COMPASS
Navigating Mental Health Pathways

November 15, 2021

The Honorable Ron Wyden, Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo, Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: U.S. Senate Committee on Finance: Mental Health Policy Solutions

Dear Chairman Wyden and Ranking Member Crapo:

COMPASS Pathways appreciates the opportunity to provide feedback on the current state of mental health care in the United States and how Congress can help to address existing barriers to care.

COMPASS Pathways (Nasdaq: CMPS) is a mental health company dedicated to accelerating patient access to evidence-based innovation in mental health. COMPASS' focus is on improving the lives of those who are suffering with mental health challenges and who are not helped by current treatments. A vital part of this focus is creating equitable patient access through collaboration, partnership across industries, and advocacy for policies that support mental health care professionals, patients, caregivers, and communities. At the root of equitable patient access is the notion that all members of society deserve adequate, affordable, and accessible care, regardless of their social or economic capital. Reducing the stigma associated with mental health care across all levels of existing and future systems, and society more broadly, is vital in order to change behaviors that perpetuate disparities. Mental health must be prioritized as a part of total healthcare, embedded in a commitment to caring for the whole person.

Effective policy solutions will help to mitigate existing care gaps, especially for the vulnerable and most in need. Based on the questions put forth by the Senate Finance Committee, COMPASS has identified the following policy solution themes to improve the state of mental health care including:

- Integration of mental health care into the primary care system
- Increase the number of available behavioral health care providers, including resources and support for upskilling and training in new treatments and innovations
- Broader insurance coverage, increased reimbursements, and enforcement of parity laws for mental health care treatments, including telehealth services
- Increase the role of, and reimbursement for, technology and digital solutions

- Funding for community level mental health education and resources
- Increase resources and funding for the development of evidence-based behavioral health care models
- Increased education, resources, and benefits for people requiring disability services

Specifically, COMPASS also recommends that the Committee focus on ensuring the foundational areas addressed include resources, workforce, coverage/payment, stigma, technology, and access. Our letter continues to provide details on each, and the Appendix outlines our responses to the questions posed by the Committee.

Resources

Existing policies and systems often leave individuals with mental illness lacking adequate health care and resources, especially those suffering with serious diagnoses[1] [2] The impact of policies for those with mental illnesses is far reaching, and includes health care, education, employment, housing, and policing. Behavioral health professionals, caregivers, and those suffering from mental illnesses are increasingly experiencing high rates of burnout, highlighting the need for dedicated resources and support services for providers and caregivers, as well as patients.[3] There is a dire need for innovative approaches for the care of people suffering with mental illness, and these approaches must be supported by enhanced, evidence-based policies. Mental health care has been left behind when it comes to the development and adoption of evidence-based, innovative treatments, broader integration into value-based care models currently used to manage physical health conditions, as well as the integration of technology and digital solutions as companion services to face-to-face care. Part of the challenge is the non-existence of agreed upon evidence-based outcome measures within the mental health care space. This absence makes it difficult, if not impossible, for behavioral health providers to participate in value-based risk models that have become popular in physical health care. In order to set the entire ecosystem up for success, providers need resources and support that: 1) Help to develop processes and outcome metrics that are commonly agreed upon and understood by both providers and payers, and 2) Help to build the proper infrastructure for data exchange and advanced analytics necessary for measuring the agreed upon outcome metrics. It is important to understand that although progress has been made, most of it is fragmented and still far behind the progress that has been made in the physical health care

[1] Walker et al., psychiatry online 2015, https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400248
[2] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.
[3] Gold, J. (2021, January 22). We Need To Talk About Another Pandemic Mental Health Crisis: Therapist Burnout. Forbes. https://www.forbes.com/sites/jessicagold/2021/01/19/we-need-to-talk-about-another-pandemic-mental-health-crisis-therapist-burnout/?sh=7967e4ae4d18

space. Through improved policies, systems and structures are better able to serve and support individuals in need of care.

Workforce

Adequate mental health care requires a sufficient workforce of properly trained and informed professionals. Incorporating diversity and inclusion standards is imperative for building out a representative and well-trained mental health care workforce that includes people with different racial and ethnic, socioeconomic, geographic, academic and professional backgrounds, religious beliefs, political beliefs, sexual orientations, heritage, and those across the continuum of disabilities including the neurodiverse. There are opportunities to expand what it means to be a behavioral health care provider in terms of the credentialing required, as well as taking a team approach in place of a single provider-to-patient relationship. Providers benefit from having a team of trained professionals, including administrative support staff. Policy solutions should focus on expanding the mental health workforce by supporting students and professionals seeking to further their education across the mental health field spectrum from provider to operational support staff. Student loan forgiveness, additional financial aid, and wrap around services for those seeking to work in the mental health care can all help incentivize students to seek related education and professional tracks. Additionally, enhancing the types of services available to low income or disenfranchised student populations will help to diversify the future supply of mental health care workers.

Coverage & Reimbursement

The availability and accessibility of affordable, comprehensive health care can be achieved through improved coverage, billing, and reimbursement policies. Mental health parity laws, although well intended, have yet to change payer behaviors related to adequate coverage or reimbursement of mental health care services.[4] Payers must be held accountable for denying necessary mental health care, for instance, deeming evidence-based but more costly or intensive treatments "not-medically-necessary", thus shifting the financial responsibility onto the sick patient or caregiver(s).[5] Mental health care services must be equally prioritized to physical health care services by increasing reimbursement for mental health work. Physicians are more likely to participate in federal programs when reimbursement is commensurate with the work done and equal across specialties.[6] Increased participation will also allow for improved communication between different providers, enhanced collaboration and integration

[4] Bendat, M. (2014). In Name Only? Mental Health Parity or Illusory Reform. Psychodynamic Psychiatry, 42(3), 353–375. https://doi.org/10.1521/pdps.2014.42.3.353

[5] Shana, A. (2020, June 17). Mental Health Parity in the US: Have We Made Any Real Progress? Psychiatric Times. https://www.psychiatrictimes.com/view/mental-health-parity-in-the-us-have-we-made-any-real-progress

[6] Milliman. (2019, November). https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

with primary care, and reduced physician burnout by distributing the workload across a larger, more dynamic workforce.

Stigma

All individuals suffering with mental illness deserve to be treated with respect and dignity. The stigma associated with mental illness creates an additional challenge for those needing help as much as for those providing services. A general unfamiliarity or lack of dialogue regarding mental health diseases can contribute to individuals in need being mis-, under-, and even un-diagnosed, often exacerbating conditions and making pro-active or preventative care incredibly difficult. If people and communities are not talking about the problems that exist, it makes it nearly impossible for those in need to access appropriate services. A lack of education and awareness of what mental illnesses are and how they present themselves can lead to unnecessary burdens across all levels of society, placing emotional and physical strain on patients, caregivers and support networks, employers, and medical systems. Additionally, the cost to payers and employers for patients with untreated mental health conditions are significantly higher than for their peers, making the case for improved education and the integration of mental health services that enable earlier detection and effective treatment.[7] [8] [9] There is an opportunity to increase awareness through education at all levels of society regarding mental healthcare and how to seek appropriate care and access relevant resources. The more we respect mental health the way we do physical health, the less stigma will stand in the way of people seeking help and recognizing when others need help.

