November 1, 2021

Senator Ron Wyden, Chairman
Senator Mike Crapo, Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

RE: Bipartisan Behavioral Health Request for Information

Dear Chairman Wyden and Ranking Member Crapo,

The American Association of Nurse Practitioners (AANP), representing more than 325,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on this request for information (RFI) regarding behavioral health care. AANP looks forward to working with Congress to increase access to high-quality, evidence-based treatment for patients with behavioral health needs.

As you know, NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.), have full practice authority in 24 states, D.C., and 2 territories, and perform more than one billion patient visits annually. According to a 2020 AANP member survey, 65% of nurse practitioners report treating depression in their practice.[1]

NPs practice in nearly every health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health care settings. Throughout these settings, NPs provide both physical and behavioral health care to patients.

Nurse practitioners provide a substantial portion of the high-quality[2], cost-effective[3] care that our communities require. As of 2019, there were more than 163,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[4] Approximately 40% of Medicare patients receive billable services from a nurse practitioner[5] and approximately 80% of NPs are seeing Medicare and Medicaid patients.[6] NPs have a particularly large impact on primary care as

[1] 2020 AANP National Nurse Practitioner Sample Survey Results.
[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[4] https://www.cms.gov/files/document/2019cpsmdcrproviders6.pdf
[5] https://www.cms.gov/files/document/2019cpsmdcrphyssupp6.pdf
[6] NP Fact Sheet (aanp.org)

approximately 70% of all NP graduates deliver primary care.[7] In fact, they comprise approximately one quarter of the primary care workforce, with that percentage growing annually.[8]

Throughout this RFI, the Committee has requested feedback on how behavioral health can be improved in underserved and rural communities. NPs provide care to patients of all ages and backgrounds, including a substantial portion of health care in rural areas and areas of lower socioeconomic and health status[9], and they are integral in ensuring these populations have access to high-quality behavioral health care. For example, a recent study found that NPs "are significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[10] NPs are the second largest provider group in the National Health Services Corps[11] and the number of NPs practicing in community health centers has grown significantly over the past decade.[12]

Rural communities are disproportionately impacted by health care inequality, which is exacerbated when communities experience rural hospital closures. However, when rural hospitals do close, APRNs, including NPs, continue to provide care in those communities. According to the Government Accountability Office (GAO), "from 2012 to 2017, the availability of all physicians declined more among counties with closures (16.2 percent) compared to counties without closures (1.3 percent)" whereas "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[13]

The COVID–19 pandemic has exposed and exacerbated severe and pervasive health and social inequality in America,[14] and has highlighted long-standing vulnerabilities in the American health care system. As noted above, nurse practitioners have long been essential health care providers in underserved communities and play a critical role as primary care providers for vulnerable populations, and they understand the barriers to care that face vulnerable patients on a daily basis.[15,16,17] This is further noted in the National Academies of Science, Engineering and Medicine (NASEM) report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* "nurses work in areas that are underserved by other health care providers and serve the uninsured and underinsured."[18]

Additionally, the Committee requested feedback on several topics that would improve behavioral health care delivery including strengthening the health care workforce; increasing integration, coordination and access to care; ensuring parity; expanding telehealth; and improving access for children and young people. Our comments responding to these topics are below and we look forward to further engagement with the Committee on these issues.

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[7] https://www.aanp.org/about/all-about-nps/np-fact-sheet.
[8] Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners, Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsolf, Health Affairs 2018 37:6, 908-914.
[9] According to the 2021 AANP National Nurse Practitioner Sample Survey, 92.1% of NPs reported seeing patients below the poverty level (annual income of $13,300 or less for an individual, and $26,370 for a family/household of four - 2019 U.S. Census Bureau).
[10] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[11] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf
[12] https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf
[13] https://www.gao.gov/assets/gao-21-93.pdf.
[14] https://www.govinfo.gov/content/pkg/FR-2021-01-26/pdf/2021-01852.pdf
[15] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. Journal of General Internal Medicine, 4–6. https://doi.org/10.1007/s11606-017-4287-4.
[16]Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. Journal of the American Medical Association, 321(1), 102–105.
[17]Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. https://doi.org/10.1177/1077558718793070
[18] NASEM: The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity

Strengthening the Workforce

Removing Medicare and Medicaid Barriers to Care

Removing barriers to care for NPs and their patients is essential to improving our behavioral health care workforce, and it has garnered widespread support. In addition to bipartisan support in Congress, reports issued by the American Enterprise Institute,[19] the Brookings Institution,[20] the Federal Trade Commission[21] and the U.S. Department of Health and Human Services under multiple administrations[22,23,24] have all highlighted the positive impact of removing barriers on NPs and their patients. The NASEM *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report also recommended that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[25] The World Health Organization's *State of the World's Nursing 2020* report similarly recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, noting the positive impact it would have on addressing health care disparities and improving health care access within vulnerable communities.[26] Ensuring that Medicare and Medicaid conditions of participation authorize nurse practitioners to practice to the full extent of their education and clinical training will provide more equitable access to behavioral and physical health care, especially in underserved communities.

Examples of Medicare and Medicaid barriers that restrict the ability of nurse practitioners to practice to the full extent of their education and clinical training include physician supervision requirements in rural health clinics, federally-qualified health centers, Medicaid clinics, critical access hospitals, and acute hospitals. These barriers limit the ability of facilities to maximize the utility of their health care workforce, and impose unnecessary burdens on clinicians and patients.

Substance Use Disorder Treatment Workforce

Given the ongoing opioid epidemic, and the links between substance use and mental health disorders, it is important the Congress continues to focus on improving the substance use disorder treatment workforce. Actions taken by Congress to increase access to medication-assisted treatment (MAT) have led to better access to care for underserved patient populations, however gaps in care continue to exist. An example of NPs expanding critical access to care in rural and underserved communities is through the authorization of NPs to order MAT for patients suffering from opioid use disorder (OUD) in the *Comprehensive Addiction Recovery Act* (on a temporary basis) and in the *SUPPORT for Patients and Communities Act* (making the temporary authority permanent).

As of November 2020, the Drug Enforcement Administration (DEA) reported that over 18,000 NPs and physician assistants (PAs) obtained a Drug Addiction Treatment Act (DATA) waiver to treat patients with OUD.[27] Studies have found that NPs have greatly increased access to MAT in rural and underserved communities.[28] In rural communities, NPs and PAs were the first MAT waived clinicians in 285 rural

[19] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.
[20] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[21] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.
[22] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[23] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.
[24] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[25] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf
[26] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf
[27] 85 FR 69153. (Nov. 2, 2020).
[28] https://jamanetwork.com/journals/jama/fullarticle/2730102?widget=personalizedcontent&previousarticle=2737024.

counties, covering 5.7 million residents.[29] The Medicaid and CHIP Payment and Access Commission found that the number of NPs prescribing buprenorphine for the treatment of OUD, and the number of patients with OUD treated with buprenorphine by NPs increased substantially in the first year NPs were authorized to obtain their DATA waiver, particularly in rural areas and for Medicaid beneficiaries.[30] These actions have been important to increasing the number of clinicians providing substance use disorder treatment. **AANP supports the *Mainstreaming Addiction Treatment Act (MAT Act)* (S. 445/ H.R. 1384) which would remove the federal DATA waiver so that more patients have access to the lifesaving MAT, while reducing patient stigma for seeking OUD treatment. We encourage the Committee to include the *MAT Act* in any behavioral health legislation.**

Increased Clinical Training Opportunities:

