November 1, 2021

To: Senate Finance Committee Chairman Ron Wyden and Ranking Member Mike Crapo

From: Health Information and Management Services Society (HIMSS) and,
Personal Connected Health Alliance (PCHAlliance)

Subject: Input on Policy to Enhance Behavioral Health Care

Delivered by Email to: mentalhealthcare@finance.senate.gov

HIMSS and PCHAlliance appreciate the Senate Finance Committee outreach to obtain input on evidence-based policies to enhance and improve access to behavioral health services. The letter seeking input included thoughtful and robust questions that demonstrated a keen understanding of the complex issues surrounding the delivery of mental and behavioral health services in this country and the need to reform how these types of services are accessed. Long before the COVID-19 pandemic, our health care system has largely delivered behavioral health services through a siloed, separate, and often less resourced, delivery system. HIMSS and PCHAlliance members work to support health care delivery, including behavioral health services, through the use of information and technology which serves serve as the backbone to evidence-based health care.

HIMSS is a global advisor, thought leader and member association committed to transforming the health ecosystem. As a mission-driven non-profit, HIMSS offers a unique depth and breadth of expertise in health innovation, public policy, workforce development, research and analytics to advise leaders, stakeholders and influencers from across the ecosystem on best practices. With a community-centric approach, our innovation engine delivers key insights, education and engaging events to healthcare providers, payers, governments, startups, life sciences and other health services organizations, ensuring they have the right information at the point of decision.

PCHAlliance, a membership-based HIMSS Innovation Company, accelerates technical, business and social strategies necessary to advance personal connected health and is committed to improving health behaviors and chronic disease management via connected health technologies. PCHAlliance is working to advance patient/consumer-centered health, wellness and disease prevention. PCHAlliance members are a vibrant ecosystem of technology and life sciences industry icons and innovative, early-stage companies along with governments, academic institutions, and associations from around the world.

**Strengthening Workforce:**

Licensure: HIMSS and PCHAlliance have long supported a licensing policy framework that enables and facilitates the safe and effective delivery of care across state lines. Generally, we support policies that would allow for the continuation of the COVID-19 waivers that enhanced patient access by allowing licensed clinicians to provide telehealth care across state lines, particularly when there are pressing needs, such as clinical shortages, that make accessing in-state care more difficult. Examples include:

- Enact Incentives to encourage state participation in health professional compacts that allow for the safe and accountable mutual recognition of health professional licensure across states;

- Support the Veterans Affairs rule (38 CFR 17.417) that permits "VA health care providers to treat beneficiaries through telehealth irrespective of the State, or of the location in a State, of the VA health care provider or the beneficiary."

- Develop an approach to permit Medicare-participating licensed behavioral health providers to deliver care through telehealth in designated shortage areas irrespective of the State, or of the location in a State. This would be a modified and targeted application of the Veterans Affairs rule to the Medicare program.

- Adopt incentives for Medicaid and CHIP to adopt a similar targeted approach to allowing delivery of care by certain behavioral health providers across state lines.

Training Supervision Policy to Reduce Bottlenecks: We would support CMS establishing incentives for state adoption of policies that allow video supervision to count as supervision hours needed to obtain a master's degree, licensure or independent licensure. Many states do not recognize video or remote supervision, which creates a bottleneck in the training of mental health professionals. Additionally, there is a critical shortage of qualified individuals who can provide this type of supervision. This would provide beneficial flexibility that could help to ease the bottleneck in the training and licensing of mental health professionals.

Fund Workforce Training: Funding through debt burden reduction and internship support for Master's in Family Therapy, Master's in Social Work, and Licensed Professional Counselors would help address workforce shortages.

**Project ECHO:** Continue to support and invest in Project ECHO (Extension for Community Healthcare Outcomes). This nationally recognized model is used in a growing number of communities to improve care in underserved and rural communities. Project ECHO equips primary care providers in rural communities with specialty care training, through a hub and spoke tele-mentoring model. Project ECHO helps address workforce shortages by linking community-based primary care clinicians through a knowledge network with a centrally located inter-professional team of specialists who provide tele-mentoring and ongoing education. As of

2017, nearly 50 peer-reviewed published papers demonstrated the benefits of Project ECHO in increasing provider knowledge, self-efficacy, and professional satisfaction.

