CommonSpirit

Submitted via email to mentalhealthcare@finance.senate.gov

November 2, 2021

The Honorable Ron Wyden
Chairman

The Honorable Mike Crapo
Ranking Member

U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Dear Chairman Wyden and Ranking Member Crapo,

CommonSpirit Health ("CommonSpirit") is pleased to provide a response to the Senate Finance Committee's request for information (RFI) on legislative proposals that will improve access to health care services for Americans with mental health and/or substance use disorders (SUD). As one of the nation's largest nonprofit health systems, CommonSpirit has a mission to serve those who are vulnerable or medically disenfranchised, including individuals with mental health or SUD. Our system has more than 570 dedicated mental health/SUD beds across our footprint and employs over 200 licensed providers of mental health services. We serve patients across our 21-state footprint, including in our 140 hospitals, numerous outpatient clinics, home health agencies, long-term care facilities, and other care settings along the continuum of care.

We have evolved as a society and now understand that mental health is equivalent to physical health, that substance use disorder is a disease rather than a vice, and that whole-person health care includes both the body and the mind. We know that a person cannot separate their mental and physical health, and neither should the American health system. As an organization, CommonSpirit has partnered with mental health experts to develop innovative models to reach individuals where they receive most of their care--the primary care provider. To bridge long-standing gaps between mental and physical health

care, we have turned to evidence-based models that integrate these areas of care and provide positive outcomes. Seeking behavioral health care in the community can be challenging due to stigma, lack of access, and prohibitive costs, especially for people who are socially vulnerable or medically underserved. We offer the following recommendations to the Committee based on the learnings and best practices of our organization, as well as the road bumps we have encountered along the way that could be smoothed by policy change.

The Senate Finance Committee seeks comments on legislative proposals in five broad categories. Our main recommendations include:

1. Strengthening workforce: Congress should increase the number of mental health professionals by funding critically needed programs that support education and mentorship in mental health and substance abuse care.
2. Increasing integration, coordination, and access to care: Congress should improve integration and coordination of mental health/SUD services by revising HIPAA statutes to allow for better sharing of information between physical and mental health/SUD providers, and by providing funding for more dually trained physicians (physical and mental health) and other clinicians. Congress should further improve access to care through enforcement of network adequacy requirements.
3. Addressing chronic underfunding and ensuring payment parity: Our nation's behavioral health system has been and continues to be chronically underfunded across the continuum of care. Congress should take action to address the funding gaps in reimbursement, end disparate Medicare and Medicaid policies that single out mental health treatments for special restrictions, and create enforcement mechanisms, robust audits, and penalties for health plans that are not compliant with parity laws.
4. Expanding telehealth: Congress should continue to provide access to important behavioral and mental health services through the use of telehealth by making permanent certain COVID-19 waivers that expanded use of tele-psychiatry and appropriately reimburse telehealth services equivalently to in-person visits.
5. Improving access for children and young people: Congress should fund and incentivize more school-based mental health and SUD services to reach children and adolescents in communities across the nation.

Moreover, there should exist no place where a person's mental health is treated any differently than their physical health. There should exist no place where a person's access to psychiatric treatment is different than their access to physical specialty treatment. And there should exist no place where a

mental health provider is reimbursed less or subject to different requirements than a physical health provider. Congress should consider these principles in all health care-related legislation.

Our detailed comments follow.

Strengthening Workforce

CommonSpirit Health and indeed most health care systems across the country are experiencing significant workforce shortages across the board. One of the most acute specialty shortages is in mental health and SUD. More than 112 million Americans live in areas of the country where mental health/SUD providers are in short supply.[1] Mental health/SUD providers are underrepresented in rural areas, metropolitan areas, low-income areas, particular regions of the country, and, of course, in designated health care professional shortage areas (HPSAs). For patients needing care, the wait to meet with a psychiatrist can be months. And for patients in need of sub-specialty care, for example a parent looking for a child psychiatrist or a young adult in need of eating disorder treatment, the search can be exhausting.

