregate, analyze, and report data that is not standardized.
- Limited infrastructure for electronic information sharing: it is important to have the appropriate infrastructure to share data across the relevant care team members—both clinical and non-clinical—so that data is not repeatedly collected from individuals and stored in multiple places—making it more vulnerable to security breaches. Interoperable data sharing

will help reduce the burden of data collection on both consumers and the health care industry.

- Lack of streamlined/interoperable community resource and referral platforms. Health plans, providers, and community-based organizations often have to use multiple platforms which can be burdensome for staff. These platforms should exchange electronic information to reduce burden and inform care and services.
- Lack of funding to address socioeconomic barriers. All stakeholders—from health plans to providers to community-based organizations (CBOs)—do not have adequate resources to sustain or scale efforts to address socioeconomic barriers. Policy recommendations include:
  - To help health plans, services they provide to address socioeconomic barriers should be included in capitated rates and should be a separate category of medical services in the numerator of the Medical Loss Ratio.
  - If health plans can receive reimbursement for services that address socioeconomic barriers, they have more capacity for value-based payment arrangements with providers which could include reimbursement for providers to screen their patients for socioeconomic barriers and refer them to services that address their needs. Health plans would also have more capacity to enter into value-based contracts or capitated arrangements with CBOs that could help to better manage and expand their capacity.
  - Invest in CBOs that provide non-clinical services as there is not enough supply to meet the growing demand. Federal investment in these critical resources would be very helpful.

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?

Health insurance providers recognize the importance of coverage for behavioral health to overall patient health, and the current public health emergency has further highlighted the importance of a robust behavioral health care system. Moreover, health insurance providers have worked diligently to implement MHPAEA's protections by engaging clinical and administrative personnel across medical, behavioral, and pharmacy departments to promote understanding and implementation of the parity rules.

Recently, Section 203 of the Consolidated Appropriations Act (CAA) granted the Department of Labor (DOL) authority to request comprehensive comparative analyses of plans' application of nonquantitative treatment limitations (NQTLs) to behavioral health and medical/surgical benefits. AHIP appreciates DOL's recent compliance assistance efforts, such as the Self-Compliance Tool updated in 2020 and FAQs Part 45, released by DOL and the Departments of Health and Human Services and Treasury as guidance for complying with the CAA provisions. However, the examples and details released to date do not meet

the depth or specificity of the analyses described in the CAA, which are comprehensive and contain multi-part analyses and documentation. The Self-Compliance Tool offers basic examples of compliant and noncompliant NQTLs, but more detail and more complex examples are needed. In order to comply with the requirements of the CAA, plans and issuers need DOL to develop and provide model or sample analyses that demonstrate compliance across the different types of NQTLs. These completed analyses should include samples of documentation and data that would support the analyses and the determination of compliance.

In addition to ensuring DOL provides plans with the information necessary to demonstrate compliance, Congress should not pursue additional legislation related to MHPAEA enforcement unless these issues are addressed by DOL.

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 behavioral health care system?

In the past several years, CMS has taken action to modify the Medicare Advantage (MA) network adequacy requirements to account for the value of network telehealth providers and to expand access to plans in areas where network contracting can be challenging. In the CY 2021 MA final rule, CMS finalized a10 percentage point credit towards meeting time and distance standards for certain specialty types, including psychiatry and primary care, when the plan contracts with telehealth providers for those specialties.

In the final MA rule, CMS also implemented a 10 percentage point credit for affected provider and facility types in states that have certificate of need (CON) laws, or other state imposed anticompetitive restrictions, that limit the number of providers or facilities in a county or state; and reduced the percentage of beneficiaries that must reside within the maximum time and distance standards in non-urban counties (Micro, Rural, and Counties with Extreme Access Considerations (CEAC) county type designations) from 90 percent to 85 percent.

AHIP supports these and other flexibilities for network adequacy standards that support use of telehealth, adapt to new health care delivery modalities, address workforce shortages, and reflect the changing health care landscape.

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?

Telehealth and other forms of virtual care can be valuable tools in helping to connect patients to care, especially during the pandemic when some patients may have concerns about being exposed to a sick person in a waiting room or other setting and in-person provider capacity needs to be most dedicated to patients who are seriously ill. Telehealth use spiked early in the pandemic – with exponentially higher use across age groups, geographies, races and ethnicities, and insurance coverage types. While telehealth use rates have decreased since the early months of the pandemic, it remains multitudes higher than pre-pandemic levels. Telehealth is an important long-term tool for both acute needs and for managing chronic conditions, and it has a valuable role in behavioral health care. More experience and evaluation are needed in order to better understand the quality and cost impacts of telehealth, however, given the evolving technologies and the still-changing environment since the pandemic.

