Ascension

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

November 15, 2021

Submitted via Email: mentalhealthcare@finance.senate.gov

Re: Request for Information on Evidence-based Solutions and Ideas to Enhance Behavioral Health Care

Dear Chairman Wyden and Ranking Member Crapo,

Ascension appreciates the opportunity to respond to the Senate Finance Committee's request for information on evidence-based solutions and ideas to enhance behavioral health care.[1]

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As one of the leading non-profit and Catholic health systems in the U.S., Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2021, Ascension provided $2.3 billion in care of persons living in poverty and other community benefit programs. Ascension includes more than 150,000 associates and 40,000 aligned providers. The national health system operates more than 2,600 sites of care – including 142 hospitals and more than 40 senior living facilities – in 19 states and the District of Columbia, while providing a variety of services including clinical and network services, venture capital investing, investment management, biomedical engineering, facilities management, risk management, and contracting through Ascension's own group purchasing organization.

[1] https://www.finance.senate.gov/imo/media/doc/092221%20Bipart%20mental%20health%20RFI.pdf

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Care for those in Need of Behavioral Health is Anchored in Mission

Ascension's mission includes a call for spiritually centered, holistic care, with special attention to the vulnerable. Those suffering with substance use disorders and behavioral health impairments are some of the most vulnerable persons in our nation, and they are in need of coordinated policies that allow them to access holistic, compassionate care that will enable them to live productive lives with dignity and integrity. In 2018, Pope Francis called for compassionate care and increased coordination of policies for those suffering from addiction:

> The Church, together with local, national and international institutions, and various educational agencies, is concretely engaged in every part of the world in combating the spread of addictions, devoting her resources to prevention, care, rehabilitation and reinsertion, in order to restore dignity to those who have lost it. Fighting addictions calls for a combined effort on the part of various local groups and agencies in enacting social programmes promoting health care, family support and especially education. In this regard, I readily support the desire expressed by this Conference for a better coordination of policies aimed at halting the growth of drug abuse and addictions — isolated policies are of no use: it is a human problem, it is a social problem, everything must be interconnected — through the creation of networks of solidarity and closeness to those suffering from these pathologies.
>
> *ADDRESS OF HIS HOLINESS POPE FRANCIS TO PARTICIPANTS IN THE INTERNATIONAL CONFERENCE ON* "DRUGS AND ADDICTIONS: AN OBSTACLE TO INTEGRAL HUMAN DEVELOPMENT," *Saturday, 1 December 2018*

Because serving vulnerable persons is at the core of Ascension's mission and a priority of our faith, we want to work with this Committee and Congress to improve policies serving this important population.

We appreciate the opportunity to provide comments to the Committee as it works to develop legislation to address barriers to mental health care. In many parts of the country, patients do not have access to mental and behavioral health care, and we are committed to being a part of the solution. The issues that the Committee has raised are central to identifying and addressing obstacles that deny too many Americans access to quality care in the areas of mental and behavioral health.

Strengthening Workforce

A well-trained workforce is essential to meeting the mental and behavioral health needs of our country. Today, far too many Americans cannot access these critical services because there are not enough mental health professionals available to meet the need. Below, we address the Committee's questions about how policymakers can strengthen this workforce and ensure it is equipped to meet the demands of a changing and diversifying country.

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

Congress should consider ensuring that more behavioral health services are reimbursed by CMS. Currently, only licensed psychologists and social workers are able to bill Medicare for behavioral health services. CMS does not reimburse other providers with similar education, training, and practice rights such as licensed marriage and family therapists (LMFTs) and licensed professional counselors (LPCs). Each state Medicaid authority also independently determines which disciplines will be reimbursed. Even providers that are reimbursed by Medicare and Medicaid for these services are often reimbursed at rates significantly lower than general market rates and as recognized by commercial plans. These limits create a significant barrier to provider participation. Effective mental health care requires a collaborative team-based approach and service coordination across different types of providers. This is extremely difficult when certain providers are either reimbursed at very low rates or not reimbursed at all.

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

There are many factors related to physician and non-physician workforce that impact patient access. In many areas, there simply may not be enough providers available to provide services to the population, especially in rural areas. Navigating care can also be very difficult. Patients often do not know whether they should see a psychiatrist, a therapist, or a different mental health professional, or where to find one even if they have a sense of which one to request. Patients often discuss their need with a primary care physician who may authorize a referral, but it may still be difficult to find a local provider who accepts the patient's insurance, especially if the patient is covered by Medicaid. The use of telehealth has improved access for patients but there are still

barriers patients and providers face. Often quality internet speeds are not available in remote locations or individuals are unable to afford this service.