**Increasing Integration, Coordination and Access to Care:**

- Integration of behavioral health within primary care is an evidence-based means to improve health outcomes for both adults and children, and can lower costs, including through reduced hospitalization. The 2021 National Academy's report to Congress[1] lays out the case, including extensive evidence, for improved continuity of care, including the integration of behavioral health into primary care.

- The Medicare physician fee schedule covers important behavioral collaborative care management, which is an integration of behavioral health services into primary care. Incentives should be provided to Medicaid and CHIP to provide coverage for the full set of behavioral health integration services. Currently, only some of the services may be covered and some states do not cover collaborative care.

- We urge the Committee to also enact policies that reduce barriers for adoption of Collaborative Care models across the United States, including:
    - Provide incentives to the 30 state Medicaid agencies and CHIP plans to adopt Collaborative Care
    - Encourage or require the adoption of all panel coverage of collaborative care to allow primary care physicians to make sustained workflow changes and maximize adoption of collaborative care
    - Eliminate the two hour per month limit on collaborative care so that primary care providers can provide care based on medical necessity
    - Exempt collaborative care codes from annual Medicare rate reduction
    - Re-evaluate values to reflect that this is a higher level of care than outpatient psychotherapy

- We recommend more focus on addressing SDOH to help improve outcomes for all patients. While there are numerous efforts intended to address SDOH occurring in Medicare, Medicaid, and CHIP as well as in communities across the U.S., these activities often operate in siloes with little systematic or coordinated effort to address health and the underlying causes of healthcare challenges within those communities. Health systems, payers, health information exchanges, community-based organizations (CBOs), and other organizations are often working on addressing the same issues—sometimes without conferring with or leveraging the learnings and practices from other organizations, like CMS or CHIP plans, that could help them better address SDOH challenges. We recommend that Medicare, Medicaid and CHIP be directed to convene all the critical stakeholders within communities and ensure that opportunities exist for better communication and sharing of information. Overall, we want to ensure that the

[1] https://www.nap.edu/read/25983/chapter/8#150

individual controls access to and sharing of their personal data, is comfortable with discovering or accessing additional services, and that a certain level of trust is established between organizations, critical programs like Medicare, Medicaid and CHIP, and the individuals they serve.

**Expanding Telehealth:**
Given the devastating consequences the COVID-19 Pandemic has had on the elderly, those with chronic comorbidities, and racial or ethnic minority groups, we foresee added significant urgency to the mission of using technology as the great equalizer in healthcare. Expanding permanent access to telehealth and other connected health tools will be critical to addressing many of the obstacles around access to behavioral health services. Congress should ensure that any restrictions or additional requirements placed around the use of telemental health or telehealth delivered behavioral health services are supported by a strong evidence base and have a clinical benefit. We also note that the development of value-based payment systems has been exceedingly slow, these outcome-based approaches to reimbursement are essential for adoption of effective innovations like telehealth, remote monitoring, and new therapies. Placing undue burden on the use of these technologies only increases barriers to care and exacerbates disparities.

*Digital tools to support the delivery of behavioral health include:*

- Telehealth, live (e.g. synchronous) audio-visual services. Medicare's telehealth services list includes specific behavioral health services that may be provided via telehealth. While CMS has long-defined telehealth as care being delivered via audio-visual means, during the COVID-19 pandemic CMS has broadened the definition of telehealth to include live audio-only means. There is a strong evidence base that indicates these behavioral health services are equally effective when delivered by telehealth as in person. As part of the Consolidated Appropriations Act, 2021, Congress expanded coverage of telemental health even after the COVID-19 waivers end by removing certain geographic and originating site restrictions for Medicare beneficiaries. However, Congress did include a requirement for a previous in-person relationship with the provider and in-person visits on a periodic basis. There is no evidence that supports this in-person visit requirement, and we believe this requirement creates an undue burden to patients and providers alike, creating unnecessary and harmful barriers to those seeking care for mental and behavioral health.
- Remote patient monitoring includes the use of devices (includes mobile applications which are regulated as devices by the FDA) to track and monitor mental and behavioral health symptoms and enable educational material delivery OR live engagement with a professional based on symptom progression. Medicare covers remote physiologic monitoring and included coverage for remote therapeutic monitoring in the proposed Medicare physician fee schedule for CY2022.
- Digital tools and digital programs based on cognitive-behavioral principles. This approach typically consists of modules tailored to a specific condition, challenges, or needs and the user/patient engages on a weekly basis. It includes availability and