Health insurance providers are optimistic about the future of virtual care and its integration into health care delivery. The pandemic created the opportunity for many new consumers and providers to use telehealth, with very high satisfaction for both groups. But challenges remain. Not all care can be delivered virtually. Telehealth is most valuable in instances where all necessary clinical information can be gathered via the remote setting to evaluate, diagnose, and treat a condition. To further define what services are or are not appropriate to deliver high-quality care remotely, we encourage Congress, federal agencies, health care providers and health insurers to continue collecting data on how telehealth is being used and when and where it is the best option for care. It will also be important to work toward interoperability between virtual and in-person providers to optimize coordination of patient care.

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

Though telehealth spiked across all communities during the pandemic, there is concern that some geographies or populations remain underserved by virtual care due to lack of access to affordable broadband or needed hardware such as phones, computers, or data plans or a limited understanding of how to access virtual care. While telehealth helps increase safe and convenient access to care, it can create or exacerbate disparities by leaving some in rural regions, vulnerable communities, or those of lower socioeconomic status behind.

To address these issues, we encourage Congress to consider the following actions, which can improve access to telehealth for all:

- Support provisions to increase access to broadband Internet services, through grants or other

funding actions.

- Permanently amend the Social Security Act, section 1834(m), which governs telehealth in Medicare, to allow for flexibility in benefit design across originating sites, eligible geographies, eligible services, and eligible providers.
- Make permanent the CONNECT for Health Act, which will further improve access to telehealth by promoting quality care and alternative payment models.
- Maintain the flexibility enacted in the CARES Act for commercial insurers to cover telehealth pre-deductible in high-deductible health plans.
- Fund programs that promote provider and patient education, especially in underserved areas, to improve digital health literacy.

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

The flexibilities in Medicare coverage of telehealth during the pandemic have enabled significant use of telehealth for the delivery of care – for behavioral health care and for other types of care. The pandemic provisions enacted by Congress and CMS enabled the explosive growth of telehealth, spiking thousands of percent of utilization. For many seniors, the pandemic was their first experience with virtual care, and the results have been encouraging, with patient satisfaction well above 80%. Behavioral health has been a particular area for growth, with many health plans citing the sustained use throughout the pandemic as evidence of the potential long-term viability of virtual behavioral health. Whereas many forms of virtual care receded after the initial spike (though remain significantly above pre-pandemic utilization), behavioral health saw little reduction in use – if any – throughout the pandemic. Virtual behavioral health is valuable in that it connects patients conveniently to clinicians, from the safety and comfort of their own homes, free from stigma or travel or scheduling challenges. Additionally, providers acknowledge increased insight they gain from seeing a patient in their own environment, such as if there are particularly stressful home situations, which may not be apparent from an in-office visit.

As mentioned previously, it is premature to draw significant conclusions about the long-term use trends, quality or cost impact of telehealth on total cost of care, as the pandemic still may be skewing some figures. However, by all accounts behavioral health may be one clinical area where sustained use and satisfaction among patients and providers remains high. CMS also recently released proposed rulemaking which will permanently expand access to tele-behavioral health services by eliminating geographic restrictions, making the home an originating site, and allowing Rural Health Clinics and Federally Qualified Health Centers (FQHCs) to deliver services virtually.

However, we encourage Congress and CMS to consider eliminating originating sites entirely to add flexibility to a person's access options. We encourage policymakers to reinstitute rules requiring telehealth platforms be HIPAA compliant to protect patient privacy. To ensure that

patients have access to behavioral health services via virtual tools and reduce access disparities for those who face barriers to in-person appointments, we encourage policymakers to consider providing additional flexibility regarding the post-tele-behavioral health subsequent in-person visits that are required every six-months as a condition of coverage in the CY 2022 Physician Fee Schedule proposed rule for people who do not suffer from serious mental illness. We support reforms that would provide insurance providers and other stakeholders the flexibility to innovate in the virtual care space, rather than be limited through overly restrictive legislation or regulation, such as mandating the same pay for in-person and virtual care or defining specific services or providers that must be delivered in-person or virtually, given the rapidly evolving technology landscape.

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?

Throughout the pandemic we have seen that audio-only telehealth can increase access to behavioral health care for individuals in need by allowing them to connect with clinicians from a safe, convenient location. Health insurance providers have found an increasing number of Americans rely on audio-only connections to overcome barriers to accessing technology, challenges with digital literacy, and unaffordable or lack of access to reliable broadband internet service. The so-called "digital divide" can limit access to necessary care for some people, where audio-only telehealth may be the only option for some seniors or vulnerable populations who may experience physical limitations or inequities due to socioeconomic status.

