October 29, 2021

Hon. Ron Wyden, Chairman
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

Hon. Mike Crapo, Ranking Member
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Re: Request for Information Regarding Unmet Mental Health Needs

Dear Chairman Wyden and Ranking Member Crapo:

Oak Street Health appreciates the opportunity to respond to the important stakeholder request for information you issued on September 21, 2021. Treatment and care for behavioral health and substance misuse are critical health care issues faced by all Americans as well as an increasing concern for Medicare beneficiaries and those who care for them. In fact, Oak Street Health has seen a significant increase in the need for mental health and substance misuse services, so much so that after intake screening, 60% of those we serve demonstrate need for these services; this is 10% higher than the general prevalence for adults, as reported by the Centers for Disease Control and Prevention.

Introduction

Oak Street Health is a national network of primary care centers for adults on Medicare. Founded in 2012, we currently provide care in 19 states to over 120,000 Americans. Oak Street Health's mission is to "rebuild health care as it should be" by reducing costs, improving outcomes and providing high-quality care. We accomplish this by being personal, evidence-based, equitable and accountable. We are reimbursed through a fully capitated value-based model, which allows us the flexibility to focus on those services that have the greatest impact on keeping people healthy, such as behavioral health services. Our results versus Medicare benchmarks include a:

- ✓ 51% reduction in hospital admissions
- ✓ 42% reduction in 30-day readmission rates
- ✓ 51% reduction in emergency department visits

We invest substantially in support for behavioral health, transportation, food and housing needs and have intentionally rebuilt the entire primary care model. In fact, our financial model depends upon those under our care becoming and staying healthy, both physically and mentally. That is why we incorporate time within the day of our providers to serve their patients even when those patients are not in one of our centers; **the difference in the Oak Street model is that rather than wait for a need to arise, we incentivize our providers to proactively reach out to their patients and we particularly focus on this with our beneficiaries who need behavioral health support**. It is also why each of our facilities has an active community room with social and educational events for patients and the community.

Oak Street Health operates under the view that mental health is foundational to every American's overall well-being. A patient's history of any mental disorders has also usually been associated with lower overall health and quality of life. We put this view and knowledge into action by integrating behavioral health, not as a "nice-to-have," but as an essential component of our integrated primary care model. That is why nearly all Oak Street patients are screened for mental health needs. We acknowledge, however, that while individuals are increasingly aware of how their mental health may impact their life, most still face stigma and poor access to what is often ineffective care. Oak Street's behavioral health rubric turns this around by utilizing our Collaborative Care Model's population health based approach to universally screen and treat patients until they consistently demonstrate improvement. In the past year, we have screened 98% of our population and enrolled in treatment the nearly 50% of patients who are shown to be at risk for depression. For patients who have engaged in care with qualified mental health professionals, **we have experienced reduction in depressive symptoms in as soon as six weeks and measurable sustained improvement within six months**. These results are a considerable improvement compared to the usual care in which response to treatment can be a roller coaster of medication changes, symptom mismanagement and frequently lasts for more than two years. **Our philosophy is to challenge the common model that outpatient mental health must be a specialty service - instead, we believe access to mental health should be accessed as easily as possible and serve as a key component of a patient's primary care.**

Almost all Oak Street Health patients are adults on Medicare with 45 percent of those we serve dually eligible for both Medicare and Medicaid. As this is our main area of expertise, we are responding to these questions with respect to these two programs.

Strengthening Workforce

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

Oak Street Health believes it should be the goal of Congress to incentivize value based, capitated care; organizations running on this chassis, including Oak Street Health, are uniquely suited to

integrate behavioral health into primary care focusing on outcomes and quality rather than volume. There are many ways Congress can push towards a system based on value rather than volume and we would welcome the opportunity to discuss them with you. For the purposes of this response, and in the context of behavioral health care, Congress should lift up this goal by authorizing training grants to organizations dedicated to implementing the Collaborative Care (CoCM) model. To have the greatest impact, Congress can target these grants to organizations which provide behavioral health and substance misuse care to underserved populations. In addition, by ensuring the Centers for Medicare and Medicaid Services (CMS) are paying for behavioral health quality and positive outcomes, including enrollment in treatment, engagement and duration of care with improvements to quality of life as measured by the remission of illness (e.g. depression, anxiety), the agency will create a systemic shift away from episodic treatment for mental health challenges and towards providers treating the whole patient in order to heal them. Not only is this a way for the government to ensure providers are held accountable, but it is also a mechanism to ensure they are reimbursed for quality of care and clinical outcomes rather than volume of services.

