AMERICA'S ESSENTIAL HOSPITALS

November 12, 2021

The Honorable Ron Wyden
Chair
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo:

Thank you for seeking information on ways to improve access to mental health care. As the leading champion for hospitals and health systems dedicated to providing high-quality care to all, America's Essential Hospitals is eager to engage with the committee on policies and practices to streamline and enhance equitable access to mental and behavioral health care.

Our more than 300 members form the very fabric of the nation's health care safety net. They care for often marginalized people and anchor communities across the country, serving populations with the greatest need in areas that might otherwise lack health care access. They reach outside their walls to care for communities in which 22.3 million people live below the federal poverty line, 9.9 million have limited access to nutritious food, and 370,000 experience homelessness.[1]

This mission-driven work carries a cost, and our members are committed to meeting their mission despite having limited means. Essential hospitals operate with strained finances due to the disparity in provider reimbursements between public and private payers and their high volume of uninsured and underinsured patients; their margins are one-third that of the average U.S. hospital.[2]

Because of their mission and the patients they serve, essential hospitals understand the importance of providing comprehensive mental health services, including treatment for opioid use disorders. Behavioral health conditions also are likely to occur with other health problems, adding complexity to these patients' treatment and potentially influencing outcomes. Essential hospitals are breaking down silos between physical and mental health care while concurrently tackling the socioeconomic factors that can contribute to, or in some cases exacerbate, mental health needs or barriers to care.

COVID-19 remains both a deterrent and catalyst for this work. The pandemic has compounded the financial strain on essential hospitals, hamstringing their ability to meet current mental

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed October 18, 2021.
[2] *Ibid.*

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health care demands. The public health crisis hit the patients and communities served by essential hospitals particularly hard, especially people of color and those with underlying health conditions. COVID-19 also exacerbated the looming health care provider shortage crisis, directly impacting access to mental health care. For example, the health care workforce shortage caused by the pandemic prevented one essential hospital in Arizona from operating three behavioral health units, as planned, because the facility lacked the necessary staffing resources. COVID-19 heightened the mental health crisis in America, and it is unfortunately a barrier for many individuals to access the health care they need.

Simultaneously, facilities that increased telehealth capacity due to COVID-19 saw improvements in the provision of mental health care, allowing more patients to connect to these critical services. At one point during the pandemic, an essential hospital in Massachusetts used telehealth for more than 90 percent of outpatient psychiatric visits, enabling the hospital to meet the needs of its patients and maintain access to critical mental health services.[3] Increased use of telehealth can enhance and expand behavioral health care for patients and populations that previously lacked access.

Congress can accelerate efforts to improve mental health care by re-examining policies that hinder equitable access while investing in the mental health care workforce. Using the committee's stated areas of interest as a guide, America's Essential Hospitals encourages lawmakers to consider the issues below as you examine opportunities to improve access to mental and behavioral health care.

1. **Strengthen the health care workforce to remove barriers to mental health care access.**

Strengthening the workforce to remove mental health care barriers must be viewed on parallel tracks: lawmakers should create opportunities to support the mental and emotional wellbeing of current providers while simultaneously investing in the mental health care provider pipeline. These issues should be addressed in tandem to adequately support and grow the mental health care workforce.

Clinicians must receive adequate support and resources to maintain their wellbeing and reflect the value of their essential services. COVID-19 continues to stress our front-line health care providers, impacting their morale and overall wellness. Case surges have placed undue pressure on the health care workforce, leading to increased burnout and, in some cases, departure. To serve the elevated patient load amid a workforce shortage, providers have taken on longer shifts, further disrupting their work-life balance.

Further, lawmakers should work with essential hospitals to bolster mental health resources for the provider community. America's Essential Hospitals encourages lawmakers to pass the Dr. Lorna Breen Health Care Provider Protection Act (S. 610, H.R. 1667). This bill would provide additional training and education to prevent suicide and burnout among health care professionals. We thank the Senate for passing this important legislation and look forward to working with the House to advance the bill.