As telehealth is an evolving field, it is important that Medicare and insurance providers be able to gain insight into the use of audio-only services, such as which communities are utilizing them, and in which circumstances, in order to evaluate issues such as patient safety, quality, equity, utilization, effectiveness and efficiency of this modality. We recommend creating a new modifier for audio-only telehealth claims to allow Medicare and health insurance providers to differentiate claims for services that are furnished via audio-only technology from other telehealth services. Policymakers can use this data to inform policy decisions around coverage and payment parameters for audio-only services. Without a mechanism to identify services that are furnished via audio only technology, it is impossible to evaluate clinical outcomes, quality, and utilization trends.

We understand that the American Medical Association (AMA) Current Procedural Terminology® (CPT®) Editorial Panel is considering a request to create an audio-only telehealth modifier.[2] Accordingly, we urge Medicare to work with the CPT Editorial Panel to align and streamline reporting rules around use of an audio-only modifier. This effort should be pursued

[2]AMA, "Proposed Panel Agenda September 2021 CPT® Editorial Panel Meeting" (last updated Aug. 5, 2021); available at: https://www.ama-assn.org/system/files/cpt-panel-sept-2021-agenda.pdf (see tab 82).

expeditiously to allow for tracking and analyzing key data for audio-only services.

Furthermore, AHIP asks that Congress pass the bipartisan legislation, "Ensuring Parity in MA for Audio Only-Telehealth Act of 2021." This legislation would help ensure that seniors and individuals with disabilities continue to have access to high value care and important supplemental benefits provided by MA as well as reduce health disparities due to unequal access to health technology and audio/video telehealth platforms. The legislation would also ensure audio-only telehealth continues to be an effective source of health care for Medicare beneficiaries and support the providers caring for them throughout the course of the COVID-19 Public Health Emergency.

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?

Health insurance providers are supportive of the inclusion and expansion of virtual care in the Medicare program, especially for the delivery of behavioral health services where patient access to care can prove particularly challenging. Audio-only telehealth can be a valuable tool in connecting beneficiaries with care, especially for underserved communities. A recent CMS proposed rule included provisions to allow payment to eligible practitioners when they provide certain mental and behavioral health services to patients via audio-only telephone calls from their homes, when certain conditions are met.

We support the clinically appropriate inclusion of audio-only care in telehealth. However, we also acknowledge that there are instances where behavioral health care cannot be delivered appropriately via audio-only such as for patients who may be seriously mentally ill or being evaluated for suicidal ideation. Clinical leaders have indicated that body language can be an important element in evaluating a person's mental state, especially without a long-term relationship for reference. We support the use of audio-only telehealth as a mode for accessing behavioral health services where all necessary clinical information needed for an accurate and safe evaluation, diagnosis, and treatment can be acquired via audio-only services. There are instances where the benefits of some audio-only care far outweigh complications, such as maintenance SUD counseling during the pandemic, which proved invaluable for engaging people in recovery throughout the pandemic. Some audio-only therapy sessions, when in-person meetings are unavailable, can be helpful to patients without compromising quality of care.

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?

Prior to the pandemic, Medicare paid for telehealth services at the "facility rate" for office-based providers who are ordinarily paid at the "non-facility rate." Facilities are paid for professional services at the facility rate because they also receive a separate facility fee to account for clinical staff, supplies, and equipment. Thus, the facility rate for professional services ordinarily does not include practice expenses as a factor in the payment rate. In contrast, non-facility providers are paid a professional fee that includes practice expenses as a factor. This policy changed during the pandemic, when CMS began paying providers at the non-facility rate for telehealth services because they believe providers were incurring practice expenses, even when furnishing services virtually, due to the unique nature of the pandemic. Further, CMS anticipated there would be no facility fee associated with the professional service because patients would be at their home, rather than at a qualifying, clinical originating site of service (e.g., another physician's office, SNF, critical access hospital). While AHIP supports use of the higher payment rate during the public health emergency, we do not believe it is appropriate to pay providers at the non-facility rate once the public health emergency ends.

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?

Congress should make permanent flexibilities that expand access to telehealth services, especially for behavioral health. We support the provisions which expanded access to care in the SUPPORT Act and those that were specific to the COVID-19 pandemic. Telehealth can improve efficiency, expand access to care, enhance outcomes, and can create cost savings if barriers are appropriately addressed. We encourage Congress to pass legislation to redefine how traditional Medicare beneficiaries can access telehealth, including through the permanent elimination of originating sites (expanding upon the CMS proposed rule) and the strict definitions around services and providers eligible to deliver telehealth services. Congress should enact legislation that allows for flexibility and encourages innovation. Overly restrictive regulation prevents the continued evolution of technology in health care.

From a regulatory perspective, we encourage CMS to add eligible telehealth services and leave room for innovation, as mentioned. We support inclusion of remote services in Opioid Treatment Program bundles and for providers at FQHCs and RHCs to deliver behavioral health care

services. As telehealth services can be an important tool in connecting patients with care, we support actions to incorporate virtual care into alternative payment and delivery models of care.