Access to Innovative, Evidence-Based Care

The need for expanded mental health coverage has intensified during the COVID-19 pandemic.[10] Existing limitations of available mental health professionals, combined with restrictions on in-person services, helped pave the way for increased adoption of telehealth options. This innovation was facilitated by the loosening of restrictions on remotely delivered services. Now, the expanded reach of telehealth alternatives and technological supports are at risk if restrictions are reinstated. The technology exists, providers have proven that they are capable of navigating patient care in a virtual setting, and patients have demonstrated

[7] https://www.ajmc.com/view/employer-sponsored-behavioral-health-program-impacts-on-care-utilization-and-cost

[8] Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. Health services research, 36(6 Pt 1), 987–1007.

[9] Insel, T. R. (2008). Assessing the Economic Costs of Serious Mental Illness. American Journal of Psychiatry, 165(6), 663–665. https://doi.org/10.1176/appi.ajp.2008.08030366

[10] Gordon, J. (2021, April 9). NIMH » One Year In: COVID-19 and Mental Health. Https://Www.Nimh.Nih.Gov/about/Director/Messages/2021/One-Year-in-Covid-19-and-Mental-Health. https://www.nimh.nih.gov/about/director/messages/2021/one-year-in-covid-19-and-mental-health

willingness to engage with digital solutions, but permanent policies valuing telehealth work as equivalent to in-person care through adequate reimbursement and full integration into care models are required.[11] Nearly all sectors have embraced technological advances and used them to an advantage, health care needs to do the same. Younger generations do not know a world before advanced technology and will continue to demand innovation in all facets of their lives. There is a demand for instantaneous access to information and ease when navigating processes, including the elimination of a paper trail. Technology should be embraced as a part of health care delivery and reimbursed as such; it gives providers and patients tools to alleviate part of the existing strain on the system, allows for improved, fluid, long-term care, and has potential to positively impact the environment by eliminating unnecessary waste.

COMPASS is working to transform the patient experience of mental health care, creating a world of mental wellbeing. In doing so, active collaboration, innovation, research, and integration across systems is a priority; this request for information is an encouraging step forward for identifying the challenges and creating lasting solutions for patients in need of care. The opportunity to provide feedback is greatly appreciated. Please see direct answers and policy suggestions to specific questions in the appendix.

Thank you again for providing the opportunity for stakeholders to share insight and recommendations. COMPASS looks forward to working with the Committee toward enactment of innovative policy solutions. If you have any questions, please contact George Goldsmith at george@compasspathways.com.

Sincerely,

George Goldsmith
Co-founder, CEO, and Chairman of the Board

[11] Totten AM, McDonagh MS, Wagner JH. The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic. White Paper Commentary. (Pacific Northwest Evidence-based Practice Center, Oregon Health & Science University under Contract No. 290-2015- 00009-I). AHRQ Publication No. 20-EHC015. Rockville, MD: Agency for Healthcare Research and Quality. May 2020. DOI: https://doi.org/10.23970/AHRQEPCCOVIDTELEHEALTH.

APPENDIX

Strengthening Workforce:

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

Most behavioral health care providers choose the professional because they want to help people in need. Behavioral health professionals endure years of schooling, credentialing, training, and work experience to be able to provide safe and effective care. Unfortunately, providing behavioral health care within the existing system is difficult, time consuming, and the economic valuation of the work is not sufficient. These dynamics have created an increasingly transactional environment for providers, where they are forced to focus on the details related to billing and payment rather than providing care. Additionally, administrative burden forces mental health providers to work longer hours, but with less time spent caring for patients.

Higher reimbursement and lower administrative burdens can help to increase interest in federal program participation. Many behavioral health providers are able to opt out of federal programs, and third-party payment more generally, for significantly higher reimbursement and little to no administrative overhead.[12] [13] [14] This is difficult to overcome, even if those behavioral health providers believe in equitable access to care. It is especially striking, because Medicare participation is highly valued by non-behavioral health medical providers.[15] Reimbursement at the same level as these non-behavioral health providers and other incentives, such as loan forgiveness programs, and higher wages for less credentialed workers, could help bridge this gap. Additionally, the administrative burden associated with participating in government programs disincentivizes providers. Many providers do not have the needed administrative support to maintain billing and reimbursement processes and prior authorization paperwork required for participation in government programs.

[12] NAMI. (2016, November). Out–of–Network, Out–of–Pocket, Out–of–Options The Unfulfilled Promise of Parity. https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf

[13] Wen H, Wilk AS, Druss BG, Cummings JR. Medicaid Acceptance by Psychiatrists Before and After Medicaid Expansion. JAMA Psychiatry. 2019;76(9):981–983. doi:10.1001/jamapsychiatry.2019.0958

[14] Yu, J., Jena, A.B., Mandic, P.K. et al. Factors Associated with Psychiatrist Opt-out from US Medicare: an Observational Study. J GEN INTERN MED 34, 2460–2466 (2019). https://doi.org/10.1007/s11606-019-05246-6

[15] Frank, R. G. (2000). The Creation of Medicare and Medicaid: The Emergence of Insurance and Markets for Mental Health Services. Psychiatric Services, 51(4), 465–468. https://doi.org/10.1176/appi.ps.51.4.465

Below, we identify ways to increase provider participation:

- Increase reimbursement rates for in-person and telehealth services for mental health and reducing the barriers for telehealth services. ***Medicaid Bump Act (*S. 1727)**, sponsored by Sen. Tina Smith (D-MN) and Sen. Debbie Stabenow (D-MI), would expand access to mental health services for low-income families and children, the elderly and people living with disabilities by increasing the federal reimbursement rate for mental and behavioral health care services under Medicaid.
- Pass the ***Improving Access to Mental Health Act of 2021 (*S.870)**, sponsored by Sen. Debbie Stabenow (D-MI), would increase the Medicare reimbursement rate for clinical social worker services.
- Expand the Collaborative Care Model and other reimbursement models to integrate physical health and mental health care.
- Expand reimbursement for currently non-covered mental health providers including allied mental health workers such as peer support specialists, family support specialists, and clergy.
    - As an example, the ***Mental Health Access Improvement Act of 2021 (*S. 828)**, sponsored by Sen. John Barrasso (R-WY), would provide coverage of marriage and family therapist services and mental health counselor services under Medicare. It also excludes such services from the skilled nursing facility prospective payment system and authorizes marriage and family therapists and mental health counselors to develop discharge plans for post-hospital services.
- Include support for routine audits of Medicaid managed care organizations and other programs for compliance with state and federal parity laws by regulators.
- Support the **CMS Interoperability and Patient Access proposed rule (CMS-9123-P)**, which builds on the **CMS Interoperability and Patient Access final rule (CMS-9115-F)** with a focus on reducing physician and patient burnout by improving health information exchange, and prior authorization processes through enhanced policies and technology.