In addition, research on social determinants of health shows that patients often prefer to receive care from providers with similar lived experiences, especially with regard to race. A more diverse workforce is critical to addressing these preferences and concerns.

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

One way Congress could improve diversity in the behavioral health workforce is to reduce barriers to education and training. Specifically, Congress should develop and strengthen loan forgiveness programs for mental health care providers, particularly in areas of the greatest shortage, such as child and adolescent psychiatry and psychotherapy services. Loan forgiveness or other reimbursement programs should be simple and easy to apply for and understand.

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

Many health care professionals prefer to live in populated areas, and financial incentives are needed in order to encourage them to live in rural or underserved areas. Programs that forgive student loans or otherwise reimburse mental health professionals who train or practice in rural areas for the cost of education and training would help incentivize providers to train or practice in rural areas.

Another challenge for providers in rural areas is lack of access to integrated, advanced care. Congress should work to ensure that there are clear linkages with integrated health systems that can assist providers in rural and underserved areas and prevent them from feeling like they are practicing in a silo. Clear care escalation pathways are needed for higher levels of behavioral health care. Congress should ensure robust funding through HRSA for programs like Rural Hospital Flexibility Grants, which help small and critical access rural hospitals remain economically viable and to provide high-quality care; the Rural Provider Modernization Technical Assistance, which provides technical assistance to hospitals and other health care providers to implement sustainable models of care that address social determinants of health and health equity; and the Rural Emergency Hospital Technical Assistance Program, which provides

technical assistance to facilities to implement the new Rural Emergency Hospital model.

Congress should also consider making the Teaching Health Center Graduate Medical Education Program permanent. The program, administered by HRSA, supports the training of 769 residents in 60 primary care residency programs, across 25 states. This program is a critical workforce pipeline that not only trains health care providers but also brings those providers to communities of color, Tribal communities, rural communities, and so many other underserved areas. This program however, is not permanent and requires Congressional reauthorization, creating uncertainty that may pose an impediment to health systems contemplating creating new behavioral health primary training programs. H.R. 3671 proposes to establish more permanence in the reauthorization of this vital program and will provide incentives to health systems to consider the creation of new behavioral health training programs.

Finally, rural communities generally need resources to be vibrant and sustainable places to live, work, play, and raise a family. We recognize that this is a complicated issue that will not be easily addressed. Within these communities, health care professionals need adequate resources to provide care. Rural and underserved communities need to attract individuals and families with resources often not directly available to health care. For example, any action Congress takes to strengthen rural and underserved communities by improving access to quality education will make it more likely that health care professionals will be drawn to relocating to these communities and to raise their children there.

> *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 healthcare system?*

The lack of an interoperable electronic health record that can be easily shared between providers and the misalignments of privacy requirements related to behavioral health records and other health records have been a major barrier to coordination of care. Current practices make it very difficult for providers to share information, which has the unintended consequence of perpetuating the stigma surrounding behavioral health. We believe that privacy standards for behavioral health should be aligned with those for physical health. Congress took a positive step by including legislation in the CARES Act that would align CFR 42 Part 2 with HIPAA for the purposes of treatment, payment, and operations. We urge Congress to work with HHS and SAMHSA to ensure that provisions

mandated by the CARES Act align effectively with HIPAA, in accordance with congressional intent.

In addition, some federal policies can unintentionally result in suboptimal quality of care for certain behavioral health patients. For example, while EMTALA requires that behavioral health patients presenting to the Emergency Department receive a medical screening exam and stabilizing treatment or transfer, not all emergency departments are equipped to provide the stabilizing treatment and subsequent specialty care needed for this vulnerable population. As a result, patients can "hold" in emergency departments for multiple days awaiting transfer to an appropriate site of care for behavioral health emergencies. Increased boarding time can also lead to increased safety risk for the patient, other patients in the vicinity, and staff members. This situation can negatively impact quality of care for cases in which the emergency department is not the right place of care for behavioral health.

Another example is Medicare's 190-day lifetime limit, which is a well-intentioned policy intended to prevent institutionalization, but it also leaves some of the most vulnerable mental and behavioral health patients without coverage after they have exceeded this limit.