Expanding clinical training opportunities for clinicians in behavioral health and substance use disorder treatment is important to increasing the availability of qualified clinicians and improving the delivery of efficient, cost-effective care. This includes expanded educational opportunities for NPs who play a vital role in the provision of substance use disorder treatment and psychiatric/behavioral health. Expanding NP educational opportunities in these areas will lead to a more robust workforce trained in treating behavioral health disorders. **AANP supports the *Future Advancement of Academic Nursing Act (FAAN Act)* (S. 246/H.R. 851) which would provide grant funding to modernize schools of nursing, with a priority on underserved communities, support interprofessional and intradisciplinary educational partnerships and help increase the diversity of the nursing workforce. We encourage the Committee to include the *FAAN Act* in legislation to strengthen the behavioral health workforce.**

As mentioned previously, removing federal and state barriers to care for nurse practitioners will also help maximize the utility of our entire health care workforce and help address provider shortage issues. New and existing programs and funding for behavioral health providers must be inclusive and equitable for psychiatric-mental health and primary care NPs. Congress can continue to provide support for practices through innovative payment models and programs like the Transforming Clinical Practice Initiative with a focus on improving behavioral health care in primary care practice.

Addressing Clinician Burnout

We appreciate the Committee's recognition in this RFI of the importance of addressing clinician burnout. Clinician burnout was a significant concern prior to the pandemic, but as the Committee is aware, COVID-19 has greatly exacerbated this issue. It is important that any legislation that focuses on mental health care also focuses on the mental health care of the provider workforce which has been on the front lines against COVID-19 for over a year and a half. **AANP supports the *Lorna Breen Health Care Provider Protection Act* (S. 610/H.R. 1667) which establishes grant programs to improve mental and behavioral health among clinicians and prevent clinician burnout, as well as legislation in the House, the *Workplace Violence Prevention for Health Care and Social Service Workers Act* (H.R. 1195), which seeks to prevent violence against health care professionals and social service workers, a significant cause of stress and burnout in the workplace. We encourage the Committee to incorporate these bills into any legislation that is crafted to address behavioral health.**

Increasing Integration, Coordination, and Access to Care

Integrating Behavioral Health and Primary Care

Given the COVID-19 pandemic, and the disproportionate health and economic impact it has had on minority and underserved communities, integrated care is essential. Communities that faced greater

[29] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859.
[30] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/

challenges in terms of mental health needs and social supports before the pandemic have been the hardest hit by COVID-19. While primary care visits have decreased, nurse practitioners and other clinicians have reported increases in patient needs for mental health services. Patients who may not have previously required mental health care services will likely need these services moving forward and their primary care clinicians will be their first points of contact. Given that many communities lack access to psychiatric-mental health NPs and other behavioral health providers, integrating behavioral health into primary care not only includes bringing behavioral health care providers into primary care practices, but also providing the resources for primary care providers to effectively treat their patient's mental health needs.

Nurse practitioners, and other clinicians, participating in integrated care teams as primary and behavioral health providers must be authorized to practice to the full extent of their education and clinical training. Unnecessary federal and state practice restrictions on NPs deprive patients of their providers of choice, lead to unnecessary utilization and delays in care delivery and hinder the ability of NPs to expand their practices into underserved areas. Primary care and behavioral health care clinicians, particularly in rural and underserved areas, also experience lower reimbursement than other specialties. This is exacerbated for NPs who are reimbursed at 85% of the Medicare Physician Fee Schedule, a rate which is often mirrored by other payers.

NP-led care, which focuses on treating the whole patient, is well-designed for integrating primary and behavioral health care. Nurse-managed health clinics take a whole-person centered approach to delivering care which involves providing comprehensive social supports, patient and family education and high-quality physical and behavioral health care services. Recognizing the challenges faced by patients with mental illnesses, nurse-managed health clinics bring care to patients in their homes when necessary, breaking down barriers for integrated care. Addressing these underlying issues for patients is an essential component to providing meaningful behavioral care integration. **As the Committee considers legislation to better integrate and coordinate primary care and behavioral health care, it is essential that NPs are included and authorized to practice to the full extent of their education and clinical training in any policies or programs.**