While there is a lack of available providers nationwide, CommonSpirit believes **Congress can use its appropriations power to ensure long-term, stable funding for innovative projects that will increase the number of providers in mental health and SUD services.** For example, Congress should explore, create, and fund projects that provide:

- Dedicated funding for advanced degree programs in mental health and SUD services.
- Peer training programs to help mental health/SUD providers acclimate to their new profession or seek peer assistance when needed.
- Graduate Nurse Education programs modeled after the Graduate Medical Education (GME) programs to increase the overall number of mental health providers.
- Loan repayment for individuals in high-need specialties, like mental health, in addition to high-need localities.
- Incentivizing education programs that promote diversity and inclusion to ensure patients can find a culturally appropriate mental health provider when they need one.
- Promoting collaborative care models via the CMS Innovation Center that reduce the "revolving door" for patients seeking care. Some providers grow frustrated by seeing the same patients over and over, often because the patient cannot get the care they need at the time they need it

[1] Henry J. Kaiser Family Foundation, State Health Facts: Mental Health Care Professional Shortage Areas (HPSAs), Timeframe: as of Sept. 30, 2019, n.d.

and must delay seeing a professional until their condition has worsened, and/or the patient cannot afford the necessary treatments.
- Require increased mental health and SUD training for all graduate medical/nursing education programs.
- Funding for dual-track education programs for primary and mental health care providers.

Strengthening the workforce extends beyond simple numbers, though. Doctors and advanced practice providers who are choosing their specialty and subspecialty are often disincentivized to go into mental health or SUD treatment in large part due to reimbursement disparities and administrative burdens associated with mental health care. For example, Medicare does not reimburse for services provided by licensed professional counselors (LPCs). This untapped group of over 140,000 professionals could improve access to care for lower-acuity mental health concerns in the Medicare population. Similarly, to be reimbursed in outpatient rehabilitation facilities, partial hospitalization programs, and other treatment settings outside a provider office, Medicare requires that clinical psychologists be supervised by a psychiatrist. This unnecessary supervision requirement creates a potential barrier to care delivery in regions with psychiatrist shortages. **Congress should pass legislation to reimburse Licensed Professional Counselors for their services through Medicare and reduce supervision requirements for clinical psychologists.**

Increasing Integration, Coordination, and Access to Care

Access to Care

Ensuring a sufficient number of mental health and SUD providers in every community is difficult, as discussed above. But, even when providers are available, access to their services is often limited to those who can afford it. Overall, psychiatrists are less likely to accept any type of insurance, including Medicare, than other specialties.[2] Indeed, psychiatrists account for the largest share (42%) of all non-pediatric physicians who opted out of Medicare in 2020.[3]

But, there are federal policy levers that Congress can use to improve access to mental health and SUD professionals across the nation. The first lever is reimbursement reform. While we recognize that commercial insurance reimburses for general medical services at a higher rate than Medicare (which

[2] Tara F. Bishop et al., "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care," JAMA Psychiatry 71, no. 2 (Feb. 2014): 176–81.
[3] Nancy Ochieng et al., "How Many Physicians Have Opted-Out of the Medicare Program?," Kaiser Family Foundation, Oct. 22, 2020. At https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/.

incentivizes providers to take on a greater share of commercially insured patients) the picture is more complex for mental health services. While traditional Medicare's payment rates for mental health services are higher than in-network rates for Medicare Advantage or commercial insurance, commercial insurers' out-of-network service rates are higher than Medicare Advantage plan rates.[4] **To alleviate access challenges for Medicare patients, Congress should instruct the Centers for Medicare and Medicaid Services to reimburse mental health providers at a rate that incentivizes them to participate in Medicare and see Medicare patients.** Congress could also encourage Medicaid programs to follow the same strategy.

Similarly, Congress should enact legislation to cover psychiatric rehabilitation, peer support services, and assertive community treatment, which currently are not reimbursed. (Paradoxically, many of these treatments are covered for individuals dually eligible for both Medicare and Medicaid, but not for Medicare enrollees alone.) One pathway to improve access for these types of services for the Medicare population is through Medicare Advantage Special Needs Plans (MA SNPs). There are very few MA SNPs that serve beneficiaries with serious mental illness. We encourage Congress to work with CMS to improve availability of MA SNPs for serious mental illness.

Further, **we encourage Congress to investigate pathways to enforce existing network adequacy requirements within Medicare Advantage plans and to work with states to enforce network adequacy in state-regulated health plans**. If Congress incentivizes CMS to track and reduce network inadequacy for mental health/SUD providers, private insurers and others will follow suit.