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

Quality mental health professionals are essential to addressing America's mental health crisis. For too long, our system has placed value almost exclusively on those mental health professionals who hold terminal degrees.This dynamic has contributed to our mental health workforce crisis by significantly limiting the type of skilled professional who can improve the lives of those who have mental health treatment needs.

Right now, Licensed Professional Counselors (LPCs) are excluded from treating Medicare beneficiaries. If CMS recognized this cohort of professionals, the nation could dramatically increase access to mental health care.Traditionally, the salaries of mid-level mental health providers have not been competitive in provider practices that serve federal programs. The effect of this has been to drive these professionals to seek private practice opportunities which, historically, has excluded underserved Americans in both rural and urban locations from benefiting from the whole range of federal health benefits to which they are entitled. By expanding the definition of who is eligible to treat Medicare beneficiaries and requiring core competency training in evidence based models inlcuding CoCM, Congress can ensure increased access to quality mental health professionals.

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

We are proud that 55% of Oak Street's workforce are either African-American or Latino, 69% of all our employees are managed by a female supervisor and 58% are managed by someone who is non-white. At Oak Street Health, we invest in this commitment to our workforce by exploring

multiple avenues for diversity recruitment including Historically Black Colleges and Universities, diversityjobboard.com and the Hispanic Alliance Job Board, to ensure our staff look like the communities we serve. In addition, Oak Street engages in the following hiring best practices which could inform Congress's efforts in these areas:

- ✓ Collaborating with local community organizations to support a diverse candidate pipeline
- ✓ Implementing a pilot program of the National Football League's "Rooney Rule" for Population Health Directors to ensure a certain number of diverse individuals are screened prior to extending a job offer
- ✓ Developing a hiring manager training guide focused on unconscious bias
- ✓ Forming ongoing partnerships with external organizations that promote diversity, equity and inclusion in the workforce including local chambers of commerce.

Finally, Congress should expand both loan forgiveness program eligibility and dollar amounts while also incentivizing newly graduated medical professionals to work in underserved and rural areas.

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

Congress should continue to fund the National Health Service Corps (NHSC), yet reduce the administrative burden for organizations interested in participation and expand the definition of participating providers. In addition, Congress should consider incentivizing private institutions to participate as a recruitment and retention strategy. Currently, the site requirements can serve as a barrier to participation in the NHSC for private institutions because they are not part of auto-approved sites. Further, sites must be located in designated Health Professional Shortage Areas (HPSA). We support these eligibility requirements, however, **propose that value based care providers offering a high percentage of care to Medicare beneficiaries also be included in the auto-approved site list.** Additionally, there is a current requirement for sites to provide services for free (or, for a nominal charge, consistent with the site's policy) to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines (FPL) is. This requirement places a burden on providers to subsidize care and salaries of qualified mental health professionals. The result is that fewer private institutions participate in the NHSC program. **Congress could maintain the success of NHSC and the eligibility requirements by providing financial support via grants to institutions that could supplement a sliding scale for individuals and families with annual incomes at or below 100% of FPL. The institutions could then be held accountable to hire qualified mental health professionals that are part of NHSC and compensate more competitively.**

One of the major challenges of providing medical care in underserved and rural areas is the heightened complexity of patients who have long been left unable to access the care they need. Often, the complexity of these patients require additional resources and multidisciplinary staff if they are to experience meaningful results. Unfortunately, this dynamic may keep providers -

including those with behavioral health expertise - away from caring for these patients. It is at this intersection that the social determinants of health show up as obstacles to completing preventative screenings and in limiting overall health outcomes. **Navigating for our patients the social determinants of health is a foundation of Oak Street Health's commitment to equity. That is why we screen nearly all of our patients (92%) for certain social characteristics - such as lack of transportation, food insecurity and missing social connections - that could stand in the way of them getting the care they need. We have found that 60% of Oak Street patients experience at least one social determinant of health with 50% experiencing two or more, and we operate with the idea that it is our obligation to remove these as obstacles to care**. Given that star ratings are typically lower for dual-eligible patients, health plans have less of an incentive to enroll these patients, even though this population experiences reduced access to care and lower engagement. An example of this done well is when dual-eligible patients are partnered with care management services offering in-office and community services, but these designs operate at a higher per individual intervention cost. For these reasons, **we believe star ratings should be adjusted to account for case complexity driven by social risk factors by setting different cut points for plans with higher levels of dual-eligibles.** In addition, since all health care is local, **Congress should consider an adjustment to stars cut points which is based on census tract data rather than at the national level**. Finally, **Congress can provide additional incentive payments for those plans and providers that serve a higher proportion of dual eligible patients**. This additional revenue then can drive innovation from a team based approach. Systemic challenges often require multi-pronged solutions, yet simplifying the payment model can allow providers to build teams to adequately respond to the needs of their population and commit to underserved areas instead of avoiding them.

- **Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?**

Our current health system does a good job answering the question, "*Are patients being seen?"* It does not, however, adequately answer the question,"*Are patients getting better?"* If our overall health system and CMS aligned financing mechanisms with the right payment model, the system would better be able to sustainably hold providers accountable for access and quality. To that end, while the 2017 introduction of Behavioral Health Integration codes support a CoCM approach, they are also disproportionately lower than traditional fee for service mental health reimbursement. This lower reimbursement is a key reason why adoption of this program has been less than anticipated.

<u>We recommended a three-fold strategy to improve CoCM model adoption:</u>

1. As stated above, Congress should authorize training grants to organizations dedicated to implementing the CoCM model. To have the greatest impact, Congress can target these grants to organizations which provide behavioral health and substance misuse care to underserved populations.

2. The CoCM model works best when implemented utilizing the expertise of mid-level mental health professionals including Licensed Clinical Social Workers, Licensed Professional Counselors (LPCs) and Advanced Practice Nurses in Psychiatry. Congress should do as much as possible to enable these experts to care for Medicare beneficiaries with behavioral health or substance misuse needs by making them fully available to Medicare beneficiaries.
3. Congress should support enhanced payment related to CoCM quality outcomes which are tied to its use. This could be accomplished through the evolution of the Medicare STARs measures to include treatment response for depression and potentially many other behavioral health needs.

By ensuring CMS is paying for quality, the agency will create a systemic shift away from episodic treatment for mental illness and towards providers treating the whole patient to heal their behavioral health challenges.

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

In response to the nationwide opioid epidemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) has invested significant resources to improve substance use disorder education for practitioners and students studying health professions. These and other efforts led by organizations representing mental health professionals have contributed to a 57% increase in the number of physician assistants specializing in psychiatry over the last five years. This success indicates placing a sustained investment in student education can have a demonstrable impact on future practice decisions. This success also shows improving access to behavioral health care services is linked to removing barriers that inhibit the growth of health profession education programs. To that end, Congress should expand Medicare Graduate Medical Education (GME) specifically aimed at bolstering the pipeline of advanced practice providers.This would facilitate the growth of interprofessional teams, which have been shown to improve patient outcomes, increase operational efficiency, reduce burnout, and generate savings for health systems. The American Hospital Association offers an issue brief demonstrating the value of this team based care approach.

- **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?**

Oak Street Health strongly encourages Congress to expand the definition of who can successfully treat patients for behavioral and mental health needs. By recognizing the value of a broader swath of mental health providers, the nation can increase its ability to treat a greater number of individuals. At Oak Street, we have successfully demonstrated that mid-level providers - including Licensed Clinical Social Workers, Licensed Professional Counselors (LPCs) and Advanced Practice Nurses in Psychiatry - are vital providers who can help ensure the mental health needs of

Americans are met; we have also shown this expansion will not come at the expense of quality of care.

- **What are the best practices for integrating behavioral health with primary care?**

Oak Street Health's value based care model allows our providers the freedom to care for their patients in critical ways which the fee-for-service system does not. In our value based, fully capitated environment, it is unnecessary for providers to wonder whether or not a treatment plan is affordable for their patient, they simply have to ask, "will this care plan help my patient get better?" It is this value based structure which allows Oak Street's providers to fully integrate behavioral health into our primary care goals utilizing the CoCM structure, including screening nearly all of our patients for behavioral health needs and 92 percent for the social determinants of health. *That level of integrated behavioral and social observation is not possible in a fee-for-service structure.* We recommend four ways Congress can strengthen the ability of primary care providers who take on risk to further integrate behavioral health within primary care.

1. Congress can ensure increased access to quality mental health professionals by expanding the definition of who is eligible to treat Medicare beneficiaries and requiring core competency training in evidence based models such as CoCM.
2. Acknowledge Licensed Professional Counselors (LPCs) as eligible providers for Medicare beneficiaries.
3. Establish a national certification or fellowship in CoCM.
4. Incentivize organizations which employ health care providers to recruit and retain individuals with training in CoCM as well as culturally competent care.

- **What federal payment policies would best support care integration*?***

Moving more of the American health care financing system to a value based model is key to supporting care integration. Again, when we place emphasis on outcomes rather than services, providers are put in a better situation to focus on the health of their patients rather than the volume of their services. We recommend three ways payment policies can help better support care integration.

1. Congress can consider Medicare reform through the lens of Medicare Advantage with respect to supplemental benefit design. One example would be to ensure additional benefits are included in the benchmark calculation so the added cost is not transferred to the patient or that plan design excludes necessary care for the whole person. For example, when supplemental benefits are inclusive of solutions addressing social risk factors such as medically tailored meals (MTM) for food insecurity, providers who participate in value based care have increased flexibility to treat patient needs. Local small businesses can even partner with health plans and providers to offer meal delivery to the chronically ill. This works particularly well within a value based care structure as those organizations can

screen, diagnose and refer the patient for service. The small business can then participate in a shared risk contract for the total cost of care outcome for the patient. Together, Congress can set the stage for private and public partnerships to address basic unmet needs.

2. Congress can pass *S.870, The Improving Access to Mental Health Act of 2021*. Led by Senators Stabenow, Barasso and Sinema and co-sponsored by Senators Casey, Shaheen and Capito. This bipartisan legislation increases the Medicare reimbursement rate for clinical social worker services and alters the definition of clinical social worker services as it relates to Medicare.
3. Congress can increase coverage and payment in Medicare Advantage (MA) programs for patients presenting with Severe Mental Illness (SMI) with the expectation that participating providers will have multidisciplinary staff treat patients under this designation. By utilizing the existing authorities of MA Special Needs Plans (SNPs), which can be tailored explicitly to SMI, but also providing them with additional resources to accomplish what they were designed to do, providers will be better equipped to treat this population.

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

Technology plays an increasingly important role both in how providers deliver care but also how patients receive it. Oak Street Health employs several technology platforms which facilitate the high value care we provide. We have harnessed technology to enable our providers to effectively coordinate and engage with individual patients and each other. In our value based care structure, it would be beneficial to remove barriers related to additional authorizations for separate behavioral health information. To that end, we recommend eliminating laws and regulations which impede coordination of care between providers without offering patients much in the way of additional protection.

Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was first promulgated in 1975 to address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings such as administrative or criminal hearings related to the patient. While intended to protect the privacy of the patient, it prohibits coordinated care even with recent revisions. Under the 2020 revision, *Part 2* continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency, for the purpose of scientific research, audit, or program evaluation, or based on an appropriate court order. In practice, this burden is avoided by providers across specialities, including inpatient and outpatient settings, by simply not communicating with each other. In value-based care, however, this communication and timely case conferencing is fundamental as we monitor and intervene with patients across a continuum. This also presents unnecessary risk to patients when providers may be unaware of

potential medications and treatment plans. In order to continue protection of privacy to the patient yet drive clinical results, we encourage Congress to evaluate the opportunity to improve Title 42 and rewrite the rules around written consent. We advocate for consideration as a substitution for written consent proof of patient attribution to the treating provider practice and care team. Leveraging the medical home model and beneficiary roster, health systems can verify responsibility and engagement prior to disclosure and improve coordinated care across transitions.

A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions in a state. At a state level, PDMPs can monitor risk and impact clinical decision making and are one of our best tools in fighting the opioid epidemic. Congress should require both interstate data sharing and best practices for monitoring. A 2021 report recommends ways to increase data sharing beyond bordering states and require documentation of PDMP review prior to opioid prescribing.

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

At Oak Street Health, we have developed our own care management technology platform in which we work with health plan payers to obtain notifications for transfers and discharges. Oak Street has invested in our own product to allow data ingestion, integration and communication to key members on our care teams. We have implemented the Coleman Care Transition Intervention (CTI) Model, an evidence based coaching model, which utilizes the expertise of a Registered Nurse to follow high risk patients for 30 days after an admission. The intervention has demonstrated results in reducing readmission rates; however it is dependent on timely notification that the patient has been hospitalized. At Oak Street we are often notified of the admission after the patient has already been discharged for 1-2 weeks and we have missed the most critical window to intervene, identify medication errors, and offer social support. Some patients are even readmitted before we even know about the first admission. If Congress or CMS required more timely alerts and notifications that can integrate into our technology, our high touch relationship based interventions with people in the community will have a greater impact on outcomes. Improved handoffs and provider communication can have a positive effect on hospital readmissions, quality of care, and patient satisfaction, ultimately reducing overall health care costs while potentially avoiding CMS penalties for excessive rehospitalization rates. (NCBI, 2015).

In 2022, a new STARS measure will address transition in care gaps via two sub-measures rating provider timeliness of admission notifications and discharge summary retrieval. This is further impetus for hospitals and skilled nursing facilities to share timely data and information with community providers such as Oak Street Health. Additionally, another measure added in 2022 is *Follow Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC)*, requiring providers to follow up with patients within seven days of their emergency department visit. While the STARS measure places the burden of coordination on the primary care

provider, there are also opportunities for acute settings to support this effort. We offer the following recommendations CMS can use to support further collaboration across the continuum of care:

- ✓ Partner with state-based health information exchanges (HIEs) to obtain admission, discharge, and transfer (ADT) notifications for attributed patients.
- ✓ Partner with external ADT vendors in geographies where there is either a lack of adequate coverage via HIEs or HIEs do not exist.
- ✓ Improving the CMS *Conditions of Participation (CoPs*), specifically the *Interoperability and Patient Access Rule*, which requires hospitals, psychiatric hospitals, and Critical Access Hospitals, to share electronic event notifications, or e-notifications, with other providers across the continuum of care whenever patients have inpatient or emergency department care events. This will help improve ADT networks available via HIEs and vendors.
- ✓ Incentivize best practices such as deployment of care coordinators to obtain discharge summaries from hospitals and skilled nursing facilities using a combination of remote EMR access and fax requests.
- ✓ Increase requirements for hospitals around data sharing and interoperability to ensure timely receipt of discharge summaries to support medication reconciliation post-discharge, care coordination, and readmission prevention efforts.
- ✓ Support creation of uniform access to hospitals and skilled nursing facilities as an extension of the patient's primary care provider to meet with patients and inpatient teams in person rather than navigating credentialing and other related barriers.
- ✓ Evolve Health Information Technology (HIT) into a universal electronic health care language.

- **How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?**
- **How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?**

Too often, our nation's main way of assisting a person during a mental health crisis is to call the local police or fire department. However, in some communities, these first responders may experience minimal trust from those in crisis, a dynamic which could lead individuals to delay or avoid care when they need it the most; the CAHOOTS model successfully changes this situation. As a model for pre-hospitalization, CAHOOTS partners a non-clinical crisis worker with police to respond to a particular crisis. Because the workers are dispatched by police, the crisis worker can intercede with the right intervention and appropriate training. Congress can require and fund CAHOOTS model programs within states through both public and private partnerships. Rather than require current first responders to become crisis workers, we can train police dispatch operators and officers to recognize signs early while engaging trusted community members with expertise in this work. Post-crisis, the affected individual can engage with the service provider and, hopefully, interrupt these cycles and transition the person to stabilization.

We've also seen creative ways public and private partnerships can help connect people to non-clinical services that maintain wellness. For example, Illinois has implemented the CIT-Y program, *Crisis Intervention Team for Youth*, within the Chicago Police Department (CPD). The CIT-Y program is a five-day, 40-hour course for law enforcement officers on recognizing the symptoms of youth mental disorders, assessing risk levels youth have for hurting themselves and others, applying corresponding crisis de-escalation techniques, and, when appropriate, diverting youth from the juvenile justice system to community-based treatment services. We recommend Congress take action in this area via a four point approach:

1) Provide incentives for local police departments to require training for first responders in the recognition of mental health disorders and crisis
2) Provide incentives for partnerships with community service providers and first responders to act together during a known crisis
3) Fund additional resources required by community service providers to have public contracts to fulfill crisis responder roles.
4) Evaluate and reward community service providers for patient engagement in treatment post crisis to promote stabilization and prevent future crisis
    a) This could be monitored via existing reporting of admission and readmission related to mental health disorders

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?**

✓ Congress should enhance existing federal parity law by passing the *H.R. 1364, the Parity Enforcement Act of 2021*. This bipartisan legislation would strengthen the Department of Labor's authority over mental health parity.
✓ Congress should increase funding to support stronger federal agency oversight and enforcement of insurers' compliance with current federal parity law.

- **How can we better understand and collect data on shortfalls in compliance with parity law?**

Health plans should be required to submit their internal analyses to demonstrate that coverage is compliant with the Parity Law, including identification of all non-quantitative treatment limitations (NQTLs) and their application. Regulatory agencies should develop model contracts that fully describe mental health and substance misuse benefits, align standards with Parity Act requirements and inform consumers of their rights under the law. (LAC, 2017)

- **How can Congress ensure that plans comply with the standard set by *Wit* v*. United Behavioral Health?***

Regulatory Agencies should enhance the provider community's capacity to identify potential violations and advocate for plan compliance in network adequacy and rate setting standards.

- **Are there other payer practices that restrict access to care and how can Congress address them?**

Congress should develop policies that will broaden providers' scope of practice while improving workforce mobility, including telehealth, to encourage innovation and to allow providers to more easily meet patients' needs. Congress can do this by promoting choice and competition in provider markets, including state action to repeal or scale back Certificate of Need laws and encourage the development of value-based payment models that offer flexibility and risk-based incentives for providers, especially without unduly burdening small or rural practices.

- **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*?***

Access to care is greatly impeded by timeliness to an appointment. Oak Street Health's collaborative care model leverages task-sharing and the strength of a team to deliver person-centered, evidence-based treatment of common mental health problems, such as depression and anxiety, in primary care settings with the goal of same-day, next-day access.We also provide transportation to appointments via our own van service to 100% of Oak Street patients.

- **How could Congress improve mental health parity in Medicaid and Medicare?**

Improvement of mental health parity in Medicaid and Medicare can be achieved via focusing on access to high quality care. There are two barriers to access and quality at this time that Congress can address:

✓ Co-insurance discrepancies in mental health services
✓ Recruitment and retention of qualified professionals.

Congress should ask CMS to do an evaluation of private plan patient responsibility for co-insurance, particularly for out of network care. While the mental health parity laws have reasonably impacted access to care, co-payments by patients are disportionately higher for mental health services than medical ones largely because mental health networks are inadequate and beneficiaries are forced to seek out of network care resulting in significantly higher out of pocket patient costs. In fact, patients are six times more likely to receive out of network mental health care

as opposed to traditional medical care. In order to better understand the inequity in financial responsibility to the patient and the barriers that may impact access, we propose a review of all health plan co-insurance expectations and continue dedicated work on examining network adequacy in mental health. The review will provide visibility and insight into how patients continue to delay or avoid care when they are unable to pay for services.

Expanding Telehealth

- **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?**

The COVID-19 pandemic has unleashed a significant and positive change in the comfort Americans have with receiving medical care in a telehealth setting.This has been particularly true for behavioral health care.There is also now a significant body of literature - and our own experience at Oak Street Health - which supports the equivalent quality of telehealth to treat mental health needs. Specific to our value based model of integrated behavioral health care, a recent systematic literature review supports the efficacy of remote or Tele-Collaborative Care Models (CoCM) in depression, anxiety, and post traumatic stress disorder (PTSD). Given the relative ease of telehealth engagement - and provided a patient has access to the internet or a phone - this modality has the added benefit of ameliorating longstanding geographic barriers to access resulting in improved care continuity.

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

Congress should craft policies taking into account multiple modalities of engagement, including audio-only forms of telehealth, which not only have the benefit of providing quality care but also can expand access. Current disparities driven by lack of broadband access and technological savvy can be overcome if patients have the opportunity to select their preferred modality of engagement from a menu of options, including some “lower tech” options such as phone or audio-only.

We understand there is concern in Congress about the possibility of over-utilization for telehealth services and, in particular, audio-only modalities. This is not an issue in value-based and fully capitated structures such as Oak Street Health. Due to the fact that our providers focus on what is necessary for their patients to get better rather than billing for a specific service rendered, we are able to have as many, or as few, telehealth interactions as is necessary to meet the care objective, which is to get our patients better and keep them healthy.

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

The expanded scope of Medicare coverage has been critical in enabling millions of Americans to receive needed mental and behavioral health services during the ongoing pandemic, which has concurrently resulted in a sharp increase in diagnosis for anxiety, depression, substance misuse disorders and other behavioral health conditions. This dynamic has brought about an unprecedented expansion of access, many times via telehealth, to behavioral health services, particularly to those Americans who have traditionally had significant geographic barriers to mental health care in rural regions. In the past three years, our mental health staff has grown ten fold across our states and we are able to offer telepsychiatry consultation to over 100 communities. In the past year, we have screened almost all of our patient population for behavioral health needs and enrolled in treatment the nearly 60% of patients who are shown to be at risk for depression. This would have been impossible without the expanded scope of Medicare coverage of telehealth. We encourage Congress to maintain the expanded scope of telehealth to ensure individuals who recently gained behavioral health access do not lose it and also to ensure organizations such as Oak Street Health can continue to offer services in new areas to as many patients as possible.

- **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?**

We see audio only forms of telehealth as not only highly effective - but also accepted - modalities as we aim to remain proactive with our behavioral health interventions and upstream social support, including addressing food insecurity, housing and other social determinants of health. One way we can leverage current financing mechanisms to support expansion of audio-only forms of care is by expanding the Behavioral Health Integration codes to include this service.

- **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?**

From a clinical perspective, the visual component is most helpful during the initial encounter with a patient, particularly if the patient may be suffering from a severe psychotic illness such as schizophrenia. Fortunately, the prevalence of schizophrenia and related psychotic disorders in the United States is relatively low at between 0.25% and 0.64% of the population. Group-based psychotherapy is also challenging without the visual component given the risk of participants talking simultaneously and the innate barrier to reading the non-verbal communication in the “room” for both the therapist and the participants.

- **For which specific mental and behavioral health services is there no clinically meaningful difference between audio visual and audio-only formats of telehealth?**

We have found no clinically meaningful difference between audio visual and audio-only formats of telehealth in the following interactions within the traditional Collaborative Care Model (CoCM) we employ:

✓ Collecting PHQ-9 and General Anxiety Disorder-7 data
✓ Traditional follow-up outpatient psychotherapy
✓ Medication management/Evaluation and Management visits when treating patients with mild to moderate depression (unipolar or bipolar), anxiety, or PTSD

- **How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?**

Acute and severe presentations present additional challenges within a telehealth visit. That said, we are comfortable managing any clinical presentation via telehealth as long as pre-defined risk and safety protocols are in place around suicidal and homicidal ideation and grave disability secondary to severe depression, mania, or psychosis. There will be times when local authorities must be called to a patient's home to initiate the process of inpatient psychiatric admission and clinicians must have clear direction about what to do in these acute, often stressful situations.

- **How should Medicare pay for the practice expense portion of Medicare's telehealth payment for mental and behavioral health services?**

Given our fully capitated, value-based structure which already includes coverage of the "practice expense" portion of telehealth payment, Oak Street Health will continue our successful hybrid approach to care which is enabled by our up-front funding model. We will ensure this model is proactive, flexible, and inclusive of multiple modalities including in-person care, audio-visual care with the patient located in one of our centers, audio-visual care into the home, and audio-only into the home. In addition, **we strongly advocate for increasing coverage and payment in Medicare Advantage (MA) programs for patients presenting with Severe Mental Illness (SMI) with the expectation that participating providers will have multidisciplinary staff treat patients under this designation.**

- **Should the practice expense resources needed for telehealth forms of these services be independently measured, or should Medicare rely on the practice expense values used for in-person forms of Medicare payment for the services?**

As shared above, we believe a clinically targeted hybrid model is the most efficient and appropriate path forward. We urge Congress to continue to move towards models which, Oak Street Health

has proven, provide patients with superior care - a capitated, value-based PMPM rate appropriate for the severity of a certain population. This rate should be adequate to fund a high-functioning, proactive hybrid behavioral health model inclusive of both in-person and telehealth interventions. These rates should be linked not only to the severity of diagnosis but also the complexity of the patient being served. At Oak Street Health, we constantly work to remove any obstacles to care faced by our patients. Many of these obstacles are associated with the social determinants of health and must be taken into consideration when ensuring a patient receives the care they need. As we point out earlier in this letter, any payment should reflect this complexity and incentivize obstacle-removal in addition to direct access to care. In Medicare Advantage in particular, it would be beneficial to ensure any additional benefits are included in the benchmark calculation so the additional cost is not transferred to the patient or that plan design excludes necessary care for the whole person.

- **What safeguards should be included for beneficiaries and taxpayers*?***

We are ardent supporters of our capitated, value-based model of care incentivizing meaningful, proactive primary and behavioral care to achieve and maintain health as opposed to over-utilization of downstream “sick” care via fee-for-service telehealth services. Capitated, value-based models with aligned incentives and concurrent measures of quality care inherently provide safeguards to both beneficiaries and taxpayers.The professionals within these provider organizations are incentivized to offer the correct amount of care to achieve health amongst their patient panels. In order to monitor that adequate care is being provided within these models, payer quality metrics are employed to demonstrate adequate utilization, evidence-based processes of care, and target health outcomes.

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

Beyond promoting a transition to capitated, value-based models of care as delineated above, legislative action to permanently expand telehealth to include audio-only forms of interaction would increase access to care within our current model and have a positive impact on the efficiency and cost-effectiveness of our upstream interventions.

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

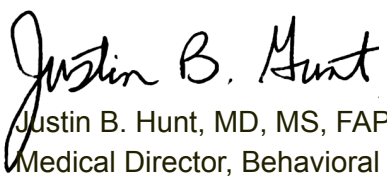
First and foremost, uneven broadband distribution across geographies is a major impediment to telehealth utilization. **By expanding broadband to areas where it is not reliable or available, Congress will also increase access to health care services - and we should look at the two as linked.** In addition, technological knowledge of - and comfort with - personal computer or mobile-based audio-visual telehealth technology, including camera and microphone management,

and basic skills around linking to WIFI versus a cellular signal are challenges our providers consistently face with our patients.

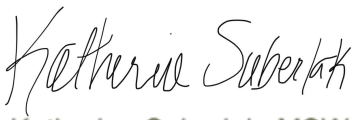
Conclusion

Thank you for the opportunity to respond to your Request for Information. Mental and behavioral health along with substance misuse are critical issues facing the American people. Oak Street Health appreciates your interest in this area and stands ready to work with each of you and your Senate colleagues to improve these essential services, including the transition to value based care overall. If you would like to talk further about Oak Street Health, our model or any other health care related matters, please feel free to contact Andrew Schwab, our Vice President & Head of Government Affairs at andrew.schwab@oakstreethealth.com.

Sincerely,



Justin B. Hunt, MD, MS, FAPA
Medical Director, Behavioral Health



Katherine Suberlak, MSW
Vice President, Clinical Services