Improving Data Collection

COVID-19 has been shown to have long-term cognitive impacts on patients, and it is important to gain a better understanding of the short- and long-term mental health impacts of the COVID-19 pandemic to better tailor clinical and policy responses to the needs of patients. **AANP supports the *COVID-19 Mental Health Research Act* (S.631/H.R. 1716) which would direct the Secretary of Health and Human Services, through the Director of the National Institute of Mental Health, to conduct research on the mental health impacts of COVID-19. We encourage the inclusion of this legislation in actions taken by the Committee.**

Expanding Telehealth

In a 2020 AANP member survey, 76% of nurse practitioners identified federal telehealth waivers as some of the most beneficial flexibilities throughout the COVID-19 public health emergency (PHE). NPs have made a rapid transition to telehealth, with over half of AANP members reporting their practices have adopted, or increased the use of, telehealth and virtual platforms. According to the United States Health Resources and Services Administration (HRSA), there are 4,464 rural primary medical Healthcare Professional Shortage Areas (HPSA) and 2,376 non-rural primary medical HPSAs.[31] Adequate access to providers impacts patients in both rural and non-rural geographic settings. Removing the restrictions that

[31] Shortage Areas (hrsa.gov).

prevent Medicare patients in certain geographic areas from accessing telehealth has also become increasingly important.

The expanded coverage of certain services throughout the PHE, including audio-only care, have enabled NPs and other clinicians to reach patients who otherwise may have been unable to receive medically necessary health care, particularly in rural and underserved communities and for patients with behavioral health needs. Coverage of audio-only telehealth has been critical for NPs and patients who do not have access to adequate broadband or technological devices capable of synchronous two-way audio video technology. In an AANP membership survey conducted in August of 2020, our members reported that the three most significant barriers to telehealth adoptions were patient connectivity issues, patient access to technology and the internet and patient comfort with technology. For patients experiencing issues that prohibit them from utilizing synchronous two-way technology, the permanent coverage of audio-only visits will be an important component of telehealth moving forward.

Telehealth is an important modality of care for patients who face barriers to access, which can include physical distance from a healthcare facility or limitations to accessible transportation. As the Committee further considers telehealth legislation, we respectfully request that increased coverage of telehealth removes barriers to care, and that policies intended to maintain program integrity are flexible and do not inadvertently inhibit patient access to care. Important policy changes include coverage of audio-only services, and the removal of geographic restrictions for telehealth services for Medicare beneficiaries. **AANP supports the *CONNECT for Health Act* (S. 1512/HR 2903) which would address many of these longstanding telehealth barriers, and we encourage its inclusion in behavioral health legislation. We encourage the inclusion of the *CONNECT for Health Act* in legislation to address behavioral health.**

Improving Access for Children and Young People

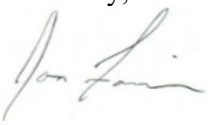
According to a 2020 AANP member survey, approximately 34% of nurse practitioners report seeing patients between zero to five years of age, 39% see patients 6-12 years of age, and 52% see patients 13-18 years of age.[32] As mentioned previously, nurse-managed health clinics have successfully integrated physical health, behavioral health, social supports and patient and family education in their care models. Involving the child's family and addressing underlying social issues are importing for integrating all aspects of health care in a pediatric practice. Nurse practitioners also run many school-based clinics which need to be involved in any policies directed at integrating physical and behavioral health for children, as they are often the only health care providers for children in need. **As the Committee considers legislation to improve behavioral health for children and young people, it is important that nurse practitioners are included in any policies and authorized to practice to the full extent of their education and clinical training, given their importance in caring for pediatric patients.**

[32] 2021 ANP National Nurse Practitioners Sample Survey Results.

Conclusion

As the Committee continues to address behavioral health, AANP looks forward to working together to ensure patients gain access to high-quality, evidence-based treatment they so desperately need. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,



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