American Foundation for Suicide Prevention

November 15, 2021

The Honorable Ron Wyden
Chairman, Senate Finance Committee
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
United States Senate
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

Thank you for your commitment to improving mental health care in the United States. The American Foundation for Suicide Prevention (AFSP) commends you both and the Senate Finance Committee for seeking input to develop bipartisan legislation to address barriers to mental health care in the wake of the COVID-19 pandemic.

AFSP is the nation's largest non-profit dedicated to saving lives and bringing hope to those affected by suicide. AFSP was established in 1987 and gives those affected by suicide a nationwide community empowered by research, education, and advocacy to take action against this leading cause of death. AFSP has Chapters in all 50 states and sponsors a variety of community-based programming across the country each year.

AFSP is grateful for the opportunity to share our recommendations for improving mental health and suicide prevention efforts in the United States. We must acknowledge that suicide is a leading cause of death in the United States and addressing risk factors to suicide will enhance our behavioral health care system.

Detailed below are AFSP's positions on funding investments, policies, and legislation in the areas the Senate Finance Committee identified as priorities, specifically: (a) strengthening the behavioral health workforce; (b) increasing integration, coordination, and access to care: (c) ensuring mental health parity; (d) expanding the use of telehealth; and (e) improving access to behavioral health care for young people and children. Through implementing comprehensive behavioral health care policies, decreasing barriers by increasing access to care and improving affordability, improvements to mental health will be made, thus helping to reduce the nation's suicide rate.

Suicide in the United States

Suicide is the second leading cause of death for ages 10-34 in the United States and in 2019 was the 10th leading cause of death[1]. With over ten million Americans[2] living with serious thoughts of suicide, over one million[3] suicide attempts annually, and as a leading cause of death in the country, suicide is a national public health crisis that requires robust investment and response that is commensurate with the scope of the problem. We have seen a 35% increase in the national suicide rate from 1999 through 2018[4] (and fortunately two years of declining numbers of suicides, 2% decrease in 2019 and preliminary numbers

[1]https://www.cdc.gov/injury/wisqars/index.html
[2]Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic (CDC, 2020): https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm?s_cid=mm6932a1_w
[3]NIMH Suicide Statistics Webpage (NIMH, 2021): https://www.nimh.nih.gov/health/statistics/suicide#:~:text=During%20that%2020%2Dyear%20period,females%20(6.2%20per%20100%2C000).
[4] Increase in Suicide Mortality in the United States, 1999-2018 (CDC National Center for Health Statistics, 2020): https://www.cdc.gov/nchs/products/databriefs/db362.htm

showing a 5% decrease in 2020)[5]. With suicide being a leading cause of death in the United States, Congress also must keep in mind that according to the *2020 National Survey on Drug Use and Health* that in 2020 there were 12.2 million adults (18 and older) having serious thoughts of suicide and a great majority of those adults were in the 18-25 year-old age group.[6] There is a great need to not only address suicide deaths, but also the behaviors, thoughts, and ideation that can precipitate a suicide attempt.

COVID-19 and Suicide

While the decreases in suicide deaths are promising and the curve may be beginning to shift downward, efforts must continue to be expanded and built upon to ensure there is access mental health resources and care as the pandemic continues to shift and impact different populations disproportionately. Historically, suicide rates have initially gone down during some periods of wartime and other disasters and have shown mixed results during or after previous epidemics. Provisional 2020 data appear consistent with this trend. It is possible, though not pre-determined, that we could experience an increase in suicide risk as the immediate COVID-19 threat lessens and in the aftermath period if community cohesion diminishes and if less attention is paid to intentional social connections, proactive resilience and mental health self-care, and the importance at key times of engaging in mental health treatment and crisis care. Helping those who are struggling with basic needs can also mitigate suicide risk.

A 2021 CDC report looked at trends in emergency department (ED) visits for suspected suicide attempts by age group and sex over three time periods during the COVID-19 pandemic and in February-March 2021, when compared to the same time period in 2019, there was a 39% increase in ED visits for suspected suicide related concerns among youth aged 12-17 years.[7] The increase for females aged 12-17 years was 51% and for males aged 12-17 years the increase was 4%. Young people aged 18-24 years did not see a similar increase as adolescents. These are not mortality data, but rather ED presentations for "suspected suicide attempts" meaning likely self-harm (some of which is non-suicidal), suicidal ideation and suicide attempts. (It is important to note that suicidal behavior is generally more prevalent among girls than boys, while boys suicide death rates are higher than girls.) Presenting to the ED for suicidal concerns could be reflective of both higher rates of distress among the 12–17-year-old girl population but also could also be a measure of increased help seeking behavior. More recently, *2020 National Survey on Drug Use and Health* revealed that 3.0 million youth aged 12 to 17 had serious thoughts of suicide, made suicide plans, or attempted suicide in the past year.[8] Overall, it will take more time until data and research are available to understand the entire impact of COVID-19 on suicide, as research shows there can be a time lag in the manifestation of distress, even months after the acuity of a stressful or traumatic period.

Strengthening Workforce

The serious workforce shortage of mental and behavioral health providers has been exacerbated by the pandemic. Mental and behavioral health professionals capable of providing evidence-based evaluation and treatment of mental health conditions and suicidal ideation are necessary to improving our behavioral health care system and addressing the long-term impact of the pandemic. 26% of U.S. adults with any mental illness had unmet mental health needs during the previous year, and over 47% of those with serious mental illness report having unmet needs.[9] Despite the demand for services, barriers including

[5]https://jamanetwork.com/journals/jama/fullarticle/2778234?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top
[6]https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf
[7] https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w
[8]https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf
[9] Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm.

subpar Medicare[10] and Medicaid[11] reimbursement rates prevent mental health professionals from serving large volumes of patients covered by these programs. This disproportionately impacts communities and geographic areas that rely on these programs as a consistent source of accessing mental health treatment. Future legislation must ensure equitable reimbursement for in-person and telehealth services, relax interstate licensing requirements, remove originating site requirements, and consider access to internet and cultural barriers to care when designing services.

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

Approximately 130 million Americans live in nearly 6,000 mental health shortage areas.[12] Despite these shortages, neither marriage and family therapists nor licensed mental health counselors are recognized by Medicare. Providing Medicare coverage for such services would expand the pool of service providers accessible to Medicare beneficiaries[13] and would reduce the mental health provider shortage, particularly in underserved areas.[14] Congress must act to improve access to mental health services by expanding Medicare coverage to these behavioral health care providers. AFSP supports the passage of:

- The *Mental Health Access Improvement Act of 2021* (S. 828/H.R. 432), which would provide for coverage of marriage and family therapist services and mental health counselor services under Medicare.

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

Lack of access to mental healthcare in rural areas is a significant factor in rural suicidality. While roughly 8.7% of the United States lives in rural areas, only 1.6% of psychiatrists were present in those same areas resulting in a ratio of 1 psychiatrist per 46,700 rural Americans.[15] Additionally, over 60% of rural areas are designated as mental healthcare provider shortage areas.[16] AFSP supports the following pieces of legislation under the Senate Health, Education, Labor, and Pensions Committee that work to combat workforce shortages:

- The *Mental Health Professionals Workforce Shortage Loan Repayment Act* (S. 1578/H.R. 3150), which authorizes a new student loan repayment program for mental and behavioral health care professionals who commit to working in an area lacking accessible care would help incentivize providers to practice in these shortage areas.
- The *Pursuing Equity in Mental Health Act* (S. 1795/H.R. 1475), which awards grants to establish interprofessional behavioral health care teams in areas with a high proportion of racial and ethnic minority groups and reauthorizes the **Minority Fellowship Program**.

[10] Lopez, E., Neuman, T., et. al. (April 15, 2020). How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. Retrieved July 19, 2021, from https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-privateinsurers-pay-a-review-of-the-literature/

[11] Zuckerman, S., Skopec, L., et. al. (February 2021). Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019, Health Affairs, 40(2). Retrieved July 19, 2021, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611.

[12] https://data.hrsa.gov/topics/health-workforce/shortage-areas

[13] https://aamft.org/Advocacy/Medicare.aspx?WebsiteKey=8e8c9bd6-0b71-4cd1-a5ab-013b5f855b01

[14] https://www.counseling.org/docs/default-source/2016-annual-conference/2021-mental-health-access-improvement-act-one-pager.pdf

[15] The Silence Shortage: How Immigration Can Help Address the Large and Growing Psychiatrist Shortage in the United States. New American Economy. October 2017. http://www.newamericaneconomy.org/wp-content/uploads/2017/10/NAE_PsychiatristShortage_V6-1.pdf

[16] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2019 available at https://data.hrsa.gov/topics/health-workforce/shortage-areas.

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

We thank the Senate for passing the *Dr. Lorna Breen Health Care Provider Protection Act* (S. 610) to help reduce and prevent suicide and mental and behavioral health conditions among health care professionals. The COVID-19 pandemic has exacerbated the high levels of stress that health professionals have long faced. Physicians experience higher rates of suicide than the general population[17]; therefore, there is a need for changes within in the culture of health professions and policies that will break down barriers to seeking care and increase suicide prevention training among health professionals. We must prioritize the mental health of frontline health workers and ensure that our health care professionals have the resources to support their mental health, prevent suicide, and mitigate burn out.

Increasing Integration, Coordination, and Access to Care

AFSP, in collaboration with the top minds in the field and dynamic data modeling, has identified emergency departments, healthcare systems, corrections systems, and the firearms community as four critical areas where suicide prevention strategies must be implemented and scaled nationwide. By partnering with leaders across these critical areas, we can help put suicide prevention efforts, programs, policies, and interventions into practice that will reach more people in need and save the greatest number of lives in the shortest amount of time. In particular, large health care systems, including primary care are a vital component in integrating care and reaching patients in need of help. AFSP's Project 2025 is aligned with goals eight and nine of the *National Strategy for Suicide Prevention*[18] and is part of the Joint Commission's National Patient Safety goals[19].

What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration?

Large healthcare systems including primary are a critical setting where coordinated suicide prevention strategies can have a dramatic impact on lives saved. Healthcare systems must promote suicide prevention as a core component of health care during primary care and behavioral health visits by adopting and implementing minimum standards of evidenced-based suicide care. Up to 45% of people who die by suicide visit their primary care physician in the month prior to their death.[20] A great majority of patients utilize their primary healthcare services as their mental healthcare services, yet primary care providers lack the adequate training on how to assess, treat, and manage patients who are at risk of suicide. Primary care physicians identified nearly one-third (30.3%) of their patients as "mental health patients".[21]

Without proper training and awareness on suicide-specific skills, health professionals may miss warning signs and risk factors in their clients that indicate high suicide risk. Mental health screening and suicide risk assessment is congruent with the care that primary doctors already provide as part of their general health focus. The need for this training exists — the mandate does not. By identifying one out of every five at-risk people in large health care systems, we can expect an estimated 9,200 lives saved through 2025.

We recommend consideration of the following pieces of legislation and provisions, that while they may fall outside of Senate Finance jurisdiction have a vital role in caring for patients:

[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6690303/
[18] https://theactionalliance.org/healthcare/standard-care
[19] https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/
[20] https://project2025.afsp.org/
[21] Abed Faghri, N. M., Boisvert, C. M., & Faghri, S. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): Enhancing the assessment and treatment of psychiatric conditions. Mental Health in Family Medicine, 7(1), 17–25.

- The *Suicide Prevention Assistance Act* (H.R. 2648), which establishes a grant program to provide self-harm and suicide prevention services in primary care, including screening tools. SAMHSA is directed to develop standards of practice for conducting the screenings.
- The *Child Suicide Prevention and Lethal Means Safety Act* (S. 2982/H.R. 5035), which establishes a grant program to provide funding for initiatives that offer youth suicide prevention and lethal means safety education, training, and resources to health care professionals that include screening and risk assessment tools, best practices for communicating with high-risk individuals, and suicide prevention, intervention, and postvention strategies.
- Mandate standards for suicide prevention treatment, assessment and management in primary care to ensure that health professionals maintain competency and consistency when treating their most vulnerable patients.

Moreover, adopting the **Collaborative Care Model** (CoCM) within our health systems is a critical step towards integrating behavioral health and primary care. The CoCM features a primary care physician, a psychiatric consultant, and care manager working together in a coordinated fashion. Despite the model's cost savings potential, increase in treatment of mental health and substance use disorders, and increase in both physician and patient satisfaction, uptake of CoCM remains low. We recommend consideration of:

- The *Collaborate in an Orderly and Cohesive Manner Act* (H.R. 5218) would reduce barriers to implementation by providing grants and technical assistance to primary care practices.

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

Surveillance of public health data and the need for real-time results to inform interventions and guidance has become more evident throughout the COVID-19 pandemic. With that being said, there is a need to evaluate the current data collection structures that exist for suicide data, including deaths, ideation, and attempts to ensure that a comprehensive response to increased instances of suicide can be implemented quickly and effectively for communities most at-risk. Currently, suicide prevention data is two years old and only preliminary data for the year 2020 exists. There is no complete count for suicide attempts in the United States. The inability to access near real-time data on deaths by suicide has made it very difficult to identify potential spikes and therefore policies and interventions meant to reduce deaths in hotspots may take additional years after the deaths to implement response efforts. Improved data infrastructure would help inform prevention efforts, identify clusters of mental health concern and suicide death hotspots, identify populations at an increased risk, and develop more equitable data systems to capture mortality data comprehensively and accurately across different demographics.

In order to improve data collection of suicide deaths and ideation, AFSP recommends implementing the following:

- Invest $30 million to expand CDC's ED SNSRO syndromic surveillance of self-harm to all 50 states as outlined in the *Suicide Prevention Act* (H.R. 2955).
- Increase funding for the National Violent Death Reporting System (NVDRS) to $50 million to support enhanced data collection, reporting, including modernization and innovation efforts that ensures race/ethnicity/sexual orientation and gender identify are added to the death data narratives and quantitative data.
- Allocate funding via the *Suicide Prevention Lifeline Improvement Act* (S. 2425/H.R. 2981) or in another vehicle to facilitate the transmission of Lifeline data to CDC and require annual public reporting.

Moreover, while discussed in more detail in the response, telehealth, including audio-only telehealth, is a critical resource for improving access to behavioral health care. The states that have evaluated the effects of telehealth on access to behavioral health services for Medicaid enrollees all found that telehealth increased access.[22] Audio-only telehealth flexibilities, in particular, increase access in rural and urban underserved areas with provider shortages and a lack of access to broadband. Congress must ensure access to mental and behavioral telehealth services, including audio-only services, at the same reimbursement rate as in-person services to promote behavioral health care access for the most vulnerable across the nation.

AFSP recommends passage of the bipartisan *Medicaid Reentry Act of 2021* (S. 285/H.R. 955) which provides individuals who are involved with the criminal justice system the opportunity to enroll in Medicaid prior to their release and transition back to their communities. More than half of the inmates in our nation's jails and prisons live with mental health conditions and substance use disorders. Connecting these individuals to affordable coverage and care prior to their release addresses their behavioral health needs and reduces recidivism.

How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?

Access to a comprehensive mental health crisis response system is paramount in addressing the needs of those in suicidal or a behavioral health crisis. Individuals experiencing a mental health crisis need to be quickly connected to suitable resources and services, depending on their need – the Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized that crisis call centers and hotlines, mobile crisis intervention teams, and stabilization facilities and services are the core components of an effective crisis response system.[23]

As the National Suicide Prevention Lifeline is transitioning to 988 by July of 2022, there is a need to reimagine, invest, and build an infrastructure that will support an anticipated growth from over 2 million to 9 million calls in the first year of the transition, based on an analysis from Vibrant Emotional Health. Current investments and support for crisis response services cannot meet the existing demand, let alone the projected increase in demand that will undoubtedly be the consequence of this increased access as a result of 988.[24] To improve crisis services across the country, investments must be made nationally to fortify the national network, and at the local level to bolster call centers, mobile crisis outreach, and access to care. This includes expanding the current capacity of local centers to not only answer the National Suicide Prevention Lifeline calls to deescalate suicidal or mental health crises, but also to include a continuum of care that can send mobile crisis outreach when needed, provide follow-up to callers, and divert from current emergency response efforts that too often lead to poor outcomes for individuals in need.

A robust crisis service infrastructure will be a safety net for the general public, as mental health crises affect all communities, but these systems will also support our most vulnerable. The Veterans Crisis Line will become accessible through the 988-crisis hotline and specialized services for particularly at-risk

[22] https://oig.hhs.gov/oei/reports/OEI-02-19-00401.pdf
[23] National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (SAMHSA, 2020): https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[24] Our Network (National Suicide Prevention Lifeline): https://suicidepreventionlifeline.org/our-network/

populations, including LGBTQ youth and people in rural communities, will also be paramount in this new system.[25]

We appreciate the Committee's commitment to improving behavioral health crisis services and strongly support the passage of and efforts to establish:

- The *CAHOOTS Act* (S. 764/H.R. 1914), which would allow state Medicaid programs to cover certain community-based mobile crisis intervention services for individuals experiencing a mental health or substance-use disorder crisis outside of a facility setting.
- The *Behavioral Health Crisis Services Act* (S. 1902/H.R. 5611) to develop national standards for a continuum of crisis services and require coverage of those services by all federally regulated health plans.
- The *Mental Health Crisis Response Partnership Pilot Program* to help communities create or enhance already existing mobile crisis response teams as included in the House passed Fiscal Year 2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations Bill.

Beyond mobile crisis services and coverage needs, there is a larger scale effort to build a continuum of care that must be considered as the National Suicide Prevention Lifeline transitions to 988. No part of crisis services may exist in a vacuum. AFSP strongly recommends the following funding investments and policies to promote access to crisis care:

- The *Suicide Prevention Lifeline Improvement Act* (S.2425/H.R. 2981) which expands the requirements for the National Suicide Prevention Lifeline, increases the current authorization, and encourages data collection.
    - Funding to the National Suicide Prevention Lifeline will help to facilitate the development of a unified call center platform and data analytics, telecom costs for each contact and routing to local crisis centers, provision of specialized services at national back up centers for calls, chat, and text, targeted funding for call centers and national backup centers, multi-lingual assistance, quality assurance and training standards, and supporting partnership outreach.
    - Increased funding for National Suicide Prevention Lifeline Call Centers is needed to build capacity to respond to individuals in a suicidal or behavioral health crisis. Local crisis centers provide tools that build resiliency and connect to local resources to keep individuals safe and communities strong.
        - *Based on an initial analysis from Vibrant Emotional Health, the current administrator of the Lifeline, year one implementation estimates for 988 could grow to as much as $240 million for the National Suicide Prevention Lifeline overall, and an additional $441 million is needed to support Local Call Centers. There is an imperative report to be released by the Substance Abuse and Mental Health Administration and the Veterans Affairs Administration, as directed by the* ***National Suicide Hotline Designation Act*** (S. 2661)*, that will be vital in building the crisis continuum of care in the United States.*
- We recommend nationwide expansion of the pilot Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program through the bipartisan *Excellence in Mental Health and Addiction Treatment Expansion Act of 2021* (S. 2069/H.R. 4323). Created in 2014 thanks to

[25] FAQ for Understanding 988 and How It Can Help with Behavioral Health Crises (MHA, 2020): https://mhanational.org/sites/default/files/FAQ%20with%20vibrant%20FINAL%20COPY.pdf

prior federal investment, hundreds of CCBHCs now offer a comprehensive array of services needed to improve access, stabilize people in crisis, and provide essential treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHCs integrate additional services to ensure a community-based, holistic, and innovative approach to behavioral health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration, as well as coordination with hospitals, emergency departments, and law enforcement.

- Support the creation of a Behavioral Health Crisis Coordinating Office in the Office of the Assistant Secretary for Mental Health and Substance Use to support technical assistance and coordination across federal agencies to inform crisis system development and improvement, technical assistance, and data collection as included in the House passed Fiscal Year 2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations Bill.
- The *Campaign to Prevent Suicide Act* (H.R. 2862) would establish a national educational campaign to raise awareness of the three-digit suicide lifeline phone number (988), suicide prevention resources, and foster more effective discourse on how to prevent suicide.

Ensuring Mental Health Parity

AFSP acknowledges that the *Mental Health Parity and Addiction Equity Act* and the *Patient Protection and Affordable Care Act* have had significant implications for parity. However, plans are often not in compliance with some of the more complex components and continue to apply managed care practices in ways that are more restrictive for mental health and substance use disorder treatment than for other types of medical treatment. Legislation must address mental health parity and ensure that public and private payers cover all medically necessary mental health and substance use disorder services in the same manner as physical health services.

AFSP urges the enforcement and oversight of parity laws, including:

- The *Parity Enforcement Act of 2021* (H.R.1364), which amends the Employee Retirement Income Security Act of 1974 to strengthen parity in mental health and substance use disorder benefits
- The *Parity Implementation Assistance Act* (S. 1962/H.R. 3753), which authorizes $25 million in annual grant funding to states for five years for state regulators to be able to request and review the parity analyses required for insurers as passed in the Consolidated Appropriations Act. We also recommend extending these parity analysis and documentation requirements to Medicaid managed care plans.
- The *Medicare Mental Health Inpatient Equity Act of 2021* (S. 3061/H.R. 5674) which would eliminate the 190-day lifetime limit on inpatient psychiatric hospital services under the Medicare Program.
- Fully extending the provisions in the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Act)* to Medicare, all of Medicaid, and CHIP. Extending parity to Medicaid fee-for-service benefits are critically important for young people because they disproportionately rely on these programs for healthcare coverage. Accordingly, we recommend extending the full rights and benefits of the federal Parity Act to Medicare, Medicaid, and TRICARE, including extending MHPAEA requirements to Medicare Advantage plans.

Expanding Telehealth

Conditions like depression, anxiety, and substance use disorder, especially when untreated, can increase risk for suicide. Approximately 90% of people who ultimately died by suicide were living with a mental health condition, often untreated or undiagnosed.[26] Connecting individuals with mental health services and resources is a vital component of suicide prevention. Expanding telehealth services is critical to increasing access to care, broadening the reach of existing health care providers, reducing service gaps, lowering treatment costs, and ultimately saving lives.

How do the quality and cost-effectiveness of telehealth for behavioral health care services compare to in-person care, including with respect to care continuity?

A vast array of research demonstrates comparable effectiveness of telemental health and in-person services. Published scientific literature reveals consistent evidence of the feasibility of telemental health, acceptance by intended users, cost savings, and improvement in symptomology and quality of life among patients across a broad range of demographic and diagnostic groups.[27]

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

Issues of affordability and accessibility constitute some of the largest barriers to widespread implementation of telehealth. Policy must ensure that telemedicine services, including audio-only telehealth, are covered and reimbursed by Medicare and Medicaid. Additionally, telehealth policy should remove originating site requirements and allow for patients to receive telemental health services in their homes. AFSP strongly recommends the passage of the following bills which would improve access to and affordability of telehealth:

- The *Telemental Health Care Access Act of 2021* (S. 2061/H.R. 4058), which removes the statutory requirement that Medicare beneficiaries be seen in-person within six months of being treated for mental and behavioral health services through telehealth, so that patients can get the care they need from home.
- The *CONNECT for Health Act* (S. 1512/H.R. 2903), which expands use of telehealth through the removal of geographic requirements for telehealth services, expansion of originating sites, improvements to the process for adding telehealth services, and the waiver of telehealth requirements during public health emergencies
- The *Tele-Mental Health Improvement Act* (S. 660/H.R. 2264), which requires parity in coverage of mental health and substance use disorder services to individuals with private insurance, whether conducted in-person or through telehealth.

How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?

The COVID-19 pandemic has revealed the value of telehealth services, as usage has expanded dramatically during the emergency period. The percentage of older adults who had ever participated in a telehealth visit rose from four percent in May 2019 to 30 percent in June 2020.[28] During the pandemic, telehealth was more likely to be used for behavioral health than physical conditions; between mid-March

[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6165520/
[27] Bashshur, R. L., Shannon, G. W., Bashshur, N., & Yellowlees, P. M. (2016). The Empirical Evidence for Telemedicine Interventions in Mental Disorders. Telemedicine journal and e-health: the official journal of the American Telemedicine Association, 22(2), 87–113. https://doi.org/10.1089/tmj.2015.0206
[28] Buis L, Singer D, Solway E, Kirch M, Kullgren J, Malani P. (2020).Telehealth Use Among Older Adults Before and During COVID-19. University of Michigan National Poll on Healthy Aging. August 2020.

and early May 2020, telehealth was used by over 40% of patients with a chronic physical health condition and over 50% of those with a behavioral health condition.[29]

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?

AFSP supports parity in coverage and reimbursement of audio-only forms of telemental health services. Over 10.1 million U.S. patients received a Medicare telehealth service from mid-March through early-July of 2020[30], yet more than 41% of Medicare patients lack access to a desktop or laptop computer with a high-speed internet connection[31]. The need for audio-only telehealth services is apparent. Audio-only telemental health services must be covered and reimbursed at the same rate as audio-visual forms of telehealth.

Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?

AFSP supports recent legislation that has temporarily relaxed telemedicine-specific Medicare reimbursement and licensing requirements..[32] AFSP urges increased coverage, reimbursement, and permanency of flexibilities extended to patients during the COVID-19 Public Health Emergency, including the following pieces of legislation to improve access and services for patients who require telehealth:

- The *Permanency for Audio-Only Telehealth Act* (H.R. 3447), which expands accessibility of audio-only mental and behavioral health services, and substance use disorder services to Medicare beneficiaries. The legislation also removes geographic and originating site restrictions to allow Medicare beneficiaries' homes to be telehealth originating sites for audio-only telehealth services.
- The *TREAT Act* (H.R. 1647/S.340), which permanently allows telehealth services for substance use disorders and mental health disorders to be provided via audio-only technology, if a physician or practitioner has already conducted an in-person or video telehealth evaluation.

Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

There are notable concerns for the safety of patients that become high risk for suicidal behavior while accessing services at home. Typical crisis management strategies for in-person settings, including coordinating emergency services, providing consultation, and escorting patients to the emergency department, are not available via telehealth. However, with appropriate planning and training, patient

[29] Fischer, S.H., Uscher-Pines, L., Roth, E. et al. (2021). The Transition to Telehealth during the First Months of the COVID-19 Pandemic: Evidence from a National Sample of Patients. J GEN INTERN MED 36, 849–851 (2021). https://doi.org/10.1007/s11606-020- 06358-0

[30] Resneck J, Statement of the American Medical Association (2021). U.S. House Energy and Commerce Committee. The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care. 2021, March 2.

[31] Roberts ET, Mehrotra A. (2020). Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. JAMA Intern Med. 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666

[32] Mechanic OJ, Persaud Y, Kimball AB. (2020). Telehealth Systems. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan. Available from: https://www.ncbi.nlm.nih.gov/books/NBK459384/

safety can be effectively managed during telepractice, even when patients are at home.[33] In particular, before engaging in any form of treatment, providers should assess and evaluate suicidal ideation through an interview and suicide screener.[34] AFSP supports mandated suicide prevention and risk assessment training for health professionals, including those practicing via telehealth.

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

While high-quality technology is more available now, and smartphones are often able to facilitate HIPAA-compliant encounters, accessibility concerns remain.[35] Lack of broadband access is a critical barrier to telehealth services, particularly in rural areas, where only 67% of the population has access to broadband at home as compared to the national average of 79 percent.[36] Congress must address these technological barriers through legislation expanding audio-only telehealth services and increasing broadband internet access.

Improving Access for Children and Young People

Suicide is the second leading cause of death for ages 10-34 in the United States.[37] Moreover, there was a 60 percent increase in the rate of suicide among 10-to-24-year-olds from 2007 to 2018.[38] It is important to remember that while there is not yet a complete breakdown of suicide rates by demographic, the COVID-19 pandemic is certainly impacting different populations disproportionately, and youth and young adults are not exempt from these impacts. AFSP was proud to join the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) in support of their recent National State of Emergency in Children's Mental Health declaration. No matter where a child lives, goes to school, or what their financial situation may be, they deserve access to the care and support they need—the country must show children that we are listening and support is available.

In order to support children's mental health, the Senate Finance Committee should increase investments to support the training, mentorship, retention, and professional development of a clinical and non-clinical workforce. It is also imperative for the Committee to evaluate where children spend the most and look to decrease barriers to integration of mental and behavioral health care in the pediatric, primary care, and community health setting. Moreover, as Medicaid is the third largest funding stream for school districts, providing essential funds to support school health services, the Senate Finance Committee should direct the Centers for Medicare & Medicaid Services (CMS) to coordinate with the U.S. Department of Education to help the Department, states, and other stakeholders remove barriers to full participation in school-based Medicaid programs. Legislation and provisions such as the following also may bridge necessary gaps for care:

- The *Mental Health Services for Students Act of 2021* (S. 1841/H.R. 721), which provides specific statutory authority for the Project AWARE (Advancing Wellness and Resiliency in Education)

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[34] Holland, M., Hawks, J., Morelli, L.C. et al. (2021). Risk Assessment and Crisis Intervention for Youth in a Time of Telehealth. Contemp School Psychol 25, 12–26.
[35] Warren, J., & Smalley, K. B. (2020). Using Telehealth to Meet Mental Health Needs During the COVID-19 Crisis. Commonwealth Fund. https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis.
[36] Perrin, Andrew. Digital Gap Between Rural and Nonrural America Persists. Pew Research Center. May 31, 2019. https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/
[37] Ibid.
[38] https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr-69-11-508.pdf

State Educational Agency Grant Program administered by SAMHSA. The program supports school-based mental health services, including screening, treatment, and outreach programs.

The Committee should consider the following as vital efforts to support the mental health of vulnerable populations and improve equitable and affordable access to care:

- Improve access to care for children through the permanent authorization of CHIP and the bipartisan *Stabilize Medicaid and CHIP Coverage Act* (S. 646/H.R. 1738), which will provide 12 months of continuous enrollment for Americans who are eligible for Medicaid and CHIP. Both measures would stabilize vital health coverage for millions of low-income children.
- The *Helping MOMS Act* (H.R. 3345) to permanently ensure that all pregnant women on Medicaid and CHIP retain their health coverage during the critical first year postpartum. Stabilizing access to Medicaid and CHIP for new mothers addresses serious health inequities in maternal health and provides critical access to care and services, including services for mental health and substance use disorder treatment. Mental health conditions contribute significantly to maternal mortality rates with suicide as one of the leading causes of death in the first year following pregnancy.[39] In addition, mental health conditions are the most common complications of pregnancy and childbirth, affecting 1 in 5 women.[40] Untreated maternal mental health conditions can have long-term negative impacts on mother, child, and the entire family. Given Medicaid's role in covering nearly half of all births in the nation and 65 percent of births to Black mothers, stabilizing affordable health coverage for new mothers would help ensure access to vital mental health and substance use disorder treatment services and address health disparities during this vulnerable time in new mothers' lives.
- Support SAMHSA's Comprehensive Community Mental Health Services for Students with Serious Emotional Disturbances Program which provides community-based systems of care for children and adolescents with serious emotional disturbances (SED) and their families. This program ensures that services are provided collaboratively across child-serving systems. The 2016 Report to Congress notes a decrease in suicide attempts and ideation among enrolled children.[41]

Telehealth is a critical component of expanding access to behavioral health care for children, particularly children with disabilities and those from low-income families or who live in rural and underserved communities.

- The *Telehealth Improvement for Kids' Essential Services (TIKES) Act* (S.1798/H.R. 1397), which would improve access to telehealth services for children through Medicaid and CHIP and study the impact of telehealth on access, utilization, costs, and outcomes.

The American Foundation for Suicide Prevention is grateful for the Senate Finance Committee's continued support of suicide prevention and mental health and hope our comments on suicide prevention efforts are helpful in informing your legislative approach. We look forward to additional conversations about the vital resources needed to help save lives and prevent suicide. Please do not hesitate to contact Natalie Tietjen, Manager of Federal Policy (ntietjen@afsp.org) on my staff with additional questions or for clarifications.

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[39] CDC, Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017, (2019).
[40] CDC, "Pregnancy Related Deaths", Data from 14 U.S. Maternal Health Mortality Review Committees, 2008-1017 (2019).
[41] https://store.samhsa.gov/sites/default/files/d7/priv/pep18-cmhi2016.pdf