> *What characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health?*

Congress should pursue policies that reduce barriers for young people interested in pursuing careers in mental and behavioral health. Loan forgiveness or other forms of reimbursement are critical in enabling individuals who are passionate about mental and behavioral health to translate their passion into a career.

Retention of this workforce is also very important. Especially for providers who work with high acuity patients, burnout and stress can discourage mental health care providers from remaining in the field. Congress should pursue policies that help ensure that these professionals have adequate paid leave to mitigate burnout. Congress should pass legislation like the Dr. Lorna Breen Health Care Provider Protection Act (S.610/H.R. 1667) which would direct resources to reduce and prevent suicide, burnout and behavioral health disorders among health care professionals. The legislation would authorize grants to health care providers to establish programs that offer behavioral health services for front-line workers; it would require the Department of Health and Human Services to study and develop recommendations on strategies to address provider burnout and facilitate resiliency; and it would direct the Centers for Disease

Control and Prevention to launch a campaign encouraging health care workers to seek assistance when needed.

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

In addition to differing Medicaid reimbursement rules, inconsistent scope of practice rules across states are a significant barrier to care. Congress can help by setting up a system that increases the services that LPCs, LMFTs, psychiatric nurse practitioners, and social workers can provide, and standardizing these rules across states. Federal programs should also reimburse community health workers for more services and consider reimbursing for peer support services.

Current practice standards should also be modified to allow all qualified providers to provide health education. The current standard of requiring a minimum of a master's level degree to offer health education to patients is too restrictive and should be modified to allow other providers with appropriate training and supervision to provide this service. This would increase the ability to address potentially problematic health concerns before they become a chronic health condition.

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

Burnout is often a response to prolonged chronic job stressors compounded by feelings of being ineffective. Congress should help by reducing the administrative burden on providers. While federal regulation is largely intended to ensure that health care patients receive safe, high-quality care, it often forces clinical staff to devote more time to regulatory compliance, detracting from patient care. Reducing administrative burden will enable health care workers to focus on patients, not paperwork, and reinvest resources in improving care, improving health and reducing costs. For example, Congress should support efforts to eliminate duplicative and unnecessary quality reporting requirements and to simplify the CMS survey and certification process. Congress should also pass the Dr. Lorna Breen Health Care Provider Protection Act, discussed above, to support health care workers' mental health.

Increasing Integration, Coordination, and Access to Care

We believe that mental and behavioral health care should not occur in silos, but rather that it should be integrated as seamlessly as possible into patients' health care. Below, we address the Committee's questions about how Congress can encourage integrated and coordinated care that best serves patients' needs.

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

We believe that a collaborative, team-based approach to behavioral and mental health care best serves patients. Congress should create funding opportunities for more integrated behavioral health care in which mental health clinicians are embedded in a primary care practice. To that end, Congress should improve Medicare coverage of team-based behavioral and mental health care by adding coverage for preventive psychosocial treatment by those qualified providers who may not be a social worker or psychologist. Congress should also eliminate the prohibition on billing for a psychologist and a psychiatrist on the same day as these are two separate and distinct services.

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

Advances in virtual care over the past several years have the potential to significantly increase access to mental and behavioral health services. Congress should pursue policies that reduce out-of-pocket costs for virtual mental health, limit regulatory barriers that prevent providers from offering these services, including in-person visit requirements, and educate both patients and providers about the promise of these services. Reimbursement practices should be modified to allow for a variety of modes to provide care such as in-person, telephonically, virtual, text-based services.

Federal programs should also reimburse for care coordination and peer support services that help patients navigate behavioral and mental health services available to them and for nontraditional providers such as social workers placed in police departments or paramedicine programs.

Congress should support policies that enhance community-based services, especially for vulnerable populations such as individuals with intellectual and developmental disabilities, autism, and chronic psychiatric conditions.

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

Patients' health information should transition with them as they move from one care provider to another. It should be readily available to a patient's care team. All patients, and especially behavioral health patients, should not be expected to understand what information is important or necessary to each provider or how to effectively navigate our complex system. All patients deserve a system that provides health care coordination and communicates on their behalf. The technology used should keep the information protected and secure, but make it accessible to those involved in providing care. To this end, Congress should examine policies that promote interoperability between electronic health records (EHRs) and standardize and simplify rules about how behavioral health information can be shared among providers. The patchwork of state laws and regulations on patient confidentiality are very difficult for health care providers to navigate in a world where patients increasingly seek care across state lines. Congress should work to align rules with HIPAA privacy and security rules. Congress should also extend incentives for demonstrating meaningful use of EHRs to behavioral health care providers.