Improving Integration and Coordination

We know that coordination of mental and physical health care is critical to ensuring the wellbeing of the whole person. Yet, laws created in another era, when mental health care was seen as supplementary rather than integral, continue to prevent the full integration of mental health information into a person's total health record. The lack of integration is even more dire for substance use disorder treatment. A study in the New England Journal of Medicine found that electronic health record adoption is much lower in psychiatric care and among psychiatric providers.[5] These providers then lack access to patient health information, assistance with drug interactions, and other clinical decision support tools. The report identified three main barriers to EHR adoption: complex privacy laws and regulations, inadequate

[4] Daria Pelech and Tamara Hayford, "Medicare Advantage and Commercial Prices for Mental Health Services," Health Affairs 38, no. 2 (Feb. 2019): 262–67.
[5] Alisa B. Busch, et. al, "Improving Electronic Health Record Adoption in Psychiatric Care: A Cornerstone for Healthcare Transformation," N Engl J Med. 2018 May 3; 378(18): 1665–1667.

financial incentives/assistance for psychiatric providers, and misalignment between unique psychiatric clinical workflows and EHR design. Congress has the power to address two of these concerns.

First, Congress can decrease regulatory complexity by revising HIPAA laws and encouraging regulations that allow for a full sharing of information among primary care, specialist care, mental health providers, and SUD providers. Mental and behavioral health professionals of all types should be able to fully communicate their diagnostic, laboratory, and prescription information to other treating providers without fear of violating HIPAA.

Second, Congress can use incentive programs to increase use of EHR technology. Federal Meaningful Use policies accelerated adoption of EHR and connected IT systems in medical settings by helping to defray costs through the use of financial incentives. However, psychiatric hospitals were excluded from this program. Additionally, non-physician practitioners like psychologists, licensed clinical social workers, and counselors, who very often provide the lion's share of treatment to people with mental illnesses, also were excluded from EHR incentive programs. Interoperability will have limited benefit for patients with mental illness or substance abuse if adoption of EHR technology in psychiatric settings remains poor. **We strongly urge Congress to allow inpatient psychiatric facilities to have access to EHR incentive payments in the same manner as other inpatient facilities.**

Ensuring Parity

Over time, Congress and CMS have created inequities across the Medicaid and Medicare programs that exacerbate the lack of access to mental health/SUD care, lack of available providers, and other systemic problems. (We have discussed some of these already.) But, Congress also has the power to change these policies. We strongly recommend that Congress begin with fixing some of the following inequities in parity between mental health/SUD and physical health care.

- **Congress should immediately remove the Medicaid IMD exclusion**. Current law prohibits states from using Medicaid to pay for care provided in "institutions for mental disease" (IMDs), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. This is the only part of federal Medicaid law that prohibits payment for medically necessary care based solely on the type of illness being treated. This exclusion has been in place since Medicaid's enactment in 1965, and it has resulted in unequal coverage of mental health care.
- **Congress should immediately remove the Medicare 190-day psychiatric inpatient lifetime limits for acute care.** These limits do not apply to psychiatric units within general hospitals, and they also do not apply to any other Medicare specialty inpatient hospital service.

- **Congress should require Medicaid plans to cover hospital-based partial hospitalization programs (PHP) and intensive outpatient program (IOP) services** (i.e. medical treatment) in addition to a social rehabilitation model. Unfortunately, many states operate non-medical or non-integrated social rehab care models as a deterrent to hospitalization for those with serious and chronic mental illnesses.

In addition to these inequitable policies in Medicare and Medicaid, Congress should consider the following policies that could improve parity:

- Congress should explore the role copayments have on a person's access to mental health/SUD care. Copayments are often a financial barrier to mental health services that require ongoing care. PHP, IOP, and other episodic treatments often require multiple visits over a relatively short period of time, and patient co-payments can add up to a substantial financial burden.
- Congress should prioritize enforcement of existing mental health parity laws. For example, CMS should require Medicare and Medicaid managed care organizations to audit their plans for compliance with mental health parity laws. We would further encourage Congress to explore avenues to enforce parity laws across all plan types, including ERISA, HMO, and PPO plans as well as Medicare and Medicaid.
- Congress should use the authority of the Affordable Care Act to prohibit health plans from limiting the number of mental health visits a person can receive, changing the "level of care" determination made by a mental health provider, or requiring onerous ongoing authorization requirements for mental health/SUD care (particularly when these same activities do not take place for physical health care).

We also recommend that Congress study and develop policies to prevent the "work-arounds" that commercial insurers have found time and again to subvert existing mental health parity laws. These violations of the law create administrative nightmares for providers and create frustration and reduced access for patients. Here are a few examples some of our providers have reported recently:

- Being told by a health plan that continuation of care can only be requested on the last date of authorized service (thus leading to a gap in care for the patient).
- Authorization requests for continuation of care that can take weeks. In some cases, our staff is made to wait on the phone for greater than 30 or even 60 minutes to speak with a service representative from the plans.
- Requiring authorization for admission to a psychiatric inpatient service even though the patient's emergency psychiatric condition has not yet been treated by an attending psychiatrist.

