National Association for Behavioral Healthcare

Access. Care. Recovery.

1 November 2021

Sen. Ron Wyden
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Sen. Mike Crapo
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Proposals to improve access to mental health and addiction treatment services

Dear Chairman Wyden and Ranking Member Crapo:

The National Association for Behavioral Healthcare (NABH) is pleased to submit the following recommendations for changes to Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplace plans that would improve access to mental health and addiction treatment.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs including providers of medication assisted treatment (MAT). Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

The United States was already experiencing multiple behavioral health crises, even before the Covid-19 pandemic. Although overall overdose deaths had declined slightly in 2018, the number of people dying from overdoses of synthetic opioids, cocaine, and psychostimulants had increased at an alarming pace.[i] Rates of suicide had also been rising steadily, up 35% between 1999 and 2018.[ii] Serious behavioral health conditions had become so prevalent and elevated, they were driving down overall life expectancy.[iii]

The pandemic has highlighted and amplified the need for improved access to mental health and addiction treatment. Studies have consistently found significantly higher levels of anxiety and depression and suicidal ideation.[iv, v] In addition, alcohol consumption has increased significantly.[vi] Drug overdose deaths increased almost 30% in 2020 to more than 90,000 deaths, the highest number ever recorded over a 12-month period.[vii] Although suicide rates seemed to have leveled off and decreased last year,[viii] there have been troubling increases in suicides and suicidal ideation among certain subgroups including Black Americans[ix] and adolescent girls.[x]

Moreover, experts expect mental health and substance use disorders to remain elevated for many people long after the pandemic ends. Experiences with epidemics in the past indicate that the impact on behavioral health may continue for years to come.[xi]

We applaud the Finance Committee for examining behavioral healthcare needs and assessing the factors contributing to gaps in care. We include a summary of our recommendations below and provide details in the following pages.

Ensuring Parity

1. **Extend Medicaid coverage to inpatient psychiatric hospitals that are part of a continuum of care.**
2. **Clarify that parity rules require the IMD exclusion not apply to Medicaid managed care.**
3. **Apply parity to Medicaid fee-for-service coverage and clarify that the IMD exclusion is preempted.**

4. **Extend new parity compliance documentation requirements to Medicaid and CHIP.**
5. **Require federally regulated health plans to base utilization management on generally accepted standards of care.**
6. **Establish additional benefit classification in parity rules for intermediate level of care.**
7. **Eliminate the Medicare 190-day limit on care in psychiatric hospitals.**
8. **Apply parity to Medicare Advantage plans along with requirements to use generally accepted standards of care for utilization management and stronger network adequacy rules.**
9. **Increase Medicare Advantage accountability for access to mental health and addiction treatment.**

Expanding Telehealth

1. **Ensure continued Medicare coverage of audio-only telehealth for mental health and addiction treatment.**
2. **Eliminate in-person visit requirement for Medicare coverage of telehealth for mental health services.**
3. **Continue Medicare coverage of audio-only telehealth for behavioral health services without in-person visits.**
4. **Require guidance clarifying that Medicare reimbursement for telehealth is equivalent to in-person services for mental health and addiction treatment.**
5. **Ensure continued Medicare coverage of partial hospitalization services and intensive outpatient program services for mental health via telehealth including facility fees.**
6. **Expand Medicare to cover partial hospitalization services for addiction treatment including via telehealth.**
7. **Allow mental health and addiction treatment services to be provided via telehealth across state lines.**

Strengthening Workforce

1. **Allow nurses and other practitioners to operate to the full extent of their licenses.**
2. **Reduce regulatory burden to prevent resources being drawn away from providing services.**
3. **Improve Medicare reimbursement for behavioral healthcare providers.**
4. **Exempt increased reimbursement for behavioral healthcare providers from Medicare budget neutrality requirements.**
5. **Clarify and expand the Medicare "incident to" policy allowing additional practitioners to provide behavioral healthcare.**

6. **Remove Medicare requirements that clinical psychologists be supervised by psychiatrists in partial hospitalization programs.**

Increasing Integration, Coordination, and Access

1. **Provide subsidies for behavioral healthcare providers to implement electronic health records.**
2. **Improve Medicare coverage for full continuum of addiction treatment.**
3. **Extend Medicare and Medicaid coverage of contingency management services.**
4. **Make Medicaid mandatory coverage of MAT permanent and ensure compliance.**
5. **Improve Medicaid and CHIP coverage for low-income mothers.**

Improving Access for Children and Young People

1. **Exempt Qualified Residential Treatment Programs (QRTPs) from the IMD exclusion and require compliance with seclusion and restraint rules.**
2. **Strengthen Medicaid and CHIP coverage of behavioral healthcare.**
3. **Increase accountability of Medicaid and CHIP for ensuring access to behavioral healthcare for children and adolescents.**
4. **Incentivize states to continue Medicaid and CHIP coverage of telehealth.**

Ensuring Parity

Rising rates of suicide and overdoses highlight the need for improved access to acute care for serious mental illness (SMI) and substance use disorders (SUDs). Acute care for individuals with severe behavioral health conditions is generally provided in psychiatric hospitals and residential treatment facilities that offer safe environments, treatment teams, and intensive programs to help stabilize individuals who are determined to be a danger to themselves or others, or who are so gravely disabled they cannot care for themselves. However, Medicaid does not generally cover care provided in these settings due to the statutory "Institutions for Mental Diseases" (IMDs) exclusion, and Medicare limits coverage of inpatient care in specialized settings to 190 days total over a beneficiary's lifetime. Both limitations are inconsistent with the principle of parity.

Fully Implement Parity in the Medicaid Program

As the single largest payor of behavioral healthcare services, Medicaid plays a significant role affecting the availability of mental health and SUD services. Accordingly, the IMD exclusion has contributed to a rapid decline in availability of acute care for individuals with SMI or severe addiction. Since 1970, five years after Medicaid was established, the number of inpatient and residential treatments beds has decreased by at least 64%.[xii]

This decline in availability of acute care has resulted in tragic outcomes for many individuals with serious behavioral health conditions, including high rates of incarceration. The book *Insane: America's Criminal Treatment of Mental Illness"*[xiii] estimates that about half the inmates in U.S. jails and prisons have mental illnesses. Millions of individuals with SMI and SUDs are booked into jail every year; many for minor crimes such as loitering or vagrancy.[xiv] They tend to stay in jail far longer than other individuals and often do not receive needed behavioral health treatment.

Another result of inadequate access to acute care is an increasing reliance on emergency rooms to care for individuals with SMI or addiction, even though these settings are generally not well-suited to address these patient needs.[xv] In 2018, almost 20 years after the start of the opioid crisis, the most common type of SUD treatment provided to Medicaid beneficiaries was emergency care.[xvi] In many cases, and increasingly during the Covid-19 pandemic, as the supply of psychiatric beds has declined, the wait for a transfer from emergency departments to specialized inpatient or other treatment setting has increased[xvii] with frequent reports of people waiting for weeks for a bed to become available. [xviii]

Specific Recommendations:

1. **Extend Medicaid coverage to psychiatric hospitals that are part of a continuum of care.**

   To remedy a clear violation of parity in the Medicaid program, we urge the Finance Committee to authorize state Medicaid programs to cover services in IMDs for mental health treatment as part of a statewide initiative to provide a full continuum of care. This approach is incorporated in Rep. Grace Napolitano's *Increasing Behavioral Health Treatment Act* (H.R. 2611) that was introduced this year. This legislation is similar to a proposal included in the President's Budget for FY 2021 (pages 114-115) that would have established a state plan option allowing coverage of IMDs in states that also implement a number of specific steps to improve community-based services. Since then, seven states' section 1115 demonstrations focused on SMI have been approved, and another six states have submitted applications that are very likely to be approved. The existence of these demonstrations should significantly reduce the estimated cost of this proposal.

2. **Clarify that parity rules require that the IMD exclusion does not apply to Medicaid managed care.**

   Under current law, the *Mental Health Parity and Addiction Equity Act* (MHPAEA) applies to Medicaid managed care arrangements. These requirements were detailed in regulations finalized by the Centers for Medicare & Medicaid Services (CMS) in 2016. [xix] In this final rule, CMS asserted that the IMD exclusion is not a violation of parity because inpatient treatment can be covered in other settings that are not IMDs—namely psychiatric units and beds in general hospitals. However, these final rules also clarify that limitations on coverage due to the type of facility are non-quantitative treatment limitations (NQTLs). The exclusion of coverage for IMDs is a limitation on coverage of a specific type of facility that violates the federal parity rules because this limitation only applies behavioral healthcare. There are no processes, factors, or evidentiary standards that justify this exceptional limitation.

   Furthermore, general hospitals are increasingly using their psychiatric beds to treat other conditions, including Covid-19.[xx] The closure of inpatient psychiatric beds by general hospitals was already an increasing trend before the pandemic because treatment for other conditions generally generates more revenue. General hospitals are unlikely to resume use of those beds for inpatient psychiatric care. Thus, inpatient psychiatric treatment in general hospitals settings will be even less available as an alternative to treatment in settings that qualify as IMDs. This dynamic further demonstrates how maintaining the IMD exclusion in managed care arrangements is out of compliance with the parity requirements both in operation as well as in writing.

3. **Apply parity to Medicaid fee-for-service coverage and clarify that the IMD exclusion is preempted.**

   Many Medicaid beneficiaries are not protected by any federal parity requirements because MHPAEA only applies to Medicaid beneficiaries enrolled in managed care organizations.[xxi] Therefore, beneficiaries in the

12 states without Medicaid managed care organizations[xxii] are not protected. Although a majority of Medicaid beneficiaries are enrolled in managed care organizations, an estimated 31% are not,[xxiii] and they therefore are not protected by federal parity rules. Medicaid fee-for-service coverage includes a number of strict limitations on mental health and addiction treatment that are clear violations of parity; for example, as detailed in CMS' annual reports on state Medicaid drug utilization review policies, states regularly impose stringent limits on MAT in fee-for-service coverage of prescription drugs.[xxiv]

Medicaid beneficiaries have higher rates of behavioral health disorders than the general population,[xxv] and thus it is critical that parity requirements apply to all forms of Medicaid coverage. We urge the Finance Committee to enact legislation extending parity to Medicaid fee-for-service benefits and clarify these requirements preempt the IMD exclusion.

4. **Extend new parity compliance documentation requirements to Medicaid and CHIP.**

The *Consolidated Appropriations Act, 2021* (Pub L 116-260)[xxvi] established new requirements for commercial health insurance plans and issuers to document compliance with MHPAEA requirements regarding non-quantitative treatment limitations (NQTLs) for mental health and SUD benefits.

Although the Medicaid and CHIP parity regulations include requirements that states and MCOs document compliance with parity in their Medicaid and CHIP programs, these requirements are far less detailed than the new documentation requirements included in the CAA. We urge the Finance Committee to ensure that these new parity documentation requirements apply to Medicaid managed care arrangements and CHIP.

5. **Require federally regulated health plans to base utilization management on generally accepted standards of care.**

Ensuring compliance with parity requirements for NQTLs has proven to be very challenging in commercial plans as well as in Medicaid and CHIP benefits.[xxvii] A more straightforward solution would be to adopt the approach taken by the federal court in the ground-breaking *Wit v. United Behavioral Health* decision to require that insurers base mental health and addiction treatment medical necessity determinations and other utilization management practices on generally accepted standards of care. Although the court ruling in this case relied on existing requirements under the *Employee Retirement Income Security Act*, we urge the Finance Committee to work with the Senate Health Education Labor and Pensions (HELP) Committee to enact a requirement that all federally regulated health plans, including Medicaid and CHIP coverage, Medicare Advantage, and the ACA marketplace plans, base utilization management on generally accepted standards of care to improve compliance with parity and help address many of the challenges with implementation of NQTL requirements.

6. **Establish additional benefit classification in parity rules for intermediate level of care.**

Partial hospitalization, intensive outpatient, and residential treatment programs are widely recognized as critical for helping people with serious behavioral health conditions transition out of acute inpatient settings when they no longer need to be there. These treatment settings in the intermediate level of care can also serve as alternatives to inpatient care for those who require fairly intensive services but do not need acute care. However, capacity of these treatment settings is quite limited, and managed care plans and issuers often place strict limits on receiving care in these settings.

The MHPAEA regulations designated six classifications of benefits to be used in determining compliance with parity rules: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescriptions drugs, and emergency care. The MHPAEA final rule clarified that managed care plans and issues should categorize these intermediate level programs in either the outpatient or inpatient

benefit classifications for purposes of a parity analysis. However, partial hospitalization, intensive outpatient, and residential treatment programs clearly belong in a separate intermediate level of care comparable to skilled nursing facilities and rehabilitation programs for medical conditions. Designating a separate intermediate level of care classification would help to clarify how parity applies to these services and could improve health plan coverage of partial hospitalization, intensive outpatient, and residential programs. We urge the Finance Committee to work with the HELP Committee to require this change in the parity rules for commercial health plans and issuers as well as Medicaid and CHIP coverage and the ACA marketplace plans.

Implement Parity in the Medicare Program

There are ample indications that Medicare beneficiaries lack adequate access to mental health and substance use disorder treatment. According to a CMS Data Brief from 2017, "[b]eneficiaries with depression, regardless of age, were more likely to report having trouble getting healthcare, obtaining prescription medicines, and not seeing doctors than those without depression."[xxviii] In addition, "[b]eneficiaries with depression regardless of age, were more likely to report that they have no usual source of care due to high cost."[xxix] Over 1.2 million individuals ages 65 or older had an SUD in 2019.[xxx] As detailed below, Medicare coverage for addiction treatment is even more limited than for mental health conditions.

Moreover, Medicare Advantage (MA) provides even worse coverage than traditional Medicare. MA plans disproportionately lack in-network mental healthcare providers. MA enrollees with depressive symptoms report more difficulty getting needed treatment and rated their experience with the MA plans as worse than those in traditional Medicare.[xxxi] One study found that MA networks included only 23 percent of psychiatrists in a county on average — lower than all other medical specialties.[xxxii] Another study found that insurers paid an average of 13-14 percent less for in-network mental health services in their commercial and MA plans than fee-for-service Medicare paid for identical services while these same plans paid up to 12 percent more than traditional Medicare when the same services were provided by other physician specialties. [xxxiii] Not surprisingly, this study also found that patients went out of network more frequently for mental health services than for comparison services, which increased their average cost-sharing payments.

Specific Recommendations:

7. **Eliminate the Medicare 190-day lifetime limit on care in psychiatric hospitals.**

   Serious mental illness (SMI) affects 23% of beneficiaries in traditional Medicare and 12% of those in MA plans.[xxxiv] The 190-day lifetime limit on care in inpatient psychiatric facilities is one of the major barriers for Medicare beneficiaries with these conditions accessing treatment. No other lifetime limits exist in Medicare for any other type of inpatient care. This limitation is entirely inconsistent with the principle of parity.

   Eliminating this lifetime limit would expand beneficiary choice, increase access for those with more serious behavioral health conditions, improve continuity of care, create a more cost-effective Medicare program, and align Medicare with parity, the standard required for practically all other healthcare coverage programs.

8. **Apply parity to Medicare Advantage plans along with requirements to use generally accepted standards of care for utilization management and stronger network adequacy rules.**

   In light of numerous indications that MA enrollees do not have adequate access to behavioral healthcare (as discussed above), we urge the Finance Committee to enact a requirement that MA plans comply with MHPAEA just as Medicaid managed care plans are required to do.[xxxv] Moreover, provisions applying MHPAEA requirements to MA plans should clarify that as a result, this coverage will no longer incorporate the 190-day lifetime limit. According to CMS staff, although Part C plans may provide additional inpatient

psychiatric care beyond the 190 lifetime limit, only about nine percent of plans offer a supplemental benefit of "inpatient psychiatric additional days".

In addition, we urge enactment of a provision to require that medical necessity decisions and other NQTLs by MA plans be based on generally accepted standards of care consistent with the *Wit v. United Behavioral Health* decision. These new requirements for Medicare Advantage plans also should include stronger requirements for network adequacy for mental health and addiction treatment as well as the new parity documentation requirements enacted as part of the *Consolidated Appropriations Act, 2021*.[xxxvi] (See discussion of these requirements in the Medicaid parity proposals above.)

9. **Increase Medicare Advantage accountability for access to mental health and addiction treatment.**

   The Medicare Star Rating program is intended to help beneficiaries and providers compare the quality and performance of MA plans.[xxxvii] In addition, MA plan ratings on the measures included in the Star Rating program affect plans' eligibility for bonus payments. However, there are no measures assessing access to addiction treatment included in these measures, and the only measure assessing mental healthcare is a short beneficiary survey assessing improving or maintaining mental health. Recently, CMS announced that even this one mental health measure will not be incorporated into the Star Rating calculations for 2022 and 2023 star ratings due to the impact of Covid-19 on data collection.[xxxviii] We urge the Finance Committee to enact a provision directing CMS to include measures in the MA Star Rating program that specifically assess access to and outcomes from mental health and addiction treatment services among MA enrollees and require that these measures be assigned the highest weight in the calculation of MA plan star ratings.

Expanding Telehealth

One positive outcome of the pandemic has been broader awareness of how helpful telehealth can be for increasing access to mental health and addiction treatment in communities without local providers and for individuals who have difficulty attending in-person appointments. CMS' use of emergency authorities during the pandemic to expand Medicare coverage of telehealth and waive administrative regulations has helped providers adjust to social distancing and other infection control policies. On-going flexibility and expanded coverage of telehealth will be critical as previous epidemics have shown that the impact on mental health and substance use will continue for years to come.[xxxix]

Telehealth is particularly effective in behavioral healthcare delivery, especially psychiatric and psychological services.[xl] Examples of behavioral health services that can be delivered effectively via telehealth include depression screening, follow-up care after hospitalization, behavioral counseling for substance use disorders, medication management, and psychotherapy for mood disorders.[xli]

Telehealth can also facilitate collaboration and consultation between behavioral healthcare specialists and primary care and emergency department clinicians to expand capacity to provide care for mental health and substance use disorders.[xlii] Telehealth has been found to increase retention for SUD treatment, including MAT, especially when treatment is not otherwise available or requires lengthy travel to treatment.[xliii] In addition, there is evidence of reduced utilization of higher-cost services associated with providing access to behavioral healthcare services via telehealth technologies.[xliv] The experience of our members in delivering behavioral healthcare during this pandemic is consistent with these research findings.

Specific Recommendations:

1. **Ensure continued Medicare coverage of audio-only telehealth mental health and addiction treatment.**

Coverage of services provided via audio-only technology is particularly important for certain vulnerable populations, including Medicare beneficiaries who are older and/or challenged with disabilities. These individuals often face additional barriers to accessing care through the newer video-based technologies and platforms. Among Medicare beneficiaries who had a telehealth visit last summer and fall, more than half of them accessed care using a telephone only.[xlv] A recent study found that among telehealth users, individuals who are older, Black, American Indian, male, or non-native English speakers have been significantly less likely to use video technology. [xlvi] Our members are also concerned that many of their more vulnerable patients are unemployed or under-employed and sometimes homeless and simply do not have access to internet service to support video technology.

Moreover, access to broadband service to support video and audio technology is often very limited in rural areas, which also face the most severe shortages of behavioral healthcare providers. Coverage of telehealth services for mental health and addiction treatment can help fill those gaps by enabling people who live in underserved areas to access specialists including behavioral healthcare providers residing in other areas. Limiting coverage to services provided via video and audio-enabled technology will limit the utility of telehealth for reaching individuals in those areas that often have very limited access to behavioral healthcare.

CMS has proposed in a recent rulemaking to continue Medicare coverage of audio-only services for mental health treatment and services provided by opioid treatment programs (OTPs).[xlvii] We urge the Finance Committee to enact legislation to ensure this coverage is provided on an on-going basis and expanded to include Medicare coverage of audio-only telehealth provided by office-based buprenorphine treatment programs that are also critically important for improving access to opioid use disorder treatment. In addition, the CMS policy should be expanded through legislation to include on-going Medicare coverage of behavioral healthcare treatment for addiction to other substances, such as alcohol, which is far more prevalent, and methamphetamines, which are also growing at an alarming rate. Individuals struggling with any form of addiction face similar barriers to care as those who need mental health treatment, and often these conditions are co-occurring. NABH urges the Finance Committee to ensure continued Medicare coverage of audio-only services for addiction treatment in additional settings as well as OTPs and mental health services.

2. **Eliminate the in-person visit requirement for Medicare coverage of telehealth for mental health.**

The *Consolidated Appropriations Act, 2021* (Pub. L.116-260) added an in-person visit requirement for mental health services only and exempted telehealth services for SUD and co-occurring mental health disorder treatment from this in-person requirement. It is not clear why an in-person visit within the six months prior to a telehealth visit (as required by statute) and every six months after that (as proposed by CMS in its rulemaking) is necessary for mental health treatment via telehealth. It will significantly reduce the degree to which telehealth can improve access to these critically needed services, particularly for individuals facing the most challenges to accessing care, including those with severely disabling behavioral health conditions and those who are homeless or have very low incomes.

NABH supports the *Telemental Health Care Access Act of 2021* (S. 2061) introduced by Senators Cassidy, Smith, Cardin, and Thune that would eliminate the in-person visit requirements that apply to Medicare coverage of telehealth services for mental health treatment.

3. **Continue Medicare coverage of audio-only telehealth for behavioral health services without in-person visits.**

Telehealth can be a critical component of providing care to individuals experiencing a serious mental health condition or substance use disorder. Accordingly, we oppose CMS' suggestion in the Physician Fee

Schedule proposed rule[xlviii] that the agency may exclude Medicare coverage of audio-only telehealth for crisis psychotherapy as well as other high-level evaluation and management codes. We encourage the Finance Committee to ensure Medicare coverage of crisis psychotherapy services via telehealth and clarify that these services may be supervised or provided directly via telehealth by providers eligible to bill Medicare for these services.

4. **Require guidance clarifying that Medicare reimbursement for telehealth is equivalent to in-person services for mental health and addiction treatment.**

   The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (*SUPPORT Act)* (Pub. L. 115-271) and the *Consolidated Appropriations Act, 2021* amended Title XVIII of the *Social Security Act* to extend Medicare coverage of mental health and SUD treatment services via telehealth in a beneficiary's home or community and regardless of the geographic area where the beneficiary is located. These changes also require that reimbursement for providers providing these services via telehealth be at the same rate as if these services were provided in person, although facility fees would not be provided.[xlix] We urge the Finance Committee to direct CMS to issue guidance raising awareness about these recent expansions in Medicare coverage of telehealth for mental health and additional treatment. CMS should highlight that reimbursement for these telehealth services must be the same as if those services were provided in person to raise awareness about this important provision and encourage additional providers to participate.

5. **Ensure continued Medicare coverage of partial hospitalization services and intensive outpatient program services for mental health via telehealth including facility fees.**

   Telehealth can be used to deliver partial hospitalization program (PHP) services effectively. A recent comparative effectiveness study demonstrated that the only significant differences between those who participated in PHPs via telehealth technologies and those who attended in person was that those who participated via telehealth had greater lengths of stay and were more likely to stay in treatment until completed.[l] Consistent with this research, our members have experienced significant increases in participation in PHP sessions delivered via telehealth during the pandemic. Moreover, other studies have shown that the various types of behavioral health services often delivered in PHPs can be provided effectively via telehealth including depression screening, follow-up care after hospitalization, behavioral counseling for SUDs, medication management, and psychotherapy for mood disorders.[li]

   During the Covid-19 pandemic, CMS has recognized that when a clinician who ordinarily practices in a hospital outpatient department provides a telehealth service to a patient, the hospital still must provide administrative and clinical support for that service. Thus, CMS has allowed Medicare reimbursement for the facility fees associated with providing hospital outpatient services including PHP services via telehealth. PHPs are generally not available in rural areas and access to these services is quite limited in general. Therefore, improving coverage of PHPs via telehealth helps individuals in underserved areas access critical services. In the most recent Medicare OPPS Rule,[lii] CMS has proposed to extend Medicare coverage of partial hospitalization services via telehealth for mental health conditions, but not the facility fees. Coverage of facility fees requires a statutory change.

   To provide PHP services via telehealth, providers incur significant costs from a number of administrative and ancillary services including the cost of purchasing hardware and software licenses, scheduling appointments, record-keeping, training for staff to use the technology, assistance for beneficiaries with technological challenges, and other support services. Behavioral healthcare providers generally operate with low margins, and reimbursement rates for services are often much lower for behavioral healthcare than other specialty care.[liii, liv] Therefore these providers will not be able to absorb the unreimbursed facility costs associated with providing PHP services via telehealth. We urge the Finance Committee to enact legislation to extend Medicare coverage of the facility fees associated with providing PHP services via telehealth.

6. **Expand Medicare to cover partial hospitalization services for addiction treatment including via telehealth.**

   Telehealth has been found to increase retention for addiction treatment, including MAT, especially when treatment is not otherwise available or requires lengthy travel.[lv] Furthermore, PHPs and intensive outpatient programs (IOPs) are included as a critical level of care in the leading treatment guideline on addiction treatment, the ASAM Criteria.[lvi] However, Medicare does not cover PHP treatment for individuals with a SUD as a primary diagnosis or IOPs.

   We urge the Finance Committee to enact legislation to add coverage of PHP and IOP services including telehealth services for those with an SUD as a primary diagnosis.

7. **Allow mental health and addiction treatment services to be provided via telehealth across state lines.**

   During the pandemic CMS waived of the Medicare requirement that practitioners be licensed in the states where they are providing care. This waiver allowed treatment services provided via telehealth across states lines as long as authorized by the state where the patient is located. We urge the Committee to enact legislation to continue the change in Medicare policy.

Strengthening Workforce

The Covid-19 pandemic has magnified the need for improved access to behavioral healthcare; however, we know there are severe shortages of behavioral healthcare providers in many parts of the United States. According to the Health Resources and Services Administration, as of September 2, 2021, more than one-third of Americans (125 million people) lived in one of the 5,788 mental health professional shortage areas.[lvii] In these areas, the number of mental health providers available were adequate to meet about 27% of the estimated need.[lviii] About half of U.S. counties and 80% of rural counties have no practicing psychiatrists, and more than 60% of psychiatrists are nearing retirement.[lix] By 2030, the number of psychiatrists is expected to decrease by 20%, and addiction counselors will also be in short supply.[lx] These shortages are so severe that states are resorting to extreme measures; for instance, Oregon had to request that the National Guard assist with staffing mental health facilities, and Virginia stopped admitting new patients in its five state mental hospitals due to its staffing crisis.[lxi]

Specific Recommendations:

1. **Allow nurses and other practitioners to operate to the full extent of their licenses**

   During the Covid-19 pandemic, CMS has provided flexibility regarding a number of regulatory restrictions that ordinarily prevent psychiatric facilities from being able to fully utilize their staff.[lxii] This regulatory flexibility has allowed hospitals to use nurse practitioners and other mid-level providers to the fullest extent of their licensure and scope of practice expanding the capacity of existing staff in treatment settings to provide behavioral healthcare.

   In many states mid-level providers are considered independent practitioners; however, due to the Medicare Conditions of Participation, all patients in inpatient psychiatric facilities must be under the care of a psychiatrist. As a result, although mid-level providers can see patients independently in their own offices, once employed by or privileged by an inpatient psychiatric facility, the care they provide must be supervised by a psychiatrist under the Medicare rules.

   Continuing the flexibilities in the Medicare rules regarding staffing is particularly important because a)

there are such significant shortages of behavioral healthcare providers in many parts of the country, and b) we expect these shortages to increase significantly in the coming months and years. We urge the Finance Committee to enact legislation to ensure that these flexibilities will be maintained allowing mid-level providers to operate to the full extent of their state licenses and scope of practice rules.

2. **Reduce regulatory burden to prevent resources being drawn away from providing services.**

   Inpatient psychiatric settings are subject to an additional set of Conditions of Participation for Medicare reimbursement. These additional regulations for inpatient psychiatric facilities are outdated and draw critical resources into administration instead of expanding access to care and improving quality.

   Moreover, the guidance implementing these regulations has not been updated since the 1980s and the regulations date back to the 1960s when treatment in psychiatric hospitals was custodial in nature and not focused on recovery.

   Some of these additional regulations have become outdated; however, they are still enforced, and facility alternations to adhere to the regulations are often costly. Furthermore, some of these regulations overlap with other Conditions of Participation that apply to all inpatient settings. These additional inpatient psychiatric care regulations have been estimated to impose $1.7 billion in compliance costs each year based on a survey of inpatient psychiatric facilities.[lxiii] Despite these additional regulatory burdens, inpatient psychiatric care is often reimbursed at a much lower rate than other conditions.[lxiv]

   We urge the Finance Committee to enact legislation eliminating the special regulations for inpatient psychiatric facilities. Alternatively, we request that the Finance Committee enact legislation establishing a commission (with representation from inpatient psychiatric providers) to determine whether these additional regulations remain relevant and whether some or all should be eliminated. In addition, we urge the Finance Committee to direct CMS to update its guidance regarding implementation of inpatient psychiatric facility regulations and explicitly direct surveyors to allow inpatient psychiatric facilities to achieve compliance with regulations by adopting reasonable approaches for compliance—as they allow for general hospitals.

3. **Improve Medicare and Medicaid reimbursement for behavioral healthcare providers.**

   NABH encourages Congress to direct CMS to reexamine reimbursement rates for behavioral healthcare services in Medicare to bring reimbursement for behavioral healthcare providers to levels that are more consistent with their education and credentialing and aligned with their peers in general medicine. This effort should include reexamination of reimbursement rates for psychiatric inpatient services that are often inadequate to cover costs.[lxv]

   CMS should also incentivize states to reexamine and improve their Medicaid rates for behavioral healthcare to encourage greater participation in those programs and improve access to care for beneficiaries. One recommendation for addressing this issue would be to expand the Demonstration to Increase Substance Use Provider Capacity in Medicaid (authorized in Sec. 1003 of the *SUPPORT Act)* to permit more states to participate in this demonstration and ensure participating states also examine and improve Medicaid rates for mental health services in addition to SUD treatment services.

4. **Exempt increased reimbursement for behavioral healthcare providers from Medicare budget neutrality requirements.**

   We have strong concerns about decreases in Medicare reimbursement for certain behavioral healthcare

practitioners proposed in the most recent physician fee schedule rule.[lxvi] This is particularly problematic at a time when the need for care is so great and capacity to address those needs is stretched so thin. The 3.75% reduction in the Medicare conversion factor will significantly reduce reimbursement for psychiatrists, psychologists, and licensed clinical social workers. These reductions in reimbursement will undoubtedly further strain behavioral healthcare providers at a time when reduced capacity and increased costs are already reducing access to treatment. We urge the Finance Committee to enact legislation modifying the budget neutrality requirement to avoid reducing payment for and access to critical mental health and addiction treatment services.

5. **Clarify and expand the Medicare "incident to" policy allowing additional practitioners to provide behavioral healthcare.**

   The most recent Medicare hospital OPPS proposed rule[lxvii] discusses how services by counselors and other licensed professionals can be billed to Medicare as "incident to" professional services by physicians and other covered practitioners.

   As CMS highlights in the proposed rule, several types of behavioral health practitioners— including counselors and other licensed professionals— are qualified to provide PHPs services, including psychoanalysis and psychotherapy, but are not authorized to bill Medicare directly. This policy creates a significant coverage gap because these practitioners provide much of the care in behavioral healthcare facilities.

   The proposed rule discusses how services by counselors and other hospital staff who may not directly bill Medicare may nevertheless be billed by hospitals under the OPPS or by supervising physicians or other practitioners as incident to their professional services under the physician fee schedule. CMS also notes that supervision must be under the physician's or other practitioner's overall direction and control, but the physician's presence is not required. This discussion highlights how PHPs can extend the capacity of certain higher credentialed clinicians by having additional practitioners provide services under their supervision.

   These are helpful clarifications that are not well-known and buried in a proposed rule that extends over 340 pages in the Federal Register. It would be helpful for Congress to direct CMS to clarify and expand on these policies in guidance for providers, e.g., a Medicare Learning Network publications as well as updates to the State Operations Manual. In addition, this guidance should address the use of telehealth for supervision and to support "incident to" services by licensed behavioral healthcare practitioners who are qualified and authorized to provide services by their states but not authorized to bill Medicare.

Increasing Integration, Coordination, and Access to Care

To improve integration, coordination, and access to behavioral healthcare, we recommend that the Finance Committee support broader implementation of electronic health records (EHRs) and health information technology (HIT) among behavioral healthcare providers, fill the significant gaps in Medicare coverage of SUD treatment, and make other improvements to Medicare and Medicaid coverage of critical services described below.

Specific Recommendations:

1. **Provide subsidies for behavioral healthcare providers to implement electronic health records.**

   As discussed in detail at the Medicaid and CHIP Payment and Access Commission meeting on Sept. 24, behavioral healthcare providers trail far behind other types of providers in implementing electronic health

records that are critical for improving integration and coordination of care for individuals with mental health and/or substance use disorders. Less than half of psychiatric hospitals have implemented certified electronic health record technology compared with 96% of general hospitals.[lxviii]

This discrepancy is due to the exclusion of psychiatric hospitals from the $35 billion in subsidies for EHR implementation provided by the *Health Information Technology for Economic and Clinical Health Act* of 2009 (*HITECH Act*) (Pub. L. 111-5), as well as low operating margins at these facilities that make it impossible to absorb these additional costs.[lxix] As the rest of healthcare is moving toward increased interoperability and electronic communication, behavioral healthcare providers are being increasingly left behind which inhibits integration and coordination of care.

In 2018, Congress authorized the Center for Medicare and Medicaid Innovation (CMMI) to offer incentives to behavioral health providers for health IT use under Sec. 6001 of the *SUPPORT Act*. Nevertheless, CMMI has not yet developed a model to implement the provision. At the very least, we urge the Committee to ensure that this demonstration is funded and developed by CMMI as previously directed by Congress.

2. **Improve Medicare coverage for full continuum of addiction treatment.**

Medicare does not cover some of the most widely available and effective forms of SUD treatment, including intensive outpatient programs and PHPs for SUDs, as well as residential treatment facilities. These programs and settings comprise intermediate levels of care that are included in the American Society of Addiction Medicine (ASAM) Criteria as critical elements of a full continuum of care. In addition, Medicare does not cover services provided by many practitioner types who provide most of the services in SUD treatment settings namely licensed or certified professional counselors, addiction counselors, and marriage and family therapists as well as peer specialists. We urge the Committee to expand Medicare coverage to fill these unjustifiable gaps in coverage.

3. **Extend Medicare and Medicaid coverage of contingency management services.**

From 2012 through 2018, drug overdose deaths involving cocaine more than tripled, and overdose deaths involving psychostimulants such as methamphetamine increased by a factor of 4.9.[lxx] Contingency management (CM) is a therapeutic intervention that effectively engages stimulant-addicted individuals into care to reduce their stimulant use and initiate recovery. Importantly, it is the most effective treatment for stimulant use disorder. However, it is underused. We recommend that Medicare and Medicaid programs reimburse providers for CM and engage the public in developing appropriate financing methodologies through a request for comment.

4. **Make Medicaid mandatory coverage of MAT permanent and ensure compliance.**

The *SUPPORT Act* included a provision (section 1006(b) requiring state Medicaid agencies to cover all forms of MAT as of Oct. 1, 2020 through Sept. 30, 2025. Long-standing research establishes that medications play a central role in successful long-term recovery for individuals with opioid use disorder (OUD) by engaging and retaining patients in treatment, reducing overdoses, injection drug use, infectious disease risk, and involvement with the criminal justice system as well as improving social and vocational outcomes.[lxxi]

The primary impact of this provision was to require states to include methadone treatment for OUD in their Medicaid benefits because state Medicaid programs covered other forms of MAT. Methadone is a highly effective form of MAT.[lxxii] Methadone via opioid treatment programs is often provided for individuals with the most severe cases of OUD.

However, as of FY 2019, seven state Medicaid programs still did not cover methadone.[lxxiii] We urge the Committee to ensure state implementation of the *SUPPORT Act* requirement to cover all forms of MAT including with a General Accountability Office report on this topic. We also recommend that this provision be extended permanently to provide states and providers with certainty regarding on-going Medicaid coverage policies and ultimately improve access to treatment for OUD that has proven to be more deadly than ever with the dramatic increase in overdose deaths in 2020.

5. **Improve Medicaid and CHIP coverage for low-income mothers.**

   Mental health conditions and overdoses are among the top causes of pregnancy-related deaths[lxxiv] that have been increasing in the United States in recent years.[lxxv] Moreover, mental health conditions are the most common complications of pregnancy and childbirth, affecting one in five women.[lxxvi] Furthermore, women with OUD experience high rates of overdose and mortality, particularly in the postpartum period.[lxxvii] Medicaid plays a critical role in increasing access to behavioral healthcare services for pregnant and postpartum women. The program pays for over 40% of U.S. births and more than two-thirds of births in some states.[lxxviii] Although Congress took a significant step in the *American Rescue Plan Act* (Pub. L. 117-2) by giving states the option to extend Medicaid coverage for women to one year post partum, we urge the Finance Committee to ensure this critical coverage is provided by making Medicaid and CHIP coverage for one-year postpartum mandatory.

Improving Access for Children and Young People

According to the most recent survey data from the Substance Abuse and Mental Health Services Administration (SAMHSA), about 3 million adolescents (ages 12-17) seriously considered suicide last year and more than 1 million had a suicide plan.[lxxix] These findings are shocking especially in light of widespread shortages of behavioral healthcare providers and lack of adequate capacity in inpatient and residential treatment settings. Children's hospitals in numerous states have reported increased numbers of children with severe depression presenting in their facilities and troubling spikes in the number of patients who thought about or attempted suicide.[lxxx] The Centers for Disease Control and Prevention (CDC) reported a 50% increase in emergency department visits for suspected suicide attempts among girls ages 12-17 in early 2021 compared with the same period in 2019, and a 31% increase in mental health-related emergency department visits among all adolescents during this period.[lxxxi] Moreover, children's hospitals also report having to maintain these children and adolescents for longer periods in their emergency departments as access to inpatient psychiatric care has been more limited due to physical distancing measures and repurposing of psychiatric beds in response to surges in Covid-19 patients.[lxxxii] Children and adolescents are at increased risk of depression and anxiety even after the pandemic ends according to studies on the impact of social isolation.[lxxxiii]

Specific Recommendation:

1. **Exempt QRTPs from the IMD exclusion and require compliance with seclusion and restraint rules.**

   We urge the Finance Committee to address a legislative issue that is reducing access to residential treatment for children and adolescents with more serious behavioral healthcare conditions. The *Family First Prevention Services Act* (*FFPSA Act)* (Pub. L. 115-123) established new requirements for childcare settings that were intended to ensure quality of care for children in foster care. An unintended consequence of this legislation has put Medicaid coverage of children in these settings at risk because many of these settings potentially qualifying as Institutions for Mental Diseases (IMDs).

Although psychiatric residential treatment facilities (PRTFs) may be covered by Medicaid, many settings that qualify as QRTPs do not meet the criteria to be a PRTF. Although the *FFPSA Act* requires that QRTPs be accredited and meet a number of additional requirements to ensure good qualify of care, these settings tend to be less focused on medical approaches to behavioral health and therefore may not meet the PRTF requirements regarding physician oversight and involvement in the care provided to children and adolescents in these settings.

We urge the Committee to clarify that QRTPs are exempt from the IMD exclusion in Medicaid as was intended by Congress when QRTPs were designated as appropriate childcare settings for children and adolescents with serious emotional disturbances who need specialized support from qualified professionals.

2. **Strengthen Medicaid and CHIP coverage of behavioral healthcare.**

Many of the proposals outlined in the prior sections of this letter would also increase access to behavioral healthcare for children and adolescents. Ensuring full implementation of parity in Medicaid and CHIP as well as extending parity to Medicaid fee-for-service benefits are critically important for young people because they disproportionately rely on these programs for healthcare coverage.

As of January 2021, 39 million children were enrolled in Medicaid and CHIP, comprising the largest group of of Medicaid and CHIP enrollees.[lxxxiv] Medicaid and CHIP are particularly important for adolescents with significant mental health conditions: one in three adolescents with a past year major depressive episode with severe role impairment are enrolled in these coverage programs.[lxxxv]

We urge the Finance Committee to permanently extend authorization for CHIP and enact the *Stabilize Medicaid and CHIP Coverage Act* (S. 646/H.R. 1738) to provide 12 months of continuous enrollment in Medicaid and CHIP. Ensuring basic healthcare coverage is critical for improving access to behavioral healthcare for millions of low-income children and adolescents.

3. **Increase accountability of Medicaid and CHIP for ensuring access to behavioral healthcare for children and adolescents.**

We urge the Finance Committee to improve accountability in Medicaid and CHIP so that these federal programs ensure access to behavioral healthcare for children and adolescents. Our members are constantly struggling with denials of medically necessary care despite the early and periodic screening, diagnostic, and treatment (EPSDT) requirement that is supposed to ensure access to all medically necessary treatment. We urge the Finance Committee to *require* states to report separately for fee-for-service and managed care coverage on the Medicaid and CHIP Core Measures regarding behavioral healthcare for children and adolescents. In addition, we recommend providing additional resources to CMS to support the data analysis required for posting these findings and for developing new behavioral healthcare measures focused on assessing access to behavioral healthcare to include in the Medicaid and CHIP core measure sets.

4. **Incentivize states to continue Medicaid and CHIP coverage of telehealth.**

During the pandemic, our members have continued serving many children and adolescents largely because of the emergency telehealth coverage that state Medicaid and CHIP programs extended. Expanded telehealth services have facilitated access in rural areas for children and youth who would otherwise have

had great difficulty accessing specialized behavioral healthcare. Telehealth can also facilitate access to behavioral healthcare in schools.[lxxxvi]

We are concerned that some states will not maintain Medicaid and CHIP coverage of telehealth after the pandemic has ended. We urge the Finance Committee to enact incentives through an enhanced administrative match or grant program to help cover administrative costs of states implementing Medicaid and CHIP coverage policy changes and/or to support broader implementation of telehealth among behavioral healthcare providers.

Thank you for considering our recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient

programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C. The association was founded in 1933.

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