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

Congress should study policies that would reduce the stigma associated with receiving mental and behavioral health treatment. Policies that integrate behavioral health into primary care will reduce stigma, lower costs, and improve quality of care. A public relations campaign spearheaded by the SAMHSA, featuring well-known, respected people in recovery, who identify substance use disorders and mental health conditions as health care disorders similar to physical healthcare conditions would also help in de-stigmatizing these behavioral and mental health disorders.

Access to broadband is also critical for reaching rural and underserved communities. As virtual care services continue to expand, Congress should work to make sure all Americans have access to the tools needed to take advantage of these services.

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

Congress should pursue policies that expand mobile crisis services, which can prevent visits to emergency departments and connect patients to the appropriate level of care with in-home crisis respite.

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

Digital self-service tools that connect patients with support services will continue to grow over the next several years. Congress can encourage this growth and expand access by improving access to broadband, clarifying information sharing between providers, and allowing reimbursement for peer support services.

Ensuring Parity

Mental and behavioral health are a critical part of a patient's overall health. For a long time, the stigma associated with mental health meant that these issues were treated differently by the health care system. While that is beginning to change, much more is needed to ensure mental health is treated the same as physical health. Below, we address the Committee's question on how Congress can promote mental health 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?*

Congress should ensure that prohibitions on lifetime limits on coverage already in law are enforced. Congress should also support a reporting system that is monitored and can allow the appropriate agencies to take quick action to hold insurance companies accountable when they do not comply with the law.

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

Congress should encourage the development of standard medical criteria for level of care and treatment for mental and behavioral health, and should enforce the rules with meaningful penalties for insurance companies that do not follow medical necessity guidelines established by the medical community.

Congress should also work to eliminate "mental health carve-outs" that restrict access to certain levels of care, such as Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), and Residential Treatment Centers (RTC). Congress should promote uniformity in the type of services covered through a process that is guided by clinical input.

> *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?*

Congress should address the national shortage of behavioral health providers, in particular in pediatrics. There are large rural and urban portions of the country that do not have a single child psychiatrist or pediatric psychologist. This shortage of behavioral health providers illustrates the importance of virtual care services for providing mental health care in an equitable manner. Access to virtual services can be a lifeline to a vulnerable patient suffering from a substance use or mental health disorder. It can literally mean the difference between life and death.

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

Policymakers should require health plans to simplify the process by which mental health providers are credentialed. Credentialing a mental health provider with an insurance company can take several months, which delays care or results in incorrect bills being sent to patients. An incorrect bill for a behavioral health or mental health disorder may have a serious chilling effect on the patient, which in turn may negatively impact the chances for recovery.

Expanding Telehealth

Over the past two years, in part as a result of the COVID-19 pandemic, we have seen years of care delivery advancements take place to meet the clinical, safety, and access needs of our patients. Policymakers helped this process by offering providers the flexibility needed to employ telehealth technologies to serve patients. Below, we address the Committee's questions about how policymakers can protect and expand these gains while ensuring patient safety and equity, and we also support comments submitted by the American Telemedicine Association, the Alliance for Connected Care, and the Partnership to Advance Virtual Care on this important issue.

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?

We believe that telehealth increases access and improves quality of care. The availability of telehealth services allow patients to see care providers without the cost of transportation and missed time at work. This is especially true for behavioral and mental health disorders. Because of the stigma attached to these disorders, virtual care is a critically important gateway to future care. Often, a patient with these disorders is far more likely to investigate the potential for care if the first visit is virtual, providing the patient with the distance needed for an individual suffering the unfair effects of stigma to determine the potential efficacy of a treatment plan. Our data shows that the rate at which patients miss appointments is much lower for telehealth visits than for in-person visits. Telehealth also allows patients to see providers more quickly, which improves quality of care. Telehealth has grown dramatically over the past several years, and more research is needed to determine its impact with precision. With that being said, we are confident that telehealth is and will continue to increase patient access and improve quality of care.