outreach by coaches, usually by audio connection, but it can also be audio-visual. The evidence base supporting digital/online delivery of behavior change to improve health is voluminous. This service is generally not covered, unless it meets the definitions of remote monitoring.

These tools are all essential to the delivery of efficient and effective behavioral collaborative care (discussed above). Primary care needs all these tools as a means to provide the full range of collaborative care, ensure access for their patients, and provide efficient means of support to their patients. Patients expect that the full range of telehealth or digital tools will be available, used by providers, and covered by insurance. HIMSS research on consumer perspectives was published in November 2020 and documented consumer expectations. Additionally, a recent AHRQ White Paper reiterated that a large volume of research concludes that for certain uses and patient populations, clinical outcomes with telehealth are as good as or better than usual care[2].

> AHRQ: The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion during the COVID-19 Pandemic, May 14, 2020
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> ***"The evidence of benefit was concentrated in specific uses.*** *Specifically, we found that a large body of research supports the use of telehealth for:*
>
> - *Communicating and counseling patients with chronic conditions*
> - *Providing psychotherapy as part of behavioral health"*

We urge the following policy modifications to ensure that providers have available all evidence based digital and telehealth tools to provide integrated behavioral health:

- Eliminate the harmful telemental health in-person visit requirement
- Provide additional resources to the HHS Office of Inspector General for telehealth oversight activities
- Require additional provider and beneficiary education on telehealth, including to support underserved and high-risk populations in utilizing telehealth services.
- Direct CMS to cover remote monitoring broadly in Medicare, to include FDA listed behavioral health applications, FDA listing ensures efficacy/effectiveness
- Create incentives for Medicaid and CHIP to cover remote patient monitoring, as it is seldom covered in these programs
- Direct CMS to identify current payment systems means and approaches to covering behavior change digital tools tailored for specific conditions, like substance abuse, pain management, depression, and post-traumatic stress disorder

[2] https://effectivehealthcare.ahrq.gov/products/telehealth-expansion/white-paper

*Equitable Access to affordable, reliable, and quality broadband*.
A 2020 Pew Research Center survey identified that more than half of U.S. adults (53%) say the internet has been essential during the pandemic and nearly half of low-income survey respondents expressed worry about being able to pay for high-speed internet connection. The ability of patients to access available resources and communicate with their care teams is reliant on access to broadband services. Broadband availability and access must be addressed for successful, modern, evidence-based health care delivery to be equitably available and provided to Americans no matter where they live or work. We have long worked to highlight and bring attention to the important and valuable role that broadband-enabled connected care plays in improving access to quality health care and services, particularly in underserved communities.

We identified several recommendations for broadband proposals that we believe would be essential for delivering connected care successfully. Broadband policy must include:

- Plans for long-term sustainability
- Commitments from all community partners, including physicians, hospitals, health systems, payer such as Medicare, Medicaid and CHIP, CBOs, and home health/community providers
- Documented commitment from all health care payer(s) or insurers who cover the population likely to receive telehealth services of their willingness to reimburse for telehealth services as well as the proposed clinician time and clinical care delivered as a telehealth service
- Evidence-based or evidence support for the telehealth services to be provided

Thank you for soliciting feedback and information to inform legislation to address unmet behavioral health needs. If you have any questions or need any further information from HIMSS or PCHAlliance, please do not hesitate to contact David Gray at David.Gray@HIMSS.org OR Jody Hoffman at Jody.Hoffman@HIMSS.org.