However, as noted, there are instances where safeguards should be included in legislation or regulation regarding telehealth. Care and services must be appropriate to be delivered via the medium – audio-only or audio-video – whereby a provider must not sacrifice quality of care to use telehealth when an in-person visit is needed. Additionally, a patient's privacy and security of PHI must be protected for telehealth the same way as for in-person care; as such, HIPAA rules must be upheld and providers must work to ensure that patients access care in appropriate settings for the care they need. And though we do not believe telehealth is any more prone to fraud, waste, or abuse than other care settings, policymakers should create and fund investigations units to combat bad actors who may attempt to exploit newfound flexibilities in the space.

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

While it is too early to fully understand the impact of telehealth or to project how it will be used moving forward, the growth across certain specialties and within communities can inform policies that enable or restrict future use. However, using data from both before and throughout the pandemic, it does not appear that quality will suffer when telehealth is used to deliver appropriate care. When a provider is able to collect all necessary information to accurately and safely evaluate, diagnose, and treat a patient, telehealth quality can be comparable to in-person care. These same rules apply to audio-only delivery of services, though the pool of services that can be delivered appropriately is smaller when using telephonic telehealth.

Though cost effectiveness of telehealth services delivered during the pandemic has not been fully analyzed, trends in use can inform future policies. Telehealth can be an efficient, effective way to connect patients with needed care, without travel time or cost, the need for child care, or to expose a patient to other sick individuals in a waiting room, and to reduce burden on the health care system. As a result, telehealth has the potential to save money – for patients, providers, and from a systemic perspective – both by making care more convenient and safer for patients and by reducing the need for traditional brick-and-mortar structures that add to costs. While many providers will maintain physical office space and staff, the need for large waiting rooms or equipment is lessened with the telehealth. By eliminating some of these costs and ensuring that higher-acuity care settings are reserved for those in need, we can create a more efficient, cost-effective system that delivers the same high-quality care.

To support these changes in care delivery and financing, policymakers must create an environment for innovation, with flexibility for patients, providers, and insurance providers. Overly restrictive regulation limits the potential growth and innovation of virtual technologies –

20 years ago, some of the home-based audio-video services that are now commonplace would have been unthinkable. A doctor can accurately diagnose conditions today via telehealth that would have been perceived as impossible, even just a few years ago. We encourage policymakers to maintain flexibility regarding innovation in financing, such as through hybrid in-person/telehealth chronic disease management programs with global payments or bundles for the diagnosis, treatment, and management of a person's whole health.

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

Though telehealth spiked across all communities during the pandemic, there is concern that some geographies or populations remain underserved by virtual care. While telehealth helps increase safe access to care, it can create or exacerbate disparities by leaving some in rural regions, vulnerable communities, or those of lower socioeconomic status behind. Challenges include lack of access to the Internet, an inability to afford the technologies needed to access telehealth (e.g., phones, computers, data plans), and a limited understanding of how to access virtual care. Health insurance providers are working to address some of these challenges, such as by providing smartphones to Medicaid recipients and connecting members with programs that provide free access to Wi-Fi. Insurance providers have also built community centers, with free access to computers and Internet from which they can connect with a network provider. Insurance providers have also worked with employers to establish virtual "clinics" in workplaces, where an employee can to a secure space from which they can access telehealth care. They have also provided free or reduced cost visits via telehealth, saving a member co-pay cost while also making care more convenient. And plans have worked with seniors and other communities who are not as familiar with technology, assisting with preparation for a visit and how to best communicate with their providers via an audio or video connection.

All of these approaches have helped to close some of the gaps that may be exacerbated with virtual care, and these efforts appear to be paying off. Studies of utilization throughout the pandemic show significant growth in use of telehealth in minority communities, especially Hispanic communities, and across all ages, geographies, and income levels.

Improving Access for Children and Young People

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

The same strategies for addressing shortages of behavioral health providers in general can be targeted to promote recruitment of behavioral health providers specializing in children's behavioral health care. These strategies include:

- Increasing funding for loan repayment programs for providers who enter the behavioral

health field and specialize in children's behavioral health care;
- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include behavioral health care professions, including those that specialize in children's behavioral health care;
- Increasing the number of GME slots allotted to behavioral health providers, including those that specialize in children's behavioral health care; and
- Supporting telehealth and hub-and-spoke models (e.g., Project ECHO) to maximize child behavioral health resources.

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

These professionals can play a significant role in improving children's behavioral health, just as they can in improving adult's behavioral health. Providing flexibility to ensure a range of behavioral health provider types, such as certified peer support specialists, licensed professional counselors, and licensed mental health counselors, are able to participate as part of behavioral health care teams, is essential. Only be providing this flexibility can health insurance providers work to best serve the needs of their members via network development and benefit design.