Strengthening Workforce

1. What policies would encourage greater behavioral health care provider participation in these federal programs?
2. What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services? Services are not accessible or cost effective for the under insured or non-insured. Equitable access to these services through appropriate payer/compensation reimbursement is necessary. Education and outreach to reduce the negative stigma of seeking help should be enforced through PBS services and coordinated marketing and communication methods. Behavior/mental rotation should be included in physician training as well as ongoing requirements for continuing education. If the providers have the skills and resources to support the skills they may be more likely to engage in integrated practice.
3. What policies would most effectively increase diversity in the behavioral health care workforce?
4. What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?
5. 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?
6. Which characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health care?
7. Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?
8. What public policies would most effectively reduce burnout among behavioral health practitioners? For practitioners, burnout is a problematic reality. The workload dissatisfaction, emotional exhaustion, secondary and vicarious trauma and the inequities in payment structures and rates are forcing the shortage of provider participation in the field of behavior health care. Formal training plans embedded into the education requirements and then reinforced on an organizational level to include communication, social skill development, leadership training, and mindfulness techniques (yoga etc.) should be expected. Compensation for non-clinical time (reports, paperwork, travel) and manageable caseloads, as well as linkage and availability to timely and appropriate resources through community partnerships will also lead to increase feelings of support and less feeling of being overwhelmed. Data system sharing and integration of cross training for effective communication is also necessary.

Increasing Integration, Coordination, and Access to Care

9. What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration? With 1 in 5 children and teens being diagnosed with a mental health disorder, primary care pediatricians, the "boots on the ground", need to screen for these disorders during routine well exams. Integration of mental health care in the primary care office will provide for the time and resources to dedicate to prevention, evaluation, management and treatment. Federal payment policies that allow for mental health professionals to be credentialled within a medical practice would enable those who are willing to add this service for their patient access.
10. What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services? Screening is critical. Education of medical students and residents should include rotation through an integrated care model. Telehealth for improved access to care is needed to be able to allow access to the most in need. Involvement of daycares and schools with the medical home to be able to increase access is important. Dedicated care coordinators for primary care and mental health services to aid communication and timeliness of services.
11. What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers? Communication is key in integration of mind and body, holistic, care. Policy to allow for sharing of mental health visit summaries, ideally through integrated EMR platforms, with medical provider will allow for this communication.
12. What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities? Access to care through schools via telehealth or school-based mental health professionals. Simplify Medicaid and Medicare mental health credentialing for mental health providers to join primary medical homes.
13. How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?
14. How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health? Allow non-clinical services to be reimbursable by payers, and require payers to cover these services.

Ensuring Parity

15. 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?
16. 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? Access to care is restricted on many levels, beginning with mental health services being considered "carve out" services and managed and paid by "separate entities" than the health plan – this creates unnecessary additional burden on providers (and patients) for credentialing, authorization, and claim payment. Insufficient prior authorization limits (i.e. limited amount of psychotherapy visits, insufficient amount of time approved to perform psychological testing) and inconsistent authorization rules amongst different products for the

same payer further restrict access. The inability to easily credential mental health providers in the primary medical home also limits access. All of the above perpetuate the misconception that mental health is "different" than physical health.

17. 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? Yes – mental health provider networks are often "closed panels" not accepting new provider contracts, even though the demand for services far exceeds supply. Providers essentially have to beg to become an in-network provider, and then wait 3-6 months for an approval decision.
18. To what extent do payment rates or other payment practices (e.g. timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice? Payment rates for mental health services (psychiatric evaluation and follow up, psychotherapy, etc.) do not, in most instances, cover the cost of employing a qualified, licensed clinician salaries to provide these services, much less overhead such as employee benefits, care coordination and administrative support staff, necessary supplies and tools (additional square footage to house services, play therapy items, psychological testing instruments and scoring fees). The largest commercial payers (BCBS, UHC) and large Medicaid managed care payers (Centene) use carve-out practices as a way to "ping pong" financial responsibility back and forth, oftentimes until timely filing limits are expired and services must written off by providers. UHC and Centene own their own behavioral health entities (Optum/United Behavioral Health and Cenpatico, respectively), however do not communicate internally with regards to provider credentialing, approval, and payment of MH services. Cigna and Cigna Behavioral Health are examples of how this can be effectively internally managed by a single organization.
19. How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health? Extending the Medicare Incident-To guidelines (attached) for mental health services to adult and pediatric Medicaid policy. Improving payment rates for mental health services to discourage qualified providers from opting to practice as "out-of-network" to ensure fair and livable wages.

Expanding Telehealth

20. 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?
21. How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?
22. How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?
23. 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?
24. 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?

25. 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?
26. 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?
27. What legislative strategies could be used to ensure that care provided via telehealth is high-quality and cost-effective?
28. What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?

Improving Access for Children and Young People

29. How should shortages of providers specializing in children's behavioral health care be addressed?
    a. *Incentives for subspecialty training (financial), promoting awareness of key areas of need during training (education about shortages during residency), and providing mentorship opportunities at the federal level (ie training opportunities at the NIH)*
30. How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?
    a. *Coordination of training programs with standards to certify competency, providing a pathway to have "concentrations" in specific areas of behavioral health needs (ie autism, early developmental delays, anxiety/depression etc.)*
31. Are there different considerations for care integration for children's health needs compared to adults' health needs?
    a. *Completely different as in pediatrics families use their general pediatrician far more often as their medical home so in an ideal setting the pediatrician is the gatekeeper of the child's care. However, reimbursement for pediatric primary care is so low that the volume of patients a physician is required to see exceeds their capacity to provide long enough visits to coordinate care. Hence improving reimbursement to general pediatricians (federal subsidy for primary care) can result in longer visits and better coordination of care.*
32. 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?

    a. *More public mental/behavior health clinic programs, or subsidies to providers who wish to serve these populations*

33. What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?
    a. *Broadband internet nationwide, privacy in public spaces with computer access where a visit could be conducted (ie library, etc.)*