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

Now that Congress has taken important steps forward to improve access to - and affordability of - broadband internet in passage of the Infrastructure Investment and Jobs Act, it is important for Congress to continue to oversee the investment of funds to expand access to broadband internet to ensure that this effort succeeds in addressing the shortcomings in our broadband internet infrastructure. Technological progress in virtual care has grown enormously over the past several years, and access to the internet is essential to ensure households in underserved and rural communities can benefit from these services.

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

Flexibilities implemented during the COVID-19 public health emergency expanded the scope of Medicare coverage of telehealth, such as waivers of originating site and distant site rules, and improved providers' ability to serve patients and families throughout their communities. With respect to behavioral health, during the COVID-19 public health emergency, authorized providers have been able to prescribe controlled

substances via telehealth, without the need for an in-person medical evaluation. This flexibility should continue after the public health emergency ends. While well intentioned, Congress should eliminate the requirement for in-person visits to access behavioral health services over telehealth. This requirement places a barrier to accessing these services that has the greatest impact on beneficiaries who face transportation barriers to access these needed services. Congress should make every effort to avoid placing barriers to accessing care and defer to the judgement of health care professionals when an in-person visit is appropriate or necessary to deliver needed services.

Moving forward, Congress should also work to improve flexibility in licensing requirements and encourage interstate compacts that allow services to be provided across state lines.

> *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?*

Audio-only services are critical for certain populations, such as seniors and people in rural and underserved communities that lack access to broadband. For the reasons cited above, they also may be critical for stigmatized behavioral and mental health patients who may benefit from this form of access to become comfortable with a particular provider and understand the potential of future treatment. In certain contexts, audio-only care may not be adequate, which highlights the need for improved access to broadband. However, at least until broadband is more widely available, audio-only telehealth services should be covered at the same rate as audiovisual services so that patients can access these services. In order to ensure patient access to mental and behavioral telehealth services, federal programs should cover these services with little or no patient cost sharing.

> *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?*

For many patients suffering from physical, behavioral, and mental health disorders, the ideal initial consultation should have a visual component, in particular with pediatric

consultations to allow for a more comprehensive evaluation. However, as stated above, there will be instances where the ideal initial visit should be audio-only to allow the stigmatized individual the access most beneficial for his or her care plan. Follow-ups may often be better suited for audio-only when they are needed. Recognizing that in certain cases patients do not have access to audiovisual care, there should be sufficient flexibility to allow audio-only care when no other options are available.

> *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 these services?*

Most beneficiaries accessing telehealth services are doing so to obtain care from their established physician or healthcare provider. This promotes continuity of care and better coordination of services. Regardless of whether these practices are providing care in-person or through virtual care services to their patients the clinic still requires administrative and billing staff, clinical support from nurses, aides and other professionals and the cost of a bricks and mortar location. Medicare should provide reimbursement for these services based on an accurate assessment of the value of a health professional's time and the practice expense of delivering these services, just as is done with other covered services. To that end, Medicare should calculate an appropriate practice expense value based on accurate and current data on the cost of delivering these services using the methodology used for in-person forms of Medicare payment for these services. We believe the data will show that the practice expense for care offered through telehealth will be the same or similar to the current practice expense value.

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

As Congress considers ways to improve provider practice standards, policymakers should consider ways to establish standardized licensure requirements at the federal level for asynchronous provider-to-provider consultations that do not involve the patient. At a time when access to behavioral care is scarce, we should do everything we can to allow psychiatrists to provide support to primary care physicians and other specialties across state lines without requiring a license in that state. Congress should also examine current workforce or access gaps, consider ways to facilitate coverage through

telehealth, and assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.

Consistent with recommendations offered above, Congress should also repeal the in-person requirement for Medicare coverage of telehealth treatments for certain mental and behavioral health conditions enacted in the Consolidated Appropriations Act, 2021 (CAA). The CAA took the positive step of allowing Medicare beneficiaries to access telehealth treatment for a broader range of mental health conditions from a wider variety of qualifying locations, including the beneficiary's home. However, the CAA also required that a patient have an in-person visit with a provider no more than six months before telehealth treatment. While well-intentioned, our view is that this requirement will have negative unintended consequences. It will force some providers who do not have physical locations to end patient relationships or even not to enroll in Medicare at all. It will also unnecessarily increase volume by forcing patients to visit their providers when there is no clinical need in order to continue receiving telehealth treatment. Legislation such as the Telemental Health Care Access Act (H.R. 4058/S. 2061) would remove this requirement.