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

Low participation of the mental health workforce, both physician and non-physician, in government payer programs prevents patients from accessing needed care.[16] Additionally, a lack of support, through reimbursement and otherwise, for less skilled/credentialed workforce members, such as peer specialists, create barriers to care.[17] In order to provide culturally competent care, there needs to be broader support for the role of non-physician work through funding, training, and payment structures. Successful care teams have dedicated, knowledgeable support staff that understand how to manage the administrative processes and procedures necessary for handling multiple types of treatments, insurance coverage, and patient populations. The Veterans Health Administration is a notable exception with broad adoption, in-house training, and competitive wages for all levels of mental health care workers, creating a more robust supply of care providers.[18] [19] Fragmented services across the continuum of care and the lack of a central, trusted resource for finding available providers also makes finding appropriate care challenging for patients. Patients often face a high cost-burden for their mental health care for out-of-network care, on top of high deductibles, co-pays, and co-insurance for primary and specialty care.[20] This cost burden leaves patients less likely to seek mental health services.[21] Cumbersome prior authorization processes also create barriers to care through fewer providers suggesting or coordinating care that requires proof of medical necessity, or providers that are completely deterred from participating in programs in the first place.

Below are several suggested approaches to help address barriers to patient access:

- Increase integration of mental health care into primary care systems through dedicated funding for data sharing and provider education. Findings from the first round of state funding from CMS for the **State Innovation Models (SIM)** (2013) showed positive results

[16] Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. JAMA psychiatry, 71(2), 176–181. https://doi.org/10.1001/jamapsychiatry.2013.2862

[17] Olfson, M. (2016). Building the Mental Health Workforce Capacity Needed to Treat Adults with Serious Mental Illness Health Affairs, 35(6).

[18] Veterans Health Administration: Behavioral Health Services. (2019, December). https://crsreports.congress.gov/product/pdf/IF/IF11378

[19] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services. Evaluation of the Department of Veterans Affairs Mental Health Services. Washington (DC): National Academies Press (US); 2018 Jan 31. PMID: 29738208.

[20] Rowan, K., McAlpine, D. D., & Blewett, L. A. (2013). Access and cost barriers to mental health care, by insurance status, 1999-2010. Health affairs (Project Hope), 32(10), 1723–1730. https://doi.org/10.1377/hlthaff.2013.0133

[21] Leonhardt, M. (2021). What you need to know about the cost and accessibility of mental health care in America, CBNC.

regarding behavioral health integration.[22] Several of the factors that impacted positive outcomes for this integration process should be considered including:
    - Facilitation of relationships between behavioral health providers and primary care physicians.
    - Investments in infrastructure to allow for data sharing, through health information exchanges, among different providers.
    - Tailored technical support for different provider types participating in health information exchanges.
- Integrate Shared Decision-Making (SDM) processes into integrated care models in the following ways:
    - Increased diversity in the workforce, including support for the increased, reimbursable, use of peer support staff.
    - Training and education focused on addressing bias and reducing stigma for of all members of the care team, including administrative support staff, in order to address mental health and health care generally across different communities.
    - Increased investment in technology and digital solutions that allow for health information exchange among different provider types and on-going, passive collection of patient data.
    - Include patients and caregivers in research and development of care models seeking to integrate behavioral health services in order to understand real-world needs.
    - Incentivize the use of SDM through payment-model reform through designing and integrating SDM processes and agreed upon metrics.
- Ensure enforcement of parity laws to incentivize provider participation and ensure evidence-based treatments are covered, and adequately reimbursed, by federal programs.
- Provide adequate funding for technical assistance to train health care professionals responsible for administrative duties including patient attribution, processing insurance coverage, and claims submissions.
- Provide education for non-mental health physicians and specialists to ensure appropriate referral to and utilization of mental health care.
- Enhanced integrated care models that focus on community-specific wrap-around services and resources across different cultures.

[22] Milbank Memorial Fund. (2019, April). Behavioral Health Integration with Primary Care: Implementation Experience and Impacts From the State Innovation Model Round 1 States. Primary Care Collaborative. https://www.pcpcc.org/resource/behavioral-health-integration-primary-care-implementation-experience-and-impacts-state

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

Limitations in access to awareness, education and career development may hinder opportunities to develop and sustain a diverse behavioral health care workforce. Resources like mentorship programs for students interested in pursuing careers in behavioral health that begin in high school and last through higher education for individuals from a broad set of backgrounds.

Efforts in this area should consider perspectives on mental health, potential stigma, and the way care has traditionally been provided and resourced in a range of communities. Effective community-based approaches include the development of tailored awareness campaigns, education on the importance of mental health care, including career opportunities, and on-going support. Additionally, the development of structured mentorships, scholarships, and grant programs for students could provide an embedded approach to destigmatizing mental health across multiple levels of society, thus opening the door for more diversity.

Individuals with interests in a career in behavioral health in their community may themselves face challenges in accessing training and education. Reducing existing barriers to entry of higher education and targeted supports for individuals with interest in the field could incentivize people to explore career opportunities. Considerations for lowered or waived application fees and tuition costs for all behavioral health care professionals, including undergraduate and graduate level programs, and providing financial incentives for continued education and credentialing could help increase diversity in the mental health care workforce.

The following approaches may increase diversity in the mental health care workforce:

- Include student loan forgiveness for behavioral health care professionals. The Senate can pass ***Mental Health Professionals Workforce Shortage Loan Repayment Act of 2021*** **(S.1578)**, sponsored by Sen. Tina Smith (D-MN). This legislation would repay up to $250,000 in student loans for qualifying mental health professionals. This legislation highlights the eligible mental health care workers as: physician (MD or DO), psychiatric nurse, social worker, marriage and family therapist, mental health counselor, occupational therapist, psychologist, psychiatrist, child and adolescent psychiatrist, and neurologist (expands mental health care workforce by adding occupational therapists as workers).
- Include funding for community level resources that increase internet access, tablets/computers, transportation to and from school or training centers for students in need.

- Include cultural training for educational institutions and health systems to better understand how to communicate and recruit talent across different communities.
- Increase access to mental health care services across high-need communities.
- Increase and embed access to mental health services for K-12 education and FQHCs through increased funding and resources for behavioral health services.

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

Developments in technology have increased the opportunity for providers to reach patients in underserved areas using telehealth and telephonic care models. It is difficult to relocate behavioral health providers to underserved areas, but not necessarily to treat patients there remotely, though state-specific licensing requirements remain a barrier.[23] [24] Additionally, increased services for providers practicing in or moving to rural and other underserved areas, including transportation and housing, could incentivize participation. Trained support staff and better integration into the community health care system through partnerships could provide needed support for relocating physicians. Trained providers can be incentivized to work in rural and other underserved areas through service commitments similar to the National Health Service Corps. Programs like AmeriCorps, Peace Corps, and Teach for America all use similar models to incentivize work in areas with underserved populations. In those programs, participants integrate themselves into a community for a predetermined amount of time and are rewarded through financial support, specialty training, cultural and community training based on location, and in some instances receive student loan forgiveness. Service commitment programs enable a wide variety of professionals to participate as well, from new graduates to seasoned professionals, looking to give back to communities in need through their expertise.

The following activities could help to incentivize training and practice in rural and other underserved areas:

- National licensing for medical care within federal programs across state-lines to deliver remote, multi-state care and care management services.

[23] Zhou, X., Snoswell, C. L., Harding, L. E., Bambling, M., Edirippulige, S., Bai, X., & Smith, A. C. (2020). The Role of Telehealth in Reducing the Mental Health Burden from COVID-19. Telemedicine and E-Health, 26(4), 377–379. https://doi.org/10.1089/tmj.2020.0068

[24] Niskanen Center, & Orr, R. (2020, May). U.S. Health Care Licensing: Pervasive, Expensive, and Restrictive. https://www.niskanencenter.org/wp-content/uploads/2020/05/Health-care-licensing.pdf

- Expand loan forgiveness incentive programs for dedicated practice based on geography and underserved areas.
- Develop government funded, behavioral health specific, service commitments for providers to service in designated areas of high need.
- Expand Medicaid coverage including mental health care (i.e., support of the Affordable Care Act).
- Encourage CMMI (The Innovation Center) to develop models that include direct incentives for health systems to cover behavioral health services for specific geographies based on a needs assessment, as well as the providers dedicating their work in those geographies.

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 system?

A lack of parity between behavioral health professionals and other health professionals for reimbursement of equivalent services has resulted in decreased participation in federal programs that serve the majority of patients with behavioral health needs.[25] Many behavioral health providers do not participate in these programs due to a lack of adequate reimbursement for their services, along with onerous prior authorization processes and other administrative burdens.[26] This lack of participation by behavioral health providers impacts both the quality of total care as well as access to appropriate specialty mental health care for patients, due to the absence of collaboration and communication among various providers. In addition, this shifts the cost burden to patients and reduces the likelihood of proactive communication with primary care and other care providers. Behavioral health providers must be considered an integral part of care teams.

The role of technology also impacts care coordination. There is a need for improved infrastructure, training, and compliance to improve effective communication between providers, payers, and patients. Improved and increased data sharing between different provider types, payers, and patients would allow for more ownership of the process by each party involved. It becomes easier to track and measure patient outcomes as more robust data is collected and shared with decision makers. Support for an increased use of technology has the power to create a more dynamic interaction between care teams and the patients they manage.

[25] Cummings J. R. (2015). Rates of psychiatrists' participation in health insurance networks. JAMA, 313(2), 190–191. https://doi.org/10.1001/jama.2014.12472

[26] Ochieng, N., Schwartz, K., & Neuman, T. (2020), How Many Physicians Have Opted-Out of the Medicare Program? Kaiser Family Foundation. (42% of psychiatrists have opted out).

Another system deficiency contributing to a lack of access to care coordination pertains to the role of unpaid caregivers. Caregivers are often under-considered in the process of managing patients suffering from severe mental illnesses. However, a large portion of patient involvement in the care coordination falls on caregivers. Depending on the level of disease severity, it is often overwhelming for the patient in need to make important decisions about their care. Unpaid caregivers require support and resources to alleviate some of the burden implicit in caring for someone suffering from severe mental illness. Current tax credits limit who qualifies as a dependent, where the dependent resides, and the threshold for reimbursement. Income level and residence requirements for dependents undermine support for costs associated with care coordination born by caregivers. Unpaid caregivers assume immense burdens, regardless of where the patient resides, including coordinating transportation to multiple providers and supporting other medical necessities like meals, housing, adult day-care, and medications. The additional necessary care coordination managed by unpaid caregivers directly impacts their own ability to work full-time and to care for their own physical and mental health.

The following actions may improve care coordination and communication between different types of providers:

- ***Collaborate in an Orderly and Cohesive Manner (COCM) Act*** **(H.R. 5218)**, provides grants to primary care providers to invest in the Collaborative Care Model, a specific care delivery model that integrates behavioral health care within the primary care setting for treatment of mental health and substance use disorders that require regular follow-up, like depression, anxiety, and substance abuse. The senate should introduce companion legislation.
- Oppose the use of block grants to cap Medicaid, block grants limit federal funding which can result in state reductions to mental health benefits and coverage for needed medications.
- Support the **CMS Interoperability and Patient Access proposed rule (CMS-9123-P)**, which builds on the **CMS Interoperability and Patient Access final rule (CMS-9115-F)** with a focus on improving health information exchange, and prior authorization processes through enhanced policies and technology.
- Dedicate funding for digital and technological solutions that enable the integration of electronic medical records and improve claims processing.
- Expand the definition of a dependent for unpaid caregivers supports.
- Expand and increase the eligibility and the amount of the allowable credit for the Caregiver Tax Credit and the Child and Dependent Care Credit.

Which characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health care?

Factors that influence quality of life and excitement around innovation in mental health care encourage individuals to pursue careers in this field. Innovation is needed within education, research, technology, and development of standards of care and quality outcomes. Stakeholders across the behavioral health care continuum are seeking ways to prove the effectiveness of treatment in ways that translate value to payers and patients. This requires support for continued research and the adoption of innovations across the industry. it also requires the ability to access the appropriate data across multiple data sets in order to conduct meaningful analyses on patient outcomes longitudinally.

The Cures 2.0 Act draft, building on the 21st Century Cures Act (2016), highlights opportunities to improve patient access to innovative, novel products and technologies through the acceleration of medical research, and highlights the role of product development. Providers want to help people live whole, healthy lives and a major hurdle to providing the best care is a lack of support for rigorous research and a successful path forward for the adoption of new treatments. Individuals entering this field want access to innovative, evidence-based treatments and the foundation for that comes from an improved research and development process. The Cures 2.0 Act highlights several meaningful provisions in this area including: clinical trial representativeness, digital health technologies, accelerated approval, creating a US Department of Health and Human Services (HHS) -led Real-World Evidence (RWE) Task Force, expansion of a framework for the use of RWE, and notably, establishing automatic communication between FDA and CMS for products designated by FDA as breakthrough therapies and those with accelerated approval so that both agencies are sharing real-time information effectively regarding product approval and coverage decisions.

Increased support and funding of research for evidence-based treatments will continue to draw individuals to the mental health field. Specifically, we advocate:

- Support the proposed provisions and enhancements outlined related to improved medical research and product development processes in the **21st Century Cures 2.0 Act**.
- Congress can play a major role in supporting the development of key biomedical innovations that can draw clinicians and researchers to the mental health field. Specifically, Congress can take up and pass the ***21st Century Cures Act 2.0***. Another example of legislation that can improve research and development in this area is ***Advanced Research Project Agency – Health Act*** **(H.R. 5585)**. The Senate can take up

legislation similar to this which would create an independent, advanced research projects agency for health. A health agency focused on accelerating biomedical innovation to develop transformative breakthroughs in detecting and treating disease.

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?

A broad range of professionals comprise the mental health work force,[27] including physicians, psychiatric mental health nurse practitioners, mental health nurses (RN and LPN), clinical psychologists, master's level therapists (clinical social workers, licensed professional counselors, licensed marriage and family therapists, clinical alcohol and substance use counselors), technicians, peer specialists, and others. However, not all professionals receive adequate wages[28] nor are the services of all reimbursed through federal programs, despite rigorous training, certification, and reimbursement by other payers. Increased wages and broader acceptance of the work being done by different types and levels of mental health care workers, could reduce barriers for participation in federal programs. If there is not adequate reimbursement available, it is unlikely providers are willing to do the work within the existing programs. Specialized education and training, research, internships, and years of work experience require a great deal of personal and financial means that many people are not able to recoup by dedicating their work to patients in federal programs as they exist today. Thus, workers with lower credentials have incentives to shift their careers goals or leave the field.

The following approaches may reduce barriers for behavioral health care workers participation in federal programs:

- Make permanent and streamline the allowances that were made during the COVID-19 pandemic for national licensing across state-lines to deliver remote, multi-state care within federal programs.
- Behavioral health care professionals' licensure alone should not be a barrier to participation in federal health care programs. Rather, these professionals should be encouraged and financially incentivized to participate to the full extent of their education and training to meet patient needs within these programs.

