

**Statement
of the
American Hospital Association
to the
Committee on Ways and Means
of the
United States House of Representatives**

“America’s Mental Health Crisis”

February 2, 2022

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Committee on Ways and Means examines America’s mental health crisis.

As America enters the third year of the COVID-19 pandemic, health care providers are confronting a landscape deeply altered by its effects, including the emergence of behavioral health care as an even greater challenge than in previous years. While behavioral health care has long been underfunded, underappreciated and stigmatized, the pandemic has intensified the unmet need for services and has led to heightened difficulties for individuals with behavioral health conditions in accessing care.

Over the past two years, Congress has enacted several significant laws aimed at providing relief from the social and economic impacts of the pandemic. Several provisions contained in these laws are designed to address the behavioral health care crisis, but some gaps remain.

To further address the issues brought about or intensified by the pandemic, the AHA supports additional approaches to help ensure improved access to needed comprehensive, affordable and quality behavioral health services.



Workforce

Our health care system is underfunded and understaffed to meet Americans' behavioral health needs. Patients present with behavioral health care conditions in nearly every setting where they receive care, from emergency departments and acute inpatient units, to specialized psychiatric, geriatric, and eating disorder units. As noted in 2012 by the Agency for Healthcare Research and Quality, about 25% of patients admitted to a general hospital also have a behavioral health diagnosis.

The prevalence of behavioral health issues and their impact on physical health amplify the demand on hospitals and health systems across the continuum of care. Unfortunately, severe shortages in the behavioral health workforce hamper our ability to meet these needs. More than 100 million Americans live in areas with shortages of psychiatrists, as designated by the Health Resources and Services Administration (HRSA). HRSA projects shortages of psychiatrists and addiction counselors to persist through 2030. For hospitals and health systems, the pandemic exacerbated existing behavioral health challenges, with many hospitals forced to decrease the size of their behavioral health workforce due to budgetary pressures.

Additionally, the number of psychiatric beds has steadily decreased over the past few decades. The number of state-funded psychiatric beds per capita has declined by 97% between 1955 and 2016. The paucity of available beds has resulted in a sharp increase in the number of ED visits for behavioral health care services. According to the Agency for Health Care Research and Quality, between 2006 and 2014, the number of ED visits related to behavioral health diagnoses rose by 44%; visits related to suicidal ideation rose by 414%. Our members report that the practice of boarding — keeping patients in an acute-care setting or ED while they await the availability of a psychiatric treatment bed — has also increased significantly in recent years, with pediatric patients enduring the longest waiting times.

To address these shortages, Congress should:

- bolster student loan forgiveness programs to support training for behavioral health professionals at all levels;
- promote efforts to reduce variability of scope-of-practice laws and support changes that drive integration of care teams;
- lift **the cap on Medicare-funded residency slots** to enhance access to care and help America's hospitals better meet the needs of the communities they serve. enact **the Opioid Workforce Act of 2021 (S. 1438)**, which would add 1,000 Medicare-funded slots in approved residency programs in addiction medicine, addiction psychiatry and pain medicine. This would increase the number of providers available to address the nation's substance use disorder crisis.

In the Consolidated Appropriations Act, 2021, Congress created 1,000 new residency slots. The AHA supports the Pathway to Practice Training Program provisions, developed by this Committee, which would establish 1,000 medical school scholarships to promote diversity in

the medical workforce and create 1,000 new Medicare-funded residency slots annually, with a substantial number reserved for psychiatry.

Additionally, Congress should increase funding for HRSA's Title VII and VIII programs, including the health professions program, the National Health Service Corps, and the nursing workforce development program, which includes loan programs for nursing faculty. Congress should also consider expanding the loan program for allied professionals and direct support for community college education to high priority shortage areas in the health care workforce.

The Pandemic's Toll on Behavioral Health of Health Care Workers

The nation's entire health care workforce is strained from the ongoing pandemic, and health care workers often suffer emotional and physical stress from treating COVID-19 patients. A National Academy of Medicine study found that between 35%-54% of clinicians report at least one symptom of burnout, more than double the amount of burnout found in other fields.

Another recent study on the experiences of health care workers during the COVID-19 pandemic found that 93% reported experiencing stress, 86 percent reported experiencing anxiety, 77% reported frustration, 76% reported exhaustion and burnout, and 75% said they were overwhelmed. Worry and stress have led to sleep disturbances, headaches or stomachaches, and increased alcohol or drug use, according to a Kaiser Family Foundation Survey.

Through the American Rescue Plan Act (ARPA), Congress has begun to address these issues. The AHA applauds the provisions in the law dedicating \$140 million to establish programs to reduce suicide, burnout and substance use disorders among front-line workers, and directing HRSA to develop mental health and substance use disorder training programs for the health care workforce.

We urge Congress to enact the Lorna Breen Health Care Provider Protection Act, which would direct resources to reduce and prevent health care professionals' suicides, burnout and behavioral health disorders. This bipartisan, bicameral legislation would authorize grants to health care providers to establish programs that offer behavioral health services for front-line workers, and require the Department of Health and Human Services (HHS) to study and develop recommendations on strategies to address provider burnout and facilitate resiliency. Additionally, the bill would direct the Centers for Disease Control and Prevention to launch a campaign encouraging health care workers to seek assistance when needed.