- Telling a facility that they can bill for either mental health care services or physical health care services provided to a patient in an ED, but not both on the same bill.

Congress has demonstrated its commitment to mental health parity numerous times. Unfortunately, not all participants of the health care ecosystem have been as dedicated. We believe Congress has a significant opportunity to improve the lives and health care of people dealing with mental health/SUD conditions by closing some of these inequities and loopholes.

Expanding Telehealth

Despite a growing demand for mental health services, many people across the U.S. are still unable to receive the help they need because of barriers to access. Over half of U.S. counties have no psychiatrists, and even in areas that have mental health providers, there are often not enough to meet the need, as discussed above. Telehealth is a growing, effective way to provide mental health care when patients and providers are in different physical locations. By "meeting people where they are," we can improve overall access to mental health care and can give patients and providers more flexibility. Telehealth can eliminate the barrier of needing transportation, a particularly difficult burden for low-income or low-mobility patients, and decreases "no-shows," resulting in greater continuity of treatment. Additionally, telehealth can increase access to culturally competent and specialty-specific clinicians for underserved individuals.

Before the COVID-19 pandemic, Medicare covered telehealth mental health services for only a small subset of rural beneficiaries — and those beneficiaries had to receive their telehealth services at select health care facilities, not at home, for the service to be reimbursed. Medicare telemental health coverage has been substantially expanded in response to COVID-19, with the majority of services, including group counseling, covered by Medicare and reimbursed at the same rate as in-person services. Medicare policy changes also have enhanced accessibility of telemental health services by:

- Waiving originating-site requirements and thus allowing beneficiaries to receive telemedicine services from home.
- Waiving HIPAA requirements that telemental health services be delivered over secure, audiovisual software platforms and instead permitting delivery by telephone and other means.
- Allowing providers to conduct telemental health visits with new patients.
- Allowing providers licensed in one state to deliver telehealth services to consumers in a different state.

Congress can continue to improve access to mental health services by expanding the use of telehealth, providing appropriate reimbursement, and creating necessary infrastructure. Congress should take the following steps:

1. **Make permanent all of the flexibilities provided by telehealth-related COVID-19 waivers and not restrict them to rural locations.**
2. **Ensure ongoing equal payment for telemental health services.**
3. **Expand these waivers to further remove barriers to care, such as removing requirements that mandate in-person visits in order to continue with telemental health services.**
4. **Pass legislation and fund expanding access to broadband services for the entire nation.**

We have very much appreciated the flexibilities that Congress and CMS have allowed during the COVID-19 public health emergency, and those waiver flexibilities that have been made permanent. The pandemic has allowed us to take a giant leap forward in our use and understanding of telehealth services, including telemental health. Congress now has the opportunity to build on these steps and create a permanent foundation for high-quality, fully reimbursed telehealth services.

Improving Access for Children and Young People

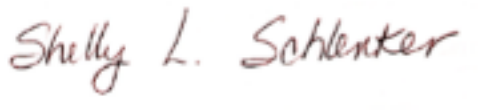
The policy changes needed to improve care for children and young people with mental health/SUD treatment are largely the same as the policy changes needed to improve access across-the-board: more providers, better reimbursement, total parity with physical health care and coverage, and improved telehealth. However, this population will need a few special considerations that Congress can try to address through legislation, task forces, or investigations, including:

- Reviewing residency requirements for child/adolescent graduate medical education programs. We believe the current requirements for an additional year of residency may be unnecessary and could be shortened without any negative changes to the quality of education. However, more study is needed before this change is appropriate.
- Expand billing codes to cover family services related to child/adolescent care. While mental health/SUD conditions can exist entirely within the child/adolescent, they are often exacerbated or affected by the child/adolescent's family. Further, any treatment for child/adolescent mental health/SUD can often be aided by involvement of their family in the treatment plan.
- Increase and incentivize access to school-based programs. Congress can fund school-based mental health/SUD programs to meet kids where they are. Further, nearly every school district can use more licensed therapists or other mental health care providers on-campus. We

encourage Congress to work with the Department of Education to explore avenues for pilot programs or grant funding to increase the number of school-based mental health providers.

CommonSpirit is committed to improving mental health and SUD treatment across the nation. Please contact me at shelly.schlenker@commonspirit.org or my colleague Rachel Tanner, System Vice President Regulatory Affairs, at rachel.tanner@commonspirit.org, if you would like any additional information. We look forward to working with the Senate Finance Committee to identify and pursue policies that can improve access and care for the millions of Americans who need mental health services each year.

Thank you,



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