[27] Congressional Research Service, & Heisler, E. J. (2018, April). The Mental Health Workforce: A Primer (No. 7–5700). https://sgp.fas.org/crs/misc/R43255.pdf

[28] Daniels, A.S., Ashenden, P., Goodale, L., Stevens, T. National Survey of Compensation Among Peer Support Specialists. The College for Behavioral Health Leadership, www.acmha.org, January 2016

- Provide increased support for the integration of reimbursable, lower credentialed workers into behavioral health care models/teams.

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

The mental health care system faces pressures due to high volumes of patients and low reimbursement, leading to burnout of providers.[29] Additionally, "therapeutic nihilism" - related to a lack of innovation relative to advances seen in other disease states such as cancer - is a contributor to burnout among mental health practitioners. Increased federal program participation with reimbursement parity may reduce practitioner caseloads, and federal support for innovation in treatment options may increase satisfaction and reduce the strain on providers.

Adoption of peer support models, including adequate reimbursement of these services, could free-up more highly skilled professionals to focus on care that requires their additional training.[30] Additionally, providing funding for patient support networks and regular check-ins could reduce inpatient hospitalizations and preventable outpatient utilization, in turn reducing visits.

Mental health should be treated like other chronic conditions by policy makers and medical professionals alike. The majority of mental illnesses are recurrent, requiring varying levels of intervention longitudinally. This is no different than patients with diabetes who can manage their chronic disease over time but may eventually experience serious episodes like diabetic ulcers or amputations. Integrated health care models attempt to reduce the burden of high utilization through holistic approaches to care management, mental health care should be treated the same. Encouraging collaborative care models by educating teams of doctors about services and proper referral pathways has the potential to alleviate a portion of the burden on behavioral health professionals.

Reducing the administrative burden associated with participation in federal programs is also important for reducing provider burnout. The **Interoperability and Patient Access final rule (CMS-9115-F)** and the **Interoperability and Prior Authorization proposed rule (CMS-9123-P)** would make program changes aimed at reducing this burden for providers, payers, and patients

[29] Pelech, D. & Hayford, T. (2019). Medicare Advantage and Commercial Prices for Mental Health Services. Health Affairs 38(2).
[30] Shalaby, R., & Agyapong, V. (2020). Peer Support in Mental Health: Literature Review. JMIR mental health, 7(6), e15572. https://doi.org/10.2196/15572

alike. The proposed rule adds Patient Access API requirements for impacted payers to provide information like pending or active prior authorizations, and an updated attestation process for third-party application developers seeking to use payers' patient data. Additionally, the proposed rule would potentially reduce burnout through the enhancement of care coordination by requiring payer-to-provider and payer-to-payer data sharing of claims, encounter, and a sub-set of clinical data. Prior authorization processes are a source of burnout for all parties involved, this proposed rule includes the following policy proposals to improve the process by expanding the buildout and use of Fast Healthcare Interoperability Resources (FHIR). A few examples of these improvements are:

- Document Requirement Lookup Services (DRLS) API
- Prior Authorization Support (PAS) API
- Denial Reason
- Shorter Prior Authorization Timeframes
- Prior Authorization Metrics

Other suggested areas of improvement for reducing burnout include reducing the use of fax machines and paper documents for health care data exchange and incentivizing the move to electronic documentation. Another aspect of burnout to consider is the emotional toll on providers while caring for patients. Mental health care providers require and deserve support and resources to care for and maintain their own mental health. Additional programming should be developed that encourages and gives providers space to manage their own mental health to better support their patients.

The following considerations may improve mental health care provider burnout:

- Pass the ***Virtual Peer Support Act*** **(S. 157)**, sponsored by Sen. Catherine Cortez Masto (D-NV), would create a $50 million grant program to help behavioral health organizations implement or expand their virtual peer support programs and build out their current online capacity. Virtual peer support programs have been proven to be a cost-effective way of providing consistent mental health support, reducing psychiatric hospitalizations, reducing outpatient visits, and giving people living with behavioral health conditions a place to build community, share coping skills, and offer support to assist one another in their recovery journeys.
- Support the **CMS Interoperability and Patient Access proposed rule (CMS-9123-P)**, which builds on the **CMS Interoperability and Patient Access final rule (CMS-9115-F)** with a focus on improving health information exchange, and prior authorization processes through enhanced policies and technology.

- Technical assistance programs that focus on helping providers and payers move from paper documentation of patient data to electronic health records and data collection/storage.
- Collection of social determinants of health data longitudinally, allowing for providers and payers to better manage patients over time.
- Develop resources and mental health services specifically for providers.

Increasing Integration, Coordination, and Access to Care:

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

Improving access to care across the continuum of behavioral health services requires a multi-pronged approach that relies on changes to the delivery system and coverage policies. General approaches include the expansion of integrated health plans, special needs plans, and managed care plans that incorporate behavioral health services into primary and specialty care management. Other approaches include improving coverage of preventative care services, i.e., care that will increase per patient upfront spend but lowers the need for long-term interventions necessary for high-risk patients, embedding mental health screenings into annual wellness checks with a multi-pronged referral system where patients can decide the level of intervention that they are comfortable with and can afford, and creating standardized definitions of and measurements for mental health diseases that allow for an effective capture of treatment outcomes between providers and payers. Providers and payers are increasingly trying to evaluate and articulate behavioral health outcomes across diverse patient populations. This is difficult to accomplish when outcomes are not clearly defined, agreed upon, and measured consistently across settings.

Other specific suggested approaches include:

- Support recommended provisions in the **21st Century Cures Act 2.0** focused on improving research and development processes that could increase patient access to innovative, novel products and technologies.
- Reduce barriers for the integration of mental health care in value-based care and value-based payment models through dedicated resources and support for developing the necessary infrastructure.
- Integrate digital solutions including, telehealth services and passive data collection, permanently into reimbursement models.

- Modify restrictions pertaining to patient-level data collection and sharing among researchers, providers, payers, etc. to improve evidence generation and outcome measurements.
- Eliminate Medicaid's prohibition on paying for mental health treatment delivered in certain inpatient settings, known as "institutions for mental disease" (IMDs).
- Eliminate the Medicare 190-day lifetime limit on inpatient psychiatric hospital care.
- Task Social Security Administration to revise, update, and expand the underlying Mental Health "listings" of disabilities used for eligibility determinations in the SSI / SSDI programs, including a re-examination of the proof needed to verify and document such disabilities.
- Task CMS to create general federal standards related to functional assessments for purposes of HCBS and LTSS, which include assessment of mental health status.
- Encourage providers to increase the use of diagnosis codes (ICD-10) specific to social determinants of health in patient records.

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

Patients benefit from improved approaches and programs that ease transitions between levels of care and providers. As an example, the ***National Action Plan to Improve Health Literacy***, enacted in 2010 by President Obama, provides education and tools related to health information that help individuals make informed decisions about their care, and provides health services in a way that is easy to understand and improves overall health and wellbeing. The approach designed in this national strategy engages stakeholders to identify ways to communicate information across organizations, health systems, policymakers, and communities. Going forward, efforts should actively integrate behavioral and mental health information, including how to challenge coverage denials.