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

If not implemented and resourced carefully, technology can be a primary barrier for many patients, especially the poor and vulnerable. Many patients lack access to broadband, access to devices with which to conduct telehealth visits, or knowledge about how to use the technology. Congress should pursue policies that mitigate these barriers. The investments in broadband included in the Infrastructure, Investment, and Jobs Act are a positive first step, and Congress should continue to work to ensure that all Americans have access to affordable broadband internet service capable of supporting two-way video.

Improving Access for Children and Young People

The devastating impact of the COVID-19 pandemic on children has highlighted the importance of a health care system able to meet children's mental and behavioral health needs. Below, we address the Committee's questions about how Congress can improve access for children and adolescents.

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

Congress should consider proposals like those in the Strengthening Kids' Mental Health Now proposal developed by children's hospitals.[2] These proposals would address the vital needs of children and pediatric providers by:

- Increasing investments to support the recruitment, training, mentorship, retention and professional development of a diverse clinical and non-clinical pediatric workforce.
- Ensuring payment models and reimbursement support clinical and non-clinical pediatric mental health providers and workers and eliminate implementation barriers hindering coordinated and integrated care.
- Improving access to mental health services, including strengthening network adequacy, expanding access to telehealth services and ensuring consistent application of Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) requirements.
- Addressing existing inequities within the pediatric mental health care system that contribute to mental health disparities in racial and ethnic minority populations and underserved communities.

Congress should also fund, implement, and expand programs that improve access to child and adolescent mental health services. For example, in Texas, the Texas Child Psychiatric Access Network (CPAN) and the Texas Child Health Access Through Telemedicine (TCHATT) can serve as models. CPAN is a network of access centers that provides educational training and free child and adolescent behavioral health consultation services for pediatricians and primary care providers. This network has greatly enhanced the mental health care provided to children and adolescents by primary care providers. TCHATT provides telepsychology and telepsychiatry services to children and adolescents in Texas schools.

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

These types of professionals are essential to improving pediatric behavioral health. They provide a greater sense of community and family support, which has been shown to be very beneficial for individuals and families struggling with mental illness.

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[2] https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Mental-Health/2021/strengthening_kids_mental_health_now_proposal_summary_070121.pdf

Are there different considerations for care integration for children's health needs compared to adults' health needs? 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? What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?

Wherever possible, children's mental health needs should be integrated with their primary caretakers, primary care providers, and schools. The increasing prevalence of mental illness among children, early age of onset, and emerging evidence about the importance of effective preventive interventions make a strong case for early identification and intervention. One in six children in the U.S. aged 2–8 years (17.4%) has a mental, behavioral, or developmental disorder, and up to half of all lifetime cases of mental illness begin by age fourteen.

Pediatricians are well positioned to detect problems in a child's social and emotional development due to their consistent and regular presence in a child's life. The undersupply of mental health professionals trained to treat children, coupled with inadequate financing, means that pediatricians are increasingly relied upon not only to detect problems but also to provide the full spectrum of mental health services without the tools and resources to do so effectively. Integrating mental health in pediatric primary care, which includes empowering primary care providers to diagnose and treat children's mental health as well as embedding and co-locating mental health providers in primary care clinics will increase the identification and intervention of children with mental health issues. In addition, including caretakers and a child's school in the care plan will provide holistic and wrap-around care for that child throughout the continuum of care. Mental health care should be seen as equal to physical health care. Creating integrated services that include primary medical care and access to social work, psychology, and psychiatry in those systems of care would be most helpful to ensure that physical and mental health needs of these vulnerable individuals are met. Where necessary, Congress should update the amount, scope, and duration of covered services in Medicaid to enable this integrated care to occur and provide the necessary resources to states to foster their implementation.

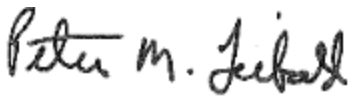
Successful expansion of telehealth will be dependent upon expansion of workforce, incentives, and reimbursement to make mental health an attractive vocation outside of the private practice model. While telehealth has increased access for children, there is an inadequate number of mental health professionals to meet the need. Payment parity

and incentives to encourage mental health care for children who rely on Medicaid and CHIP should be a priority.

Conclusion

We appreciate your consideration of these recommendations. If you have any questions, or if there is any additional information we can provide, please contact Mark Hayes, Senior Vice President for Policy and Advocacy, at mark.hayes@ascension.org.

Regards,



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