[3] Testimony of Michelle Durham, MD, MPH, before a Senate Finance Committee hearing, titled "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions." June 2021. https://www.finance.senate.gov/imo/media/doc/BMC%20Dr%20Michelle%20Durham%20Senate%20Finance%20Committee%20hearing%20on%20mental%20health....pdf. Accessed October 22, 2021.

Supporting the mental health needs of the current workforce will help retain experienced and valued providers, but Congress must concurrently work to expand and diversify the mental health provider pipeline. A dearth of mental and behavioral health providers existed before the COVID-19 pandemic; it is well documented that most of the country lacks adequate access to mental health professionals.[4] COVID-19 heightened concerns about looming provider shortages—now is the time for lawmakers make robust investments in health care workforce development. Congress must create and financially support more training opportunities for allied health professionals, nurses, and physicians—especially in underserved and underrepresented communities—to address current and pending workforce shortages and meet the changing demands of tomorrow's health care system.

More Medicare-supported graduate medical education (GME) positions for psychiatric residents at hospitals serving communities with the greatest health and socioeconomic needs could help improve mental health physician capacity. Congress last year made an important initial investment to mitigate physician workforce shortages by providing 1,000 new Medicare-supported GME slots through the Consolidated Appropriations Act of 2021—the first increase of its kind in nearly 25 years. The association is grateful for this important down payment on the provider pipeline, but more support is necessary to meet current physician training needs, prepare for future public health emergencies, and respond to the acute mental health access challenges facing our country.

To that end, America's Essential Hospitals supports the Resident Physician Shortage Reduction Act of 2021 (S. 834). This legislation would gradually phase in 14,000 new Medicare-supported GME positions and target those positions to teaching hospitals with the greatest need, including hospitals already training over their Medicare caps, hospitals in states with new medical schools or branch campuses, hospitals serving patients in health professional shortage areas, and rural hospitals. The bill also takes steps to help improve physician workforce diversity by commissioning a report to examine steps to create a more diverse clinical workforce—a key essential hospital priority. The association also supports the rural and underserved Pathway to Practice Program for post-baccalaureate and medical students, as included in reconciliation legislation developed by the House of Representatives, to provide medical scholarship vouchers to qualifying students from rural and underserved areas who commit to practicing in these communities. Residency slots for program participants will not count toward a qualifying hospital's resident cap. The bill also would provide an additional 4,000 GME slots, with a minimum number of slots for primary care and psychiatry.

Essential hospitals train and support the development of the nonphysician health care workforce, a critical component of their mission to provide high-quality, comprehensive care to all. Our members train nearly one in 10 allied health professionals instructed in an acute care facility.[5] America's Essential Hospitals urges Congress to increase federal investment in health care workforce programs to ensure an adequate, diverse, and culturally competent pipeline of health care professionals. Congress could achieve this by funding several training programs identified in reconciliation legislation developed by the House, including providing enhanced resources for:

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[4] Letter to Senate Finance Committee Chair Ron Wyden on Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic. Government Accountability Office. March 2021. https://www.gao.gov/assets/gao-21-437r.pdf. Accessed October 22, 2021.
[5] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed October 18, 2021.

- antidiscrimination and bias training;
- mental health and substance use disorder workforce development, including for practitioners focused on maternal mental health and substance use disorder;
- National Health Service Corps and Nursing Corps;
- medical, osteopathic medical, and nursing school recruitment, enrollment, and retention of new students, with priority given to underrepresented populations; and
- Health Profession Opportunity Grants demonstration programs for education and training, including for justice-involved individuals, for careers in health care.

To strengthen the workforce and improve the care provided to essential hospital patients and communities, Congress should take additional steps to diversify the health care provider pipeline. In her testimony before the Senate Committee on Finance earlier this year, Michelle Durham, MD, MPH, a psychiatrist at association member Boston Medical Center, cited data that only 2 percent of psychiatrists identify as Black and poignantly noted that "where a person lives, the color of their skin, and language they speak is highly determinative of the quality of education and resources available, the level of exposure to the mental health field, and stigma associated with mental illness."[6]

Eliminating the barriers raised by Durham will require a whole-government approach to tackling social determinants of health and structural racism. America's Essential Hospitals is committed to this work and looks forward to continuing to engage with lawmakers to improve health equity and end health disparities. As it relates to strengthening and diversifying the mental health care workforce, the association encourages lawmakers to explore additional educational opportunities for recruiting providers from communities served by essential hospitals and to support training programs that aid comprehensive, culturally competent care.

Further, immigration policies should allow a clear and easy path for all foreign nationals with medical and clinical backgrounds who wish to work, train, or study in the United States. This is a critical way to address the provider gap and offer culturally appropriate care to diverse communities, especially during periods of increased staffing needs or critical clinical shortages, including among behavioral health providers.

Many foreign-born clinicians are trained in the United States and want to remain here to practice, but struggle to do so because of administrative backlog and complexity with H-1B and J-1 visas. America's Essential Hospitals supports the Healthcare Workforce Resilience Act (S. 1024), which would recapture unused immigrant visas for nurses and physicians that Congress previously authorized and allocate those visas to help bolster the clinician workforce. The association also supports the Conrad State 30 and Physician Access Reauthorization Act (S. 1810) to extend authorization of the Conrad 30 program, which allows foreign-born physicians to remain in the United States upon completing their residencies under the condition that they practice in a high-need area.

In addition to ensuring an adequate number of mental health providers, Congress should explore policies that enable future practitioners to both train and practice in underserved areas, including communities served by essential hospitals. Due to their strained finances, essential hospitals need adequate reimbursement to achieve their community-drive missions while

[6] Testimony of Dr. Michelle Durham before a Senate Finance Committee hearing titled, "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions." June 2021. https://www.finance.senate.gov/imo/media/doc/BMC%20Dr%20Michelle%20Durham%20Senate%20Finance%20Committee%20hearing%20on%20mental%20health....pdf. Accessed October 22, 2021.

offering salaries and benefits that enable recruitment and retention of staff in today's increasingly competitive market.

Policy changes that reduce or threaten critical safety net support, such as Medicaid disproportionate share hospital payments or the 340B Drug Pricing Program, could further harm the precarious finances of essential hospitals and impede their ability to recruit mental health providers and offer robust behavioral health services. Supporting essential hospitals, as well as providing practice incentives through programs, like the rural and underserved Pathway to Practice Program and targeted GME slots, will help our members draw, train, and retain mental health practitioners.

2. Support further use of telehealth services.

Provider and patient experiences with telehealth encounters during the COVID-19 pandemic make clear the value of this technology to the provider-patient relationship. The benefits of this mode of care are especially apparent for increasing access to mental health services. In addition to increased use of telehealth for behavioral health care, essential hospitals reported improved no-show rates in the behavioral health space tied to telehealth offerings.[7]

Further, telehealth has helped mitigate barriers to care caused by social determinants of health; it streamlined opportunities for follow-up care while eliminating the need for transportation and reducing the amount of time a patient needs to take off work or secure child care to attend an appointment. Further, telehealth visits enable providers to better see and assess patients' living situations, including assessing factors in the home that providers might not have discovered in an office setting.

It is important to remember digital connectivity is a social determinant of health and, as noted by the committee, expanding telehealth availability should not exacerbate existing disparities in access to mental health care. The ability of technology to provide mental health services and connect individuals to community resources is only realized if individuals have equitable access to it.

To help mitigate disparities in access to mental health services, America's Essential Hospitals urges lawmakers to work with the Centers for Medicare & Medicaid Services (CMS) to permanently adopt coverage of audio-only services for which the agency added reimbursement during the COVID-19 public health emergency (PHE), including for mental and behavioral health services.

Essential hospitals and their patients have benefited from this flexibility during the pandemic. The use of audio-only capabilities helps marginalized patients who do not have access to computers or phones with video capabilities, as well as those with limited access to broadband that can support synchronous video visits. When the provider can deliver care and assess the patient without seeing the patient, it is entirely appropriate to offer these services through audio-only means.

A recent study from an essential hospital in Oregon found that certain populations—including patients who are Black, American Indian, do not speak English, and are insured through

[7] Mehrotra M, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider E. The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases. Commonwealth Fund. February 2021. https://doi.org/10.26099/bvhf-e411. Accessed October 25, 2021.

Medicaid—are more likely to rely on audio-only telehealth services rather than two-way video.[8] Maintaining robust and equitable access to audio-only services could help mitigate barriers to mental health care.

Through rulemaking, CMS allowed certain services to be provided using audio-only technology during the COVID-19 PHE. These codes include audio-only evaluation and management services, as well as various codes for behavioral health assessments and evaluations. In the calendar year (CY) 2022 Physician Fee Schedule (PFS) final rule, CMS redefined the term "interactive communications technology" to include audio-only communications when a telehealth service is provided to a beneficiary in their home at the time of the service and is for the diagnosis, evaluation, or treatment of a mental health disorder. However, CMS states it will pay for audio-only mental health services only if the beneficiary receives an in-person visit from the practitioner within the six months before the initial audio-only visit and within 12 months of subsequent audio-only visits. Congress should work with CMS to allow audio-only communications for mental health telehealth services without requiring an in-person visit within six months of the initial telehealth visit, which will hinder access to mental health services.

Because telehealth can expand access to care, including mental health services, Congress should permanently eliminate the geographic and site-of-service restrictions on Medicare telehealth services. In practice, lack of transportation and other barriers to access prohibit more than just rural patients from timely access to care. Large populations in many urban areas are in health care deserts and are classified as medically underserved. Drawing a distinction between rural and urban underserved populations artificially restricts access to health care for those who need it most. Even if these patients live in heavily populated urban areas, receiving a timely telehealth service from a physician can result in the early diagnosis of a life-threatening condition and play an important role in providing cost-effective follow-up care.

America's Essential Hospitals appreciates a requirement within the Consolidated Appropriations Act (CAA) of 2021 to permanently waive the geographic restrictions imposed on telehealth services for the diagnosis, treatment, or evaluation of mental health disorders in Medicare. This provision allows a practitioner to treat a beneficiary via telehealth, even if the beneficiary is located in their home or in an urban area at the time of treatment. In the final CY 2022 PFS rule, CMS imposed a condition, as required by the CAA, that the beneficiary must have received an in-person visit from the practitioner in the six months preceding the initial telehealth visit and within 12 months of each subsequent telehealth visit. Lawmakers should work with CMS to lift this unnecessary barrier to access by lengthening the time period between the required in-person visit and initial telehealth visit from six months to a year. Requiring beneficiaries to receive in-person visits before a telehealth visit runs counter to the CAA's intended purpose of expanding access to mental health services. Particularly for underserved populations facing social risk factors, such as lack of transportation, the in-person requirement is unnecessarily restrictive and jeopardizes access to vital mental health services.

Congress also should provide adequate hospital reimbursement for costs associated with Medicare telehealth services. When a Medicare service is provided in-person, hospitals typically are reimbursed for the facility fee under the Outpatient Prospective Payment System to cover the costs of personnel, equipment, supplies, and other overhead. Though furnishing telehealth

[8] Sachs J, Graven P, Gold J, Kassakian S. Disparities in telephone and video telehealth engagement during the COVID-19 pandemic. *JAMA*. 2021;4(3). https://doi.org/10.1093/jamiaopen/ooab056. Accessed October 22, 2021.

services to patients does not require the patient's physical presence within a hospital, these services nonetheless require significant hospital and staff resources. Hospitals incur substantial costs investing in telehealth technology and maintaining staff and equipment to ensure operation of their platforms. CMS recognized this by allowing hospitals to bill an originating-site facility fee for services provided through telehealth as long as the patient is a registered outpatient of the hospital, even if the patient receives the service from their home during the COVID-19 PHE. This additional support has been critical to help essential hospitals maintain and expand telehealth offerings during the pandemic and would be helpful in keeping this mode of care for mental health services moving forward.

Further, to maximize the benefit of telehealth expansion policies enacted during the COVID-19 PHE, Congress should work with CMS to provide additional flexibility on the provision of telehealth services for the diagnosis, treatment, or evaluation of mental health disorders. This could include ensuring behavioral health services permanently remain on the list of reimbursable Medicare telehealth services. America's Essential Hospitals also encourages Congress to continue the Federal Communication Commission's COVID-19 Telehealth Program. Through this program, eligible health care providers can apply for funding for information services, telecommunications services, and devices to provide telehealth during the COVID-19 pandemic. This has been particularly beneficial for providing care to disadvantaged people, equipping patients who might not typically have access to these services or devices. Maintaining this program could help mitigate technological barriers to mental health care for some patients and should be continued beyond the PHE.

3. Increase integration, coordination, and access to care.

America's Essential Hospitals has long believed that policymakers should work with and support efforts by providers to integrate mental and physical health care in all settings. This is especially true for essential hospitals, which treat patients more likely to face social risk factors and comorbid conditions, including those related to behavioral health. Evidence shows a significant portion of behavioral health conditions go untreated, often on account of stigma, lack of detection, or lack of access to effective care.[9] As such, essential hospitals are leaders in creating programs to better integrate behavioral health with primary care, taking a collaborative, comprehensive approach to treating patients and improving outcomes while lowering costs.[10]

For example, an essential hospital in Indiana integrated behavioral health services, in addition to other wraparound services, onsite at nine federally qualified health centers. Before 2011, these services were available via referrals to outside providers. A 2018 study of the hospital's colocation of wraparound services associated the program with a 7 percent drop in the expected number of hospitalizations and a 5 percent reduction in emergency department visits during the following year. Researchers estimate these services saved between up to $14.2 million between 2011 and 2016.[11] These types of arrangements demonstrate the potential of behavioral health integration to improve outcomes, decrease unnecessary utilization, and control costs.

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[9] America's Essential Hospitals. Behavioral Health and Primary Care Integration at Essential Hospitals. October 13, 2015. https://essentialhospitals.org/institute/behavioral-health-and-primary-care-integration-at-essential-hospitals/. Accessed October 22, 2021.
[10] *Ibid.*
[11] Schweich E. Eskenazi Health Wraparound Services Reduced Costs, ED Visits. America's Essential Hospitals. October 11, 2018. https://essentialhospitals.org/institute/eskenazi-health-wraparound-services-associated-reduced-costs-ed-visits/. Accessed October 22, 2021.

Another essential hospital, in New York, operates an integrated behavioral health primary care practice to help patients with behavioral health needs better control their diabetes. In 2010, before the start of this innovative primary care practice, surveys found patients reported feelings of embarrassment and a perceived lack of empathy from their primary care providers. The hospital built a new primary care practice within its behavioral health building, where patients were accustomed to getting their care and where staff already were proficient at helping patients with mental illness feel comfortable. Patients received longer appointment times, and newly hired primary care staff were educated in cultural needs. Because of these changes, a higher percentage of the practice's patients showed A1c levels lower than eight, compared with other patients at the hospital and in the hospital's broader health system. The practice's patients also had a no-show rate of 8 percent, compared with 30 percent among patients contemporaneously receiving medical services without behavioral health services.[12]

Another association member, in Minnesota, identified a distinct group of behavioral health patients who were receiving inappropriate care due to the system's fragmented infrastructure. The hospital observed common misuse of services—for example, primary care instead of necessary specialized care—and issues related to follow-up care. To overcome these challenges, the hospital created a system of customized clinics, including a coordinated care clinic where patients can access both primary and specialty psychiatric care. The hospital uses a mental health and substance abuse screening process upon enrollment to appropriately place patients.

4. Ensure parity between behavioral and physical health care.

Three-quarters of patients cared for at essential hospitals are uninsured or covered by Medicaid or Medicare.[13] Ensuring parity for behavioral and physical health care, particularly among federal payers, is critical for essential hospitals to provide high-quality, comprehensive care to all. A key component to achieving parity is providing adequate payments for mental and behavioral health care, particularly for Medicaid beneficiaries.

The vital link between adequate reimbursement for Medicaid providers and access to care for Medicaid beneficiaries cannot be overstated. The history of low Medicaid base payment rates is rooted in structural racism, discriminating against the underrepresented and undervaluing the provision of care to patients the program serves.[14] Adequate Medicaid payments would ensure people who rely on the program—a population disproportionately comprising people of color—have equal access to care through providers who, themselves, are not disadvantaged due to below-cost payment rates.[15]

While essential hospitals will always serve the Medicaid population, their ability to do so becomes severely compromised when they are compensated well below cost, directly impacting the care available to Medicaid beneficiaries. Payment rates for mental health care must be actuarially sound to ensure plans can viably cover the needs of Medicaid beneficiaries and are able to appropriately reimburse providers for their services.

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[12] Guinan M. Premier Collaboration Highlights Correlation Between Behavioral Health, Readmissions. America's Essential Hospitals. April 19, 2019. https://essentialhospitals.org/premier-collaboration-highlights-correlation-behavioral-health-readmissions/. Accessed October 22, 2021.
[13] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey.* America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed October 22, 2021.
[14] Kozminski J. Structural Racism and Chronic Underfunding of Medicaid. America's Essential Hospitals. September 14, 2021. https://essentialhospitals.org/policy/structural-racism-chronic-underfunding-medicaid/. Accessed November 4, 2021.
[15] *Ibid.*

To further promote parity between physical and behavioral health care services, Congress should work with mental health care stakeholders to ensure medical necessity criteria and reason for denial of payment standards from mental health care are no more stringent than for other types of covered services. This is particularly important for the Medicaid population, which might not have the knowledge or resources to advocate for themselves.

5. Improve access to behavioral health care for children and adolescents.

In developing policies to mitigate barriers to mental health care, Congress must eschew one-size-fits-all approaches and ensure proposals accurately reflect the needs of the populations they are intended to serve. This is especially true for the pediatric population, which requires tailored services to meet their unique care needs.

Several essential health systems across the country include children's hospitals; these facilities witness daily the challenges presented by a growing mental health crisis among children and adolescents. Congress could help mitigate this issue through the Child Suicide Prevention and Lethal Means Safety Act (H.R. 5035), legislation to provide additional education, training, and access to resources to help health care providers prevent suicide among this population.

It is important for lawmakers to invest in the pediatric mental health workforce and ensure adequate access to evidence-based behavioral health services across the care continuum.

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The health of people and communities across the nation is only as strong as the investments we make to increase access to comprehensive, affordable care; grow and sustain a diverse workforce; and reduce disparities in underrepresented communities. Removing barriers to equitable, high-quality mental and behavioral health care will further aid essential hospitals in meeting their mission. Because essential hospitals care for all people, we care for the nation. When the nation supports our work, America works.

America's Essential Hospitals thanks the committee for the opportunity to share the essential hospital perspective, and we encourage lawmakers to keep these points in mind during the legislative development process. We look forward to working with lawmakers on a bipartisan basis to improve the provision of mental health care throughout the country.

If you have any questions, please contact Senior Vice President of Policy and Advocacy Beth Feldpush at 202-585-0111 or bfeldpush@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO