Statement for Hearing on
"Americans in Need: Responding to the National Mental Health Crisis"

House Committee Energy and Commerce
Oversight and Investigations Subcommittee

February 17, 2022

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. AHIP appreciates the Committee's focus on the ongoing mental health crisis in the United States. Our members strongly share your commitment to increase access to quality, affordable behavioral health care, including both pediatric and adult mental health care and treatment for substance use disorders (SUD) in the context of whole-person care. We look forward to working with you to achieve these goals.

Health insurance providers engage in a wide variety of activities and programs designed to improve behavioral health care access, quality, and value for their members. Our member companies promote policies that protect patient safety, emphasize evidence-based care, drive better health outcomes, and support quality and affordability. In addition to offering behavioral health benefits on par with medical and surgical benefits in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), health insurance providers are pioneering innovative programs to improve the behavioral health of their members. The industry is raising patient awareness of the importance and availability of behavioral health care, working to reduce stigma, integrating behavioral health care with primary care, collaborating with providers, and proactively identifying and addressing each individual's behavioral health needs.

In addition to widespread elevation in stress, anxiety, and depression, COVID-19 has exacerbated a loneliness crisis in America, which is why health insurance providers have made resources available to help people find ways to manage isolation and loneliness throughout this time of extraordinary social distancing. AHIP has also partnered with Psych Hub, a COVID-19 Mental Health Resource Hub coalition. Psych Hub was created to address the need for quality and engaging online education resources for consumers and providers on timely and essential

topics, including mental health, substance use, and suicide prevention. Moreover, health insurance providers have been leaders in supporting access to telehealth, including tele-behavioral health services, the need for and utilization of which has been accelerated by the pandemic.

Strengthening the Mental Health Workforce

Challenges in accessing behavioral healthcare are longstanding and multifaceted. Key among them is the availability and supply of behavioral health providers. Challenges to accessing behavioral health care long pre-date COVID and have been exacerbated by the increased need resulting from social isolation, fear and uncertainty, economic factors, and other challenges resulting from the pandemic.

One estimate projects that by 2030, there will be a 20% decrease in the supply of adult psychiatrists. This same estimate, however, indicates that the supply of other types of behavioral health providers – nurse practitioners, psychologists, school counselors, and others – will exceed the demand for them. Aligning supply and demand with licensed authority, skill and experience will be critical to assuring that people have access to high quality, evidence based behavioral healthcare.

There is also relatively low participation of behavioral health providers in health insurance plan provider networks. Provider participation is a complicated issue that can be affected by rate of payment but is also influenced by whether the provider has capacity to take on additional patients and their willingness to participate in the administrative, quality and oversight requirements of health plans and public programs.

AHIP members believe that providers should receive training and be able to deliver culturally competent care. We support training of providers and staff on cultural competency, cultural humility, unconscious bias, and anti-racism in order promote empathy, respect, and understanding among provider networks and between providers and their patients. In addition, AHIP members believe in promoting diverse provider networks that reflect the communities they serve so that beneficiaries can find providers that meet their needs and preferences. This includes provider and practitioner demographic diversity as well as diversity of staff and care team members. As part of our efforts, AHIP is exploring solutions to facilitate a standardized approach to collecting provider demographic data to inform member choice. Two promising policy options are partnering with state medical licensure boards or using the National Provider and Plan Enumeration System (NPPES) as data collection vehicles.

AHIP supports legislative policies that provide incentives for individuals to enter the behavioral health field. These could include:

- Increasing funding for loan repayment programs for providers who enter the behavioral health field;

- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include behavioral health care professions with an additional emphasis on promoting workforce diversity;
- Increasing the number of graduate medical education (GME) slots allotted to behavioral health providers;
- Expanding the behavioral health provider types covered under Medicare, such as certified peer support specialists, licensed professional counselors, and licensed mental health counselors; and
- Providing funding to CMS to collect provider demographic information in NPPES and requiring CMS to share that information with all health plans.

Pediatric Mental Health

During the COVID-19 pandemic, children have experienced major disturbances as a result of pandemic mitigation measures – including social distancing, school and childcare closures. Parents have reported poor mental health effects in their children since the beginning of the pandemic. In May 2020, in the beginning of the pandemic, a Gallup poll found that 29% of parents report that their child's or children's mental health was already worsen by the pandemic.[1]

Prior to the pandemic, many children were living with mental health disorders. On average in the years leading up to the COVID-19 pandemic, among youth between the ages of 3-17, 2.3 million reported having depressive disorder and 5.2 million reported having anxiety disorder.[2] However, according to CDC, only about 20% of children with mental, emotional, or behavioral disorders receive care from a specialized mental health care provider.

The same strategies for addressing shortages of behavioral health providers in general can be targeted to promote recruitment of behavioral health providers specializing in children's behavioral health care, including:

- Increasing funding for loan repayment programs for providers who enter the behavioral health field and specialize in children's behavioral health care;
- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include behavioral health care professions, including those that specialize in children's behavioral health care;
- Increasing the number of GME slots allotted to behavioral health providers, including those that specialize in children's behavioral health care; and
- Supporting telehealth and hub-and-spoke models (e.g., Project ECHO) to maximize child behavioral health resources.

Behavioral Health Integration

[1] https://news.gallup.com/poll/312605/parents-say-covid-harming-child-mental-health.aspx
[2] https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/

Because the front door to health care for most individuals is their primary care provider (PCP), making that primary care practice a one stop shop for people's physical and behavioral health needs can significantly increase the identification of behavioral health needs and the accessibility of behavioral health services. That's why health insurance providers are exploring different ways to integrate behavioral health care with primary care.

Integration of physical and behavioral health can provide multiple benefits to patients, including earlier diagnosis and treatment, better care coordination, timely information sharing, improved outcomes, and improved patient and provider satisfaction. Many people with behavioral health conditions also have other chronic medical conditions. Integrating behavioral health with primary care can allow for earlier diagnosis and better coordination of care for patients with multiple complex physical and behavioral health conditions. Also, while PCPs often prescribe many, if not most, medications used to treat behavioral health conditions, they often prefer consultation with psychiatrists/clinical psychologists for certain more serious mental health conditions and atypical psychotic drugs. Finally, PCPs are accustomed to doing measurement-based care and reporting quality metrics, which may be helpful as we work toward greater use of measurement-based care and improve quality measurement in the area of behavioral health care

The Center for Integrated Health Solutions, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), has developed a framework for levels of integrated healthcare, on which the Center for Health Care Strategies has based its continuum of behavioral health integration models. This integration continuum includes models that emphasize coordinated care through screening and consultation, models that supplement that care coordination with care management and co-location, and models that are more fully integrated at the health home or system-level. Along this continuum, there are several best practices for integrating behavioral health with primary care.

The Collaborative Care Model (CoCM) is one such model designed to promote integration that many health insurance providers have implemented with their primary care partners. This model of integration includes care management support for patients receiving behavioral health treatment and psychiatric consultation. While some providers and health systems have implemented the CoCM, uptake among providers has been slow, with start-up costs, complexity, and the need for technical assistance often cited as barriers to more widespread adoption. Many health insurance providers reimburse the codes available to support CoCM and some also provide technical assistance to help providers implement this model. In addition, some health insurance providers are also partnering with technology companies that provide solutions to their provider partners to help them implement CoCM.

Legislation like the Collaborate in an Orderly and Cohesive Manner (COCM) Act (H.R. 5218), which would not only provide primary care practices with start-up funds and technical assistance to adopt the model but would also fund research to build the evidence base for other models of integrated behavioral health care, is an important step in moving toward greater adoption of integration models.

In addition to the CoCM, many health insurance providers have promoted integration and team-based care through other effective approaches, including enhanced referral, expanded case management specific to behavioral health conditions, and value-based payment arrangements. These approaches rely on behavioral health and medical care managers coordinating and communicating across providers to support patients with co-morbid conditions and value-based payment incentives to encourage providers to integrate care for patients with both physical and behavioral health needs.

The range of approaches currently underway underscores the importance of flexibility and recognition that physician practices are at varying stages of readiness in their ability to deliver fully integrated physical and behavioral health care. It is important to note that all of these approaches rely on team-based care that includes PCPs using validated behavioral health screening and assessment tools to identify patients in need of services, referral/consultation arrangements and partnerships with behavioral health specialists, care management by health care professionals trained to coordinate care across behavioral and medical conditions, education and training resources to support providers, and, as discussed in more detail below, quality measurement to assess effectiveness. Acknowledging the importance of patient-centered outcomes, AHIP recommends:

- Creating flexibilities in payment policies that allow Medicare, Medicaid, and the commercial plans the ability to innovate and test new care models;
- Additional research to further build the evidence base for effective models of integrated behavioral health care; and
- Increasing funding to support provider readiness for behavioral health integration via funding for start-up costs, care coordinators, and educational resources for providers.

Measuring the Quality of Behavioral Health Care

Value-based purchasing (VBP) and alternative payment models (APMs) offer an opportunity to improve access to quality behavioral health care by incentivizing more clinicians to join payer networks and encouraging adoption of high-quality, evidence-based care standards. However, the quality and strength of available evidence and standards for assessing mental health and substance use disorder treatment trail behind other medical and surgical treatments. Moreover, where quality measures do exist, only a few are widely implemented, minimizing the ability to affect data-driven change for behavioral health services within VBP and APMs.

The Core Quality Measures Collaborative (CQMC) is a broad-based coalition of health care leaders convened by AHIP and the Centers for Medicare and Medicaid Services (CMS) to facilitate the transition to value-based care and identify best available performance measures that could be implemented across public and private payer programs to decrease the burden on clinicians. CQMC members include health insurance providers, medical associations, consumer groups, purchasers, and other quality collaboratives working together to recommend core sets of measures by clinical area. The CQMC aims to improve the quality of information available for consumers and purchasers and decrease operational challenges for providers and payers.

In addition to the inclusion of several behavioral health measures in the ACO and PCMH Primary Care Measures core set, in 2020 the CQMC undertook a review the measures that are currently available and could be used to assess the quality of behavioral health care at the clinician level. This effort culminated in a consensus core set of behavioral health measures that can be used to drive improvement in high priority areas. The measures address conditions including attention deficit hyperactivity disorder, depression, serious mental illness, and tobacco, alcohol, and other substance use. These core measures represent an important first step to aligning measures and promoting the inclusion of behavioral health in VBP and APMs.

Increasing the creation, use, and availability of performance measures addressing behavioral health is of the highest importance to the CQMC. A key part of this work is identifying gap areas for future consideration and measure development, as well as providing feedback to measure developers early in the process to ensure the final product meets the needs of the broad stakeholder community.

One challenge to developing better measures of the quality of behavioral challenges is the lack of standardized data on patient symptoms and disease burden. While improvement in physical illnesses can be tracked through clinical test results and vital signs easily extractable from an electronic health record, information on improvement in behavioral health often comes directly from the patient. Measurement-based care (MBC) is the practice of basing care on data collected from the patient throughout treatment. This data could also be leveraged through patient-reported outcome-based performance measures (PRO-PMs). However, MBC is not currently used consistently in clinical practice. Performance measures could be developed to assess the use of MBC; alternatively, measures could be developed to assess patient outcomes. Greater use of PRO-PMs would offer the opportunity to ensure care is helping patients meet their goals while rewarding clinicians and providers for furnishing high-quality care. Continued investment and participation in measure development and implementation will help drive improved outcomes.

We encourage Congress to support efforts to improve quality measurement in behavioral health by continuing and enhancing the appropriation for the consensus-based entity authorized under section 1890(a) of the Social Security Act to provide input on quality measure endorsement, selection, and input. This, in part, supports the CQMC gathering stakeholders from across the industry to determine the best available performance measures to support the transition to value-based care and seek to jointly overcome the hurdles to broader adoption. These efforts also minimize the burden on clinicians while providing consumers with better information to support their decision making. Such funding could also support the transition to digital quality measures that could facilitate the assessment of patient-reported outcomes. This will be essential to implementing MBC and to understanding its effectiveness. In addition, Congress could support both measure development as well as the creation of standards to facilitate the electronic transfer of the required data. Finally, Congress should support the development of measures of health equity. In building out more robust measurement in behavioral health, we should be moving to more patient-centered measures that harness technology and reduce disparities.

Telehealth is a Critical Tool to Behavioral Health

Patients, providers, and health insurance providers all appreciate the value of telehealth. Patients can access telehealth from wherever they are, making it a vital tool to bridge health care gaps nationwide. Patients accept – and often prefer – digital technologies as an essential part of health care delivery including the delivery of mental health and substance use disorder (SUD) services. Those accessing behavioral health services can do so from the privacy of their own homes and free from the stigma associated with seeking care in brick-and-mortar settings for mental health conditions. For patients in rural communities and other underserved areas with fewer practicing providers, telehealth can make behavioral health care more convenient, accessible, efficient, and sustainable. Patients who access care remotely can also avoid challenges associated with taking time off from work, arranging transportation, or finding childcare. Telehealth is a tool that can connect patients with care in convenient, comfortable settings and can also allow providers to see patients more efficiently, helping to increase availability and hence access to care. However, it cannot solve longstanding workforce shortages.

Health insurance providers are committed to ensuring that the people they serve, regardless of where they live or their economic situation, can access high-quality, safe, and convenient care. That's why they embrace telehealth solutions that help increase access to care.

Insurance providers are working, alongside other stakeholders, to address concerns of a "digital divide" that could be triggered through increased use of virtual care tools. AHIP has supported federal programs that support the elimination of barriers to telehealth which could provide avenues for increased access to mental health services.[3] [4] To that end, many health insurance providers are working with their provider partners to offset access barriers by increasing access to audio-only telehealth and by providing access to equipment like smartphones or Wi-Fi. Insurance providers are enthusiastic about the increased use of clinically appropriate telehealth that we have observed throughout the course of the COVID-19 pandemic and encourage Congress to continue to enable its continued expansion.

The telehealth flexibilities put in place during the ongoing COVID- 19 public health emergency, such as waiving originating site requirements for telehealth services under Medicare and allowing reimbursement of more video-enabled telehealth and audio- only telehealth services have proven critically important to the delivery of care throughout the pandemic.

Taken together, actions taken by Congress and the Administration, many of which were adopted across Federal programs and in commercial plans, allowed for increased access to telehealth for both patients and providers, leading to exponential growth in use especially for those in need of behavioral health services. Data shows that over 60% of telehealth use is for behavioral health care.[5]

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[3] https://ahip365.sharepoint.com/:b:/g/EWUf6Q7R2yBBivGcBry9JEoB8Ms6gHspfYfW9V6-5U2cdg?e=ykWhFf
[4] https://ahip365.sharepoint.com/:b:/g/EcED3OwI2dhHgsMmxFens-MBJaXn2pf54kJGbLjjKeOyyQ?e=EpT1BU
[5] https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/nov-2021-national-telehealth.pdf

We support the efforts of the Administration to extend the availability of telehealth to the extent they are able to do so, especially the provisions related to behavioral health services included in CMS' 2022 Physician Fee Schedule rule. These provisions eliminated geographic restrictions for the use of telehealth services to diagnose, evaluate, or treat a mental health condition and those which make the home a qualifying originating site.

However, legislation is required to permanently authorize these key evidence-based reforms under Medicare. We encourage Congress to act to protect health insurance providers' flexibilities in creating telehealth programs and other virtual care solutions that will best serve the needs of their members and can provide convenient access to high-quality behavioral health services in an equitable manner across all populations and communities.

We encourage Congress to consider measures to permanently eliminate geographic restrictions for all telehealth services and to eliminate originating sites entirely, so that patients can access care where and when they need it. Additionally, the CARES Act permitted pre-deductible coverage of telehealth in high-deductible health plans in 2020 and 2021 allowing millions of people increased access to care. We support the Telehealth Expansion Act of 2021 which would provide a permanent extension of that authority.

We also ask that Congress pass the bipartisan Ensuring Parity in MA for Audio Only-Telehealth Act (H.R. 2166). This legislation would help ensure seniors and individuals with disabilities continue to have access to clinically appropriate audio-only telehealth which, while less preferred than video enabled care, has proven to be an effective source of care for many Medicare beneficiaries throughout the course of the COVID-19 public health emergency, particularly individuals who are unable to use or access video enabled devices. This legislation would ensure that individuals who use audio-only telehealth services are treated by Medicare in exactly the same way as individuals who receive care and treatment in person or via video-enabled telehealth, ensuring that the high value care and important supplemental benefits provided by Medicare Advantage (MA) remain available to all beneficiaries regardless of how they choose to access care.

Mental Health and Substance Use Disorder (SUD) Treatment

The opioid epidemic continues to affect communities across the nation and many people who suffer from mental illness and/or SUD are facing many additional challenges resulting from social distancing, economic pressures, ongoing uncertainty, and shifting priorities for health care resources arising from the current pandemic.

As the demands for medical resources have focused on the immediate needs of patients with COVID-19, clinicians, care teams, and health insurance providers must find new ways to meet the ongoing needs of people suffering from mental illness and SUD. Insurance providers are working with clinicians and recovery teams to deliver necessary care to those in need and are exploring new ways to deliver those services. As discussed, telehealth has rapidly gained traction

as a means of delivering high quality care while protecting patients and clinicians from the spread of COVID-19. As mentioned above, telehealth has effectively connected patients with counseling, peer support, and other behavioral health services remotely to support access to care on an ongoing basis. For example, tools used to host conference calls for office workers can also be used to connect SUD patients with support groups.

In addition to preserving telehealth flexibilities and allowing audio-only provider visits, AHIP supports Drug Enforcement Administration (DEA) actions that allow providers to prescribe controlled substances via telehealth without a prior in-person exam, including medications such as buprenorphine to treat opioid use disorders. Some insurance providers have waived rules to allow virtual behavioral health practitioners to be the sole health care providers for SUD patients, rather than acting only as complementary to in-person care. Easing the DEA rules makes prescribing medication-assisted treatment (MAT) easier for more providers which can be particularly helpful when patients are unable to access in-person care. Insurance provider initiatives to address gaps in treatment can also help assist patients in accessing needed care. Remote monitoring for other physical conditions can also be used to maintain a connection between a patient and provider to identify and address potential issues and promote good physiological health in addition to good mental health.

Additionally, AHIP supports the recent efforts to modify the DATA 2000 waiver that expands the types of clinicians who are eligible to prescribe MAT and the number of patients they can treat and incorporates MAT training into medical school curriculum. We encourage Congress to consider further action and to eliminate the need for a separate waiver to prescribe buprenorphine entirely, such as through passage of the Mainstreaming Addiction Treatment Act (H.R. 1384). Congress should also explore ways to further expand treatment access through other actions to support providers, like providing or requiring continuing medical education (CME), training, tools, care plans, and other resources to encourage providers to work with patients suffering from SUD.

Mental Health Parity

As mentioned above, health insurance providers recognize the importance of coverage for behavioral health and are deeply committed to delivering person-centered care to improve the overall health of each member. The current public health emergency has further highlighted the importance of a robust behavioral health care infrastructure. Moreover, health insurance providers have worked diligently to implement the protections afforded by the Mental Health Parity and Addiction Equity Act (MHPAEA) by engaging clinical and administrative personnel across medical, behavioral, and pharmacy departments to promote understanding and implementation of the parity rules.

Recently, Section 203 of the transparency provisions in the Consolidated Appropriations Act (CAA) granted the Department of Labor (DOL), CMS, and states authority to request comprehensive comparative analyses of plans' application of nonquantitative treatment limitations (NQTLs) to behavioral health and medical/surgical benefits. While AHIP appreciates

recent efforts by DOL and CMS, the examples and details released to date meet neither the depth nor specificity of the analyses described in CAA and in FAQs Part 45, which are comprehensive and contain multi-part analyses and documentation. DOL's Self-Compliance tool offers some examples of compliant and noncompliant NQTLs, but more detail is needed. In order to comply with the requirements of the CAA, plans and issuers need DOL and CMS to develop and provide model or sample analyses that demonstrate compliance across the different types of NQTLs. These completed analyses should include samples of documentation and data that would support the analyses and the determination of compliance.

In addition to ensuring DOL and CMS provide plans with the information necessary to demonstrate compliance, Congress should not pursue additional legislation related to MHPAEA enforcement until these issues are addressed by the agencies and health insurance providers have had a reasonable opportunity to demonstrate compliance.

Conclusion

Mental health is an important part of a person's overall health and well-being. Health insurance providers are working everyday with people, providers, and communities to ensure access to mental health care and support. As a result, we are making progress, and more people are getting the treatment they need. But we acknowledge the need to do much more. We need more behavioral health experts, more robust accreditation standards to ensure patients are getting good care, and continued integration of mental health into patients' overall health care. AHIP appreciates the Committee's increased focus on this important issue. We look forward to working with you to develop solutions to enhance mental health care access and affordability.