Coverage

The Medicare and Medicaid programs each include policies that inherently treat behavioral health services differently than medical/surgical services in terms of remuneration; these policies should be repealed, including:

- The Institutions for Mental Disease (IMD) exclusion, which prohibits the use of federal Medicaid financing for care provided in mental health and SUD residential treatment facilities larger than 16 beds to patients ages 21 to 64. The exclusion is one of the few examples of Medicaid law prohibiting the use of federal financial participation for medically necessary care furnished by licensed medical professionals to enrollees, based on the health care setting providing the services. The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act loosened this prohibition by granting state Medicaid programs the option to receive federal matching payments for SUD treatment provided in certain IMDs for up to 30 days over a 12-month period, and this provision is set to expire in 2023. To alleviate the dire shortage of inpatient psychiatric beds, Congress should permanently repeal the IMD exclusion for both SUD and mental health treatment.
- The 190-day lifetime limit for inpatient psychiatric hospital care for Medicare beneficiaries. No other Medicare specialty inpatient hospital service has this type of arbitrary cap on benefits. Not only does this restriction limit access to care for many patients with chronic mental illness who will exceed 190 days of inpatient treatment, it also contributes to the stigma and discrimination against patients with mental illness. Currently, Medicare covers only 190 days of inpatient care in a psychiatric hospital in a person's lifetime. This 190-day limit unfairly creates a barrier to accessing care for beneficiaries who have a chronic mental illness. To remedy this discriminatory policy, Congress should enact the bipartisan Medicare Mental Health Inpatient Equity Act, (S. 3061/H.R. 5674), introduced by Senators Susan Collins (R-Maine) and Tina Smith (D-Minn.) and Representatives Paul Tonko (D-N.Y.) and Bill Huizenga (R-Mich.).

Mental Health and Addiction Parity Enforcement

More than a decade after the passage of a federal mental health and addiction parity law, hospitals and health systems still face numerous barriers in securing appropriate reimbursement from insurance companies, which continue to violate these laws and impose other administrative roadblocks that prevent patients from receiving needed care. In their 2022 Report to Congress on implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Departments of Labor, HHS, and the Treasury determined health insurers to be overwhelmingly in non-compliance with that law's requirements. The report identified specific examples of the inappropriate use of Non-Qualitative Treatment Limitations (NQTLs) that hinder patients' access to care, such as:

- Excluding coverage of certain medicines as treatment for SUD conditions, even though those medicines are evidence-based therapies;

- Covering nutritional counseling for medical/surgical conditions like diabetes, but not for mental health conditions where nutritional counseling would be appropriate, such as anorexia nervosa, bulimia nervosa, and binge-eating disorder;
- Automatically denying coverage for urine drug testing related to SUD;
- Requiring pre-certification for all mental health and substance use disorder outpatient services but only for a few medical/surgical outpatient services; and
- Applying unique criteria, such as requiring demonstrable progress for continued-stay coverage, for mental health and substance use disorder treatment, without applying similar criteria to medical/surgical benefits.

The 2022 Report to Congress recommends that Congress impose civil monetary penalties for violations of the law. A provision of the House-passed Build Back Better Act would implement CMPs for such violations. The report also recommends that the Department of Labor be given the authority to directly pursue parity violations by third parties that provide administrative services to health plans. In addition to these recommendations, the AHA recommends that Congress take the following additional actions to ensure compliance:

- Establish thresholds for “appropriate” use of the application of NQTLs in order to target potential bad actors for increased scrutiny;
- Direct the Department of Labor to use the findings in these cases to develop and disseminate guidance for health plans and require audits of health plans practices based on this guidance; and
- Require the exclusive application of streamlined and consistent eligibility criteria based on clinical evidence for admission authorization specific to behavioral health, including a standardized list of documentation necessary to demonstrate medical necessity — under such a requirement, a plan would not be allowed to ask for documentation other than what is listed.

Other payer practices that restrict access to care include overly broad use of prior authorization, automatic denials, inappropriate delays of approvals and insufficient provider networks. To address these practices, Congress should:

- Require standardized formats for prior authorization requests with standard fields for required clinical information and responses requiring detailed rationale for denial;
- Require the application of standardized claim review processes and deadlines, for example: communication protocols (e.g. use of fax machines instead of electronic transfer protocols only in rare instances), responses within 24 hours for urgent situations and 48 hours for non-urgent, regardless of business hours; and

- Require the Department of Labor and HHS to take action against plans found to have high rates of denials or delays that are overturned on appeal or that are in violation of their prompt pay contract terms.

Integration of Physical and Behavioral Health

Behavioral health is linked to patients' physical health, and both behavioral and physical health conditions are present in many hospitalized patients. To address this growing challenge, hospitals and health systems around the country are adopting integration.

For many hospitals and health systems, the ability to integrate behavioral health services into the daily operations of their affiliated primary care practices is essential. That means supporting their affiliated primary care physicians (PCPs) with evidence-based, standardized behavioral health screening and assessment tools to use at each patient visit. PCPs must be taught to effectively use those tools and apply the information produced by screenings. In addition, hospitals and health systems are establishing a continuum of services to which patients can be referred for further evaluation and treatment. When behavioral health competencies are not physically available on-site, PCPs — particularly those in geographic markets with few psychiatrists or other behavioral health specialists — may be able to access consultations via telehealth technologies. Remote specialists can consult virtually with PCPs about patients or connect directly with the patients virtually. Other hospitals and health systems are opening behavioral health urgent care centers. Some centers are stand-alone, while others are adjacent to, or co-located with, existing urgent care centers.

To further promote integration, Congress should support the development of primary care medical home models and other bundled payment models that explicitly include behavioral health providers.

Electronic Health Records

During the COVID-19 pandemic, it has been even more critical to share patient information and coordinate care. Such care coordination aids in the recovery of millions of individuals who are facing COVID-19-related stress and anxiety. Care coordination is particularly essential as mental health conditions, substance use and chronic medical conditions are often co-morbid. As one example, the American Heart Association has reported that patients hospitalized from heart attacks are three times as likely as the general population to develop depression.

To drive better health outcomes and deliver on value-based care, it is imperative that all hospitals and health systems have the ability to communicate electronically with psychiatric inpatient hospitals and outpatