ABHW

Advancing Health Care Policy
for Mental Health and Addiction

November 27, 2019

The Honorable Richard Neal
Chairman
Ways and Means Committee
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Ways and Means Committee
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Danny Davis
Co-Chair, Rural and Underserved Communities Task Force
Ways and Means Committee
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
Co-Chair, Rural and Underserved Communities Task Force
Ways and Means Committee
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Terri Sewell
Co-Chair, Rural and Underserved Communities Task Force
Ways and Means Committee
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
Co-Chair, Rural and Underserved Communities Task Force
Ways and Means Committee
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady and Representatives Davis, Sewell, Wenstrup, and Arrington:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to respond to the Ways and Means Committee's request for information on improving health outcomes within underserved communities.

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health, substance use disorders (SUDs), and other behaviors that impact health and wellness. Our

responses below outline areas to improve access to quality treatment and coordinated care for individuals with mental health and SUDs.

Given that approximately 1 in 5 adults have a mental illness and 1 in 12 have a SUD, and the fact that there is a growing shortage of behavioral health providers to respond to this significant need for services, addressing these barriers and coordinating care is vital to the growing need for ready and timely access to necessary treatment.

If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

There are continued challenges created by the Ryan Haight Act that prevent providers from prescribing medicine via telehealth services. Specifically, ABHW recommends that licensed community mental health and addiction providers, eligible to prescribe medications, gain access to a special registration process so that they may register with the Drug Enforcement Administration (DEA) to prescribe medications, through telehealth, now commonly utilized in medication assisted treatment (MAT) practice, without a prior in-person encounter. We also suggest eliminating the requirement that in order to receive treatment, the patient physically be located in a DEA registered hospital or clinic or be in the physical presence of a DEA registered practitioner. Not all people have access to these types of entities and providers due to behavioral health provider shortages or physical difficulty traveling.

We also recommend addressing two additional barriers to telehealth. Eliminating the originating site and rural limit restrictions for telehealth in Medicare fee for-service (FFS) and ensuring that these constraints are lifted for mental health and SUD in FFS, Medicare Advantage (MA), and Accountable Care Organizations (ACOs). Second, encouraging the Centers for Medicare and Medicaid Services (CMS), in the MA program, to not require plans that offer telehealth services under Medicare Part B to also provide enrollees with an in-person service option for those same services. In some locations no in-person provider is available and that is why the telehealth services are being offered.

What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Expanding access to care by addressing workforce shortages and barriers that limit available providers to treat behavioral health needs can improve health outcomes, overcome stigma, and reduce costs. ABHW recommends eliminating the DEA X waiver

to prescribe buprenorphine. It is important to remove regulatory hurdles to help reduce unmet needs for addiction treatment. In many areas ABHW members find it hard to locate a provider willing to provide MAT to the consumers they serve. Addressing this barrier would allow more providers to prescribe medication for opioid use disorder (OUD) and help individuals overcome addiction.

Additionally, ABHW recommends including coverage of peer support services. Peer support services are an effective component of behavioral health treatment and have a positive impact on consumers yet are not Medicare eligible providers. Medicaid programs in many states currently reimburse, either directly or in bundle, for peer support services. Coverage is also provided under the Veterans Administration, Department of Defense, and Tricare health services for mental health and SUDs.

Evidence shows that peer support services improve quality of life; improve engagement and satisfaction with services and supports; improve whole health; and reduce re-hospitalization rates, inpatient days, and overall cost of services.[1] Further, research and experience has shown that peer support services increase the use of outpatient services and engagement rates.[2]

Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

ABHW recommends recognizing mental health counselors (MHCs) and marriage and family therapists (MFTs) as covered Medicare providers to address the gaps in care for Medicare beneficiaries. Recognition of MHCs and MFTs would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners. Studies have shown that these providers have the highest success and lowest recidivism rates with their patients as well as being the most cost effective.[3] Further, according to the American Association for Marriage and Family Therapy, marriage and family counseling costs are typically 60 percent that of psychiatrists and 80 percent of psychologists. Additionally, studies have supported the potential for a medical offset effect after family therapy.[4]

Advancing the Mental Health Access Improvement Act (S. 286/H.R. 945) would recognize MHCs and MFTs as covered Medicare providers and help address the

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[1] Peer Support – Get the Facts. *Mental Health America*. Retrieved from http://www.mentalhealthamerica.net/conditions/peer-support-research-and-reports
[2] (May 2019) Evidence for Peer Support. *Mental Health America.* Retrieved from http://www.mentalhealthamerica.net/conditions/peer-support-research-and-reports
[3] D. Russell Crane and Scott H. Payne, "Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions," *Journal of Marital & Family Therapy* 37, no. 3 (2011): 273-289.
[4] https://link.springer.com/chapter/10.1007%2F978-3-319-03482-9_22

critical gaps in care while reducing rapidly increasing hospital costs. If a proposal to include this legislation is not feasible, an alternate recommendation is expanding access to MHCs and MFTs in designated mental health shortage areas. After this is done a study could examine the impact on access to mental health and addiction treatment; hospitalizations; and costs and quality of services.

Are there two or three institutional, policy or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

ABHW is committed to aligning 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations (TPO) to allow appropriate access to patient information that is essential for providing whole-person care while protecting patient privacy.

The Overdose Prevention and Patient Safety (OPPS) Act, H.R. 2062, promotes coordinated care and expanded access to treatment. As you continue your work to address SUDs, we highlight the importance of including H.R. 2062 in any legislative health package that is considered on the House floor this year. The OPPS Act would align Part 2 with HIPAA to allow for the transmission of SUD records for the purpose of TPO as well as enhance patient privacy and anti-discrimination protections. Only then can we promote integrated care and heightened patient safety, while providing health care providers with one federal privacy standard for all of medicine.

The recent Confidentiality of Substance Use Disorder Patient Records Notice of Proposed Rulemaking, issued by SAMHSA, proposed some helpful changes to patient consent, and clarified the ability of non-Part 2 providers to segregate any patient records received from Part 2 programs in order to avoid subjecting their own records to Part 2. The proposed rule did not fully address aligning Part 2 with HIPAA for the purposed of TPO. As a result, it remains important for you to consider H.R. 2062.

Thank you for the opportunity to comment on this important issue. We look forward to working with you to identify solutions and ensure quality, evidence-based mental health and SUD treatment in communities across our nation. Please feel free to contact Maeghan Gilmore, Director of Government Affairs at gilmore@abhw.org or 202.449.7658 with any questions.

Sincerely,

Pamela Greenberg

Pamela Greenberg, MPP
President and CEO