Advancing health literacy also relies on increased availability of resources and financial support for caregivers. Patients suffering with mental illness and their caregivers need support in navigating the care continuum, especially during transitions between levels of care and providers. Policy language, out-of-pocket expenses, surprise billing, lack of health system literacy, and access to transportation are just a few examples of challenges patients and their caregivers face that contribute to unsuccessful transitions to new forms of care and/or providers.

Health literacy is an important and evolving concept in the health care system. ***The Affordable Care Act*** defines health literacy, as "the degree to which an individual has the capacity to

obtain, communicate, process, and understand health information and services in order to make health appropriate health decisions." The necessary education and resources should be available not only to patients but their caregivers to ensure that all decision makers are empowered to make informed choices. Increased integration of technology, in the form of reimbursable patient applications and other digital tools, can improve education and access to resources for patients transitioning between levels and types of care. These digital tools have the potential to enhance care modes as well by providing real-time information to providers in an efficient way.

The following approaches could help to improve patient transitions of care:

- Expand health literacy initiatives to include language specific to behavioral and mental health services. The following sections of the **Affordable Care Act** specifically mention health literacy and should incorporate mental health in the total health literacy context:
    - **Sec. 3501**: Health Care Delivery System Research; Quality Improvement Technical Assistance
    - **Sec. 3506**: Program to Facilitate Shared Decision-making
    - **Sec. 3507**: Presentation of Prescription Drug Benefit and Risk Information
    - **Sec. 5301**: Training in Family Medicine, general Internal Medicine, General Pediatrics, and Physician Assistantship

- Provide financial as well as additional support services for caregivers, especially for those that have to stop working to provide fulltime support. Additional services like transportation to and from appointments and financial support for caregivers should be expanded.
- Improve communication across various levels of care and providers using electronic health record systems; integrate other technologies and patient-relevant data into electronic health record systems that capture the whole patient for multiple providers and levels of care.
- Support for Medicare's six protected classes policy that ensures beneficiaries have access to a range of treatment options based on individual needs.
- Prohibit insurers from requiring step therapy or "fail first" requirements for various mental health medications.
- Provide funding for community services that address social determinants of health preventing access to care.
- Support for non-emergency medical transportation (NEMT) services for Medicare and Medicaid beneficiaries.

- Support high touch pharmacy services or medication adherence services in transitions of care. Higher levels of adherence lead to lower hospital readmissions and emergency department visits – removing strain from the emergency physician workforce.[31] [32]

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

Efforts related to improving access to care for minority populations and geographically underserved communities should begin with the mental health care workforce and include perspectives of providers with different racial and ethnic, socioeconomic, geographic, academic and professional backgrounds, religious beliefs, political beliefs, sexual orientation, heritage, and those across the continuum of disabilities including the neurodiverse. Resources that address social determinants of health, including services that connect communities to transportation, food, housing, and health care facilities, should be a priority.

Embedding and expanding behavioral health services into existing community services, including FQHCs, schools, and other community-specific organizations through federal grants could support improvements in equal access to care. Community organizations and representative of the culture(s), should be given additional support and training, beginning with addressing specific community and cultural needs to gauge understanding of the unmet needs and existing services by and for community members. Minority populations and geographically underserved communities often lack access to education, technology, and/or other resources necessary to navigate the health care system, and as a result may not have the means to advocate for the same quality of care or access to services offered in wealthier communities. Community campaigns and dedicated resources for on-going education, information exchange, and assistance are necessary in high-need areas. Providers and care teams would benefit from training and education on topics related to cultural and economic issues faced by a racially and ethnically diverse patient population. Challenges exist for providers navigating cultural, language, religious, and economic differences in different communities and patient populations. Providers and care teams may benefit from tools and supports that can offer insights about approaches to patient engagement and communication

[31] Ghany, R., MD, Tamariz, L., MD, Chen, G., MD, Dawkins, M. E. S., Ghany, A., MD, Forbes, E. R., Tajiri, T. M., & Palacio, A., MD. (2020, August 6). High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population. AJMC. https://www.ajmc.com/view/hightouch-care-leads-to-better-outcomes-and-lower-costs-in-a-senior-population

[32] Roebuck, M. C., Liberman, J. N., Gemmill-Toyama, M., & Brennan, T. A. (2011). Medication Adherence Leads to Lower Health Care Use And Costs Despite Increased Drug Spending. Health Affairs, 30(1), 91–99. https://doi.org/10.1377/hlthaff.2009.1087

The following approaches could improve access for minority populations and other underserved communities:

- Permanently expand telehealth services for mental health. The Senate can reintroduce the ***Home-Based Telemental Health Care Act (*S. 3917)**, (116th Congress), sponsored by Sen. Mike Rounds (R-SD). This legislation would establish a grant program to fund demonstration projects to provide mental health services to medically underserved individuals in rural areas or in the farming, fishing, and forestry industries.
- Support for Non-Emergency Medical Transportation (NEMT).
- Expand Medicaid services across all geographies.
- Provide funding for dedicated health system and financial literacy programs.
- Support policies related to mental health workforce expansion like student loan forgiveness programs.
- Expand reimbursement strategies that account for different cultural needs like the use of clergy for mental health services in the hospital and community setting.
- Pass the ***Rural and Frontier Telehealth Expansion Act (*S. 2197)**, sponsored by Sen. Jacky Rosen (D-NV). This legislation would increase Federal Medical Assistance Percentage (FMAP) funding for telehealth services, including audio-only telehealth, by five percentage points in frontier states or states with limited access to broadband if those states cover telehealth services under Medicaid.
- Population-specific training and tools for coordinated care teams.

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

Dedicated funding for mental health education and community services, similar to diabetes and hypertension education programs and support networks, is important to enhancing behavioral health. Funding and support for the integration of community-led organizations providing access to food, education, transportation, and financial literacy into health systems could increase access to non-clinical services for patients. Reimbursement for community health services and spiritual support in palliative care and end- of-life settings should also be supported through policy. For example, chaplains provide mental health services, particularly in inpatient and hospice settings, which are financially undervalued or not reimbursed at all. These services are crucial for patients and their families when dealing with mental health issues that arise at the end of life and the work being done by non-clinical professionals to support patients on this journey deserves to be reimbursed.

The following considerations should be made to help people connect to additional services and supports:

- Pass the Senate should pass the ***Virtual Peer Support Act*** **(S. 157)**, sponsored by Sen. Catherine Cortez Masto (D-NV). This legislation creates a $50 million grant program to help behavioral health organizations implement or expand their virtual peer support programs and build out their current online capacity. Virtual peer support programs have bene proven to be a cost-effective way of providing consistent mental health support, reducing psychiatric hospitalizations, reducing outpatient visits, and giving people living with behavioral health conditions a place to build community, share coping skills, and offer support to assist one another in their recovery journeys.
- Adopt recording social determinants of health in patients' electronic health records, including the use of diagnosis codes related to social determinants of health to enable integrated care providers to connect patients to appropriate resources based on their individual needs e.g., housing, transportation, additional infrastructure in the home for those with physical limitations, and financial support.
- Include dental, vision, and hearing benefits as a primary Medicare benefit. This would provide Medicare Advantage plans more money to cover special supplemental benefits for the chronically ill – nonmedical benefits that help to improve social determinants of health. For example, coverage of congregate meal services not only improve nutrition for older adults, but also have been shown to improve loneliness and social isolation which is a key driver of mental and behavioral health issues.
- Expand the definition of reimbursable services by peers and non-clinical community support specialists.

Ensuring 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?

There is a need and opportunity to collect both qualitative and quantitative data to better identify parity compliance shortfalls. The challenge is gaining transparency into how programs are managed, and holding decisions makers, at multiple levels within programs, accountable. There must be a better balance of holding organizations responsible for not acting in the best interest of the patient, as well as improved incentives/rewards for those abiding by the laws. When organizations do not fully adopt parity laws and are threatened with being banned from participating in a federal program or not receiving federal funding, the patients most in need continue to suffer. There must be protections and restitutions in place for patients seeking mental health services.

The following considerations should be made to improve oversight and enforcement of parity laws:

- Pass the ***Parity Enforcement Act of 2021 (*H.R. 1364)**. This critical legislation provides authority for the Department of Labor to enforce the parity requirements for group health plans with respect to the coverage of mental health and substance use disorder benefits. It is necessary that the Senate introduce and pass similar legislation to advance parity for mental health services.
- Pass ***Parity Implementation Assistance Act* (S. 1962)**, sponsored by Sen. Chris Murphy (D-CT). This legislation would authorize $25 million in grants to states to support their oversight of health insurance plan'' compliance with mental health parity requirements, as long as states collect and review comparative analyses from insurers

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?

Payers should improve their coverage practices for mental health services, including what types of care/services are covered. Variation in coverage occurs more often with mental health services than physical health services and can lead to challenges and even surprise bills for patients and caregivers. Payer practices have not evolved for behavioral health care in the same way progress has been made for physical care. Services deemed necessary for improved mental health are not valued equally to physical care. For patients suffering from debilitating mental illness, caregivers have a substantial burden in navigating the system on behalf of the patient. Limiting or denying coverage exacerbates the care burden, often leaving patients and their support network feeling hopeless. These limitations can be crippling for those supporting an individual with severe illness or a disability, potentially causing long-term financial and emotional damage for the caregiver. Payers need to be accountable for coverage decisions with a direct, negative impact on patients and caregivers, Continued parity research is necessary to continue to change attitudes related to equal coverage.

The following considerations should be made to ensure plans comply with parity standards:

- Increase auditing of payer policies could help improve compliance with parity laws, thus improving access to mental health care.
- Pass the ***Parity Enforcement Act of 2021 (*H.R. 1364)**. This critical legislation provides authority for the Department of Labor to enforce the parity requirements for group health plans with respect to the coverage of mental health and substance use disorder

benefits. It is necessary that the Senate introduce and pass similar legislation to advance parity for mental health services.

- Pass ***Parity Implementation Assistance Act*** **(S. 1962)**, sponsored by Sen. Chris Murphy (D-CT). This legislation would authorize $25 million in grants to states to support their oversight of health insurance plan compliance with mental health parity requirements, as long as states collect and review comparative analyses from insurers.
- For those with severe conditions, the Social Security Administration should revise the underlying Mental Health "listings" of disabilities used for eligibility determinations in the SSI / SSDI programs, including a re-examination of the proof needed to verify and document such disabilities.
- Enhance the availability of resources for caregivers for people participating in SSI / SSDI programs.

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?

Structural barriers such as the size of the provider network directly impacts access to the behavioral health system. Network size also effects travel time to a provider, based on who is in-network and within a reasonable distance for the patient. Defining a reasonable distance to a provider is challenging as it depends on a variety of social determinants of health like employment, housing, and access to transportation. Sites of care vary across the country, and many patients are constrained by what types of services and care exist within their geographic locations. Not all sites and standards of care are created equal, for example, those living in rural areas have very different barriers to overcome than those living in urban areas under the poverty line.
Co-pays, co-insurance, and deductibles vary across plans and hinder patients without the financial means from seeking care at all. Additionally, location and available appointment times can impede access to care for those that do not have the ability to miss work for an appointment or do not have access to affordable and reliable transportation or childcare.

During the COVID-19 pandemic, the increased need for mental health services placed strain on an already limited workforce, highlighting a lack of availability. Wait times for an initial consultation, including virtual services, can take months, leaving patients without options. Telehealth and virtual care have helped to expand access for patients facing structural barriers to care, but there are still not enough available providers. Expanding telehealth and in-home mental health services, including equivalent reimbursement to in-center services provides access to care for patients lacking some, if not several, of the resources necessary for access to a provider.

The following approaches could help to reduce existing structural barriers to care:

- Increase reimbursements for telehealth, peer support, and in-home mental health services.
- Waive co-pays and deductibles for patients in high-need areas.
- Support non-emergency transportation policies for patients in need.
- Support flexible hours of appointment availability through the expansion of telehealth services.
- Pass the ***Virtual Peer Support Act*** **(S. 157)**, sponsored by Sen. Catherine Cortez Masto (D-NV). This legislation creates a $50 million grant program to help behavioral health organizations implement or expand their virtual peer support programs and build out their current online capacity. Virtual peer support programs have bene proven to be a cost-effective way of providing consistent mental health support, reducing psychiatric hospitalizations, reducing outpatient visits, and giving people living with behavioral health conditions a place to build community, share coping skills, and offer support to assist one another in their recovery journeys.

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?

Claims payment lags are occur in all sectors of the medical field.[33] Additionally, reimbursement for mental health services is low[34], a factor that contributes to a lower supply of available in-network providers. The lack of sufficient payment rates for mental health, and the undervaluing of the services provided, has disincentivized providers to accept insurance or participate in federal programs. Coding practices, including the valuation of codes for billing and reimbursement of mental health services need to be updated and expanded, including how codes are developed and used within the Collaborative Care Model. Reimbursement codes should reflect the amount of time and effort by all levels of the care team that make quality care possible. Furthermore, administrative burden for mental health care providers also hinders participation in programs.

A transactional relationship between payers and providers makes billing and reimbursement a priority over the outcomes for the patient and the patient experience. Behavioral health providers do not want to have to prioritize adequate compensation for their services over

[33] Ramlet et al., J Health Med Informat 2013, 4:4 DOI: 10.4172/2157-7420.1000136
[34] Bogusz, G. B. (2020, March 13). Health Insurers Still Don't Adequately Cover Mental Health Treatment | NAMI: National Alliance on Mental Illness. Https://www.Nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment.

caring for those in need. A lack of innovation in this space, especially with regards to updated coding practices for the valuation of physician time and the types of treatments covered, undermines the relationship between behavioral health care providers and payers.

The following considerations should be made to improve payment practices in a way that benefits the patient and encourages innovation:

- Support for the enforcement of mental health parity laws.
- Support for the generation of real-world evidence to reflect the valuation of physician work and coverage of mental health treatments.
- Creating a standard set of quality metrics and measurable outcomes agreed upon by payers to improve willingness to pay for innovative mental health care services.

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?

Mental health parity principles should be extended to traditional Medicaid and Medicare fee-for-service programs to address financial, individual, and societal challenges that arise when mental health is not valued equivalently to physical health. Extending mental health parity principles could benefit access and health by extending all benefit enhancements and coverage improvements across patient populations regardless of financial position, disability, and/or age.

Congress enacted The Mental Health Parity and Addiction Equity Act, otherwise known as the Federal Parity Law, in 2008. The law established certain rules to be followed by health plans to prevent health insurance practices that limited patients' access to mental health and substance use care. The law applies to several payer types, although there are exemptions including Medicare, Medicaid fee-for-service, Tricare, Federal Employee Health Benefits, and self-funded, small employer plans (under 50 employees).[35] Each major rule focuses on specific areas of care and distinguishes where plans should be covering behavioral health and medical benefits in a comparable fashion. The rules covered include:

1. Benefit Classifications
2. Financial Requirements and Treatment Limitations
3. Nonquantitative Treatment Limitations
4. Transparency of Health Plan Information

[35] The Mental Health Parity and Addiction Equity Act (MHPAEA) | CMS. (2021). Https://Www.Cms.Gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Mhpaea_factsheet. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

5. Out-of-Network Benefits

All health plans should be held responsible for providing equal access to for both physical and mental health services covered in these rules. Vulnerable patients with limited resources often have fewer choices for health insurance, if any at all, and many rely entirely on government programs for coverage. One in five Americans is covered by the Medicaid program, including patients with severe, life-altering illnesses, those on disability, and those lacking financial means.[36] Mental health care services are vital for all patients, especially those with limited or no power to choose their health care coverage. It is important that all government programs like traditional Medicare and Medicaid fee-for-service are held to the same parity law standards as other health plans.

Expanding Telehealth

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

Reimbursement rates for telehealth mental health services should be equivalent to in-person care. The amount of work conducted by mental health providers is the same, if not more involved, compared to in-person sessions. The use of telehealth solutions has increased the workload for mental health providers as it allows providers to reach far more patients than in-person only sessions. There are benefits in terms of time and money spent commuting to therapy sessions and physical accommodations that need to be met for in-person treatment.

The following approach could help support the expansion of telehealth services:

- Pass the ***Telemental Health Care Access Act of 2021*****(S. 2061)**, sponsored by Sen. Bill Cassidy (R-LA). This legislation would remove the statutory requirement that Medicare beneficiaries be seen in person within six months of being treated for mental health services through telehealth. Last year's end-of-year package permanently expanded access for Medicare patients to be treated in their home and other sites for mental health services but put in place an arbitrary requirement that would require the patient to be seen in-person before they could receive telemental services. This act eliminates this in-person requirement so that patients can directly access mental health services via telehealth.

[36] Rudowitz, R., Garfield, R., & Hinton, E. (2020, February 4). 10 Things to Know about Medicaid: Setting the Facts Straight. KFF. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

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 forms of telehealth for behavioral health services should be covered and paid for equivalently to audio-visual in the Medicare program. Expansion of telehealth to audio-only provides greater access to individuals in remote areas of the country, those without access to internet or cameras, as well as neurodivergent individuals who may not respond to being on camera. Although Medicare should reimburse audio-only forms of telehealth for behavioral health services, it is important to consider in any approach the amount of decision-making power providers have for patients relying on an audio-only setting. Providers should not have the ability to place a patient in an inpatient facility without their consent based on audio-only care. Audio-only forms of telehealth have the ability to improve access to populations of patients in great need of care and should be covered and paid for with patient protections.

Approaches for audio-only visits for behavioral health to consider include:

- Eliminate requirement of the patient to be established with the physician or practice in order to cover the audio-only visit.
- Expand audio-only visits to more than pre-existing conditions.
- Standardize the role of risk assessments and how to define eligibility for performing risk assessments.
- Expand coverage for audio-only sessions to be in parity with the time requirements for in-person or audio-visual
- Support for audits to be conducted by an independent body.

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 bases 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?

Congress should make permanent the flexibilities for providing telehealth services, which have proven to be effective for both providers and patients during the pandemic. In many cases those flexibilities have spurred new business models and increased innovation related to patient engagement and compliance in a virtual setting. The ability to maintain engagement and willingness to use preventative telehealth services depends on continued flexibility and adequate reimbursement for providers. Flexibilities regarding national licensing across state

lines to deliver remote, multi-state care should be made permanent as well. Remote workers caring for patients using the same model of care across multiple states should not be burdened with different licensing and credentialing requirements.

The following approaches should be made for permanent behavioral health telehealth services:

- Permanently waive geographic and originating site requirements for telehealth mental health services.
- Expand the definition of HIPAA-covered mental health care communication technologies to include commonly used, non-public-facing applications like FaceTime, Facebook Messenger, Google Hangouts, Zoom, Skype, etc.
- Allow for telehealth mental health services (audio-only and audio-visual) to be delivered and covered to established and new patients.
- Expand types of behavioral health services provided via telehealth to include counseling, psychotherapy, and psychiatric evaluations.
- Permanently establish the temporary broadband benefit program at the Federal Communications Commission (FCC) that provides funding for access to internet services at home for low-income consumers.
- Permanently establish other broadband efforts and programs through the National Telecommunication and Information Administration (NTIA) focused on underserved geographies and populations including:
    - Develop broadband and telehealth infrastructure in rural tribal communities.
    - Develop a broadband deployment program for rural and "unserved" areas
    - Establish the Office of Minority Broadband to support broadband infrastructure at Historically Black Colleges and Universities (HBCUs), minority-serving institutions, and minority-owned small businesses.
    - Permanent funding for the Broadband DATA Act to support the assessment through "broadband mapping" audits of broadband connectivity and availability to technology in underserved areas.

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

Recording of audio and visual visits, with the appropriate level of patient consent, is an effective way to ensure high-quality telehealth care. Recorded sessions will allow for auditing and continuous improvement through on-going evaluation. Additionally, there should be support and funding for digital solutions that ensure safety and the protection of patient privacy. Support for and expansion of evidence-based telehealth practices allows for a wider

variety of mental health services and care options. Provisions and requirements developed in response to the COVID-19 pandemic and the broader expansion of digital services should inform the creation of permanent policies regarding patient privacy protections, enhanced virtual consent practices, and best practices for application developers and providers using these tools.

The following approaches may help to ensure high-quality and cost-effective telehealth care:

- Establish a clear definition of how telehealth is used within care models i.e., what constitutes a visit and what can and cannot be determined within an audio-only visit.
- Define what types of audio-only visits are necessary and required to prevent charging for shorter phone calls as visits that otherwise would not be required in the in-person care setting.
- Fund and support for evidence generating research regarding the clinical benefit of providing audio-only telehealth resources.
- Permission to record audio-only visits for auditing purposes.
- Establish risk-assessment eligibility and an escalation plan for determining when a patient should seek physical, in-person care.

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

A great need for digital solutions has led to a broad range of new technologies, algorithms, and approaches to data collection among health care stakeholders. Requirements of providers and payers to adopt new tools, integrate multiple technologies, or attempt to design custom tools are challenging and contribute to a fragmented care network, similar to in-person care where not all telehealth services are created equal. Stakeholders should review and audit telehealth services and care models based on a standardized set of outcome criteria. Additionally, minority populations and rural communities do not have equal access to internet and technology. Resources including access to internet, cell phones, computers, and private spaces, need to be made available to high-need communities for the adoption of telehealth services. Public spaces like libraries and schools could be leveraged in these areas to provide access to the tools necessary to provide and receive telehealth services.

The following considerations should be made to improve existing barriers to accessing telehealth services:

- Fund and support for access to broadband and technology in underserved areas.

- Expand resources for providers focused on establishing permanent telehealth infrastructure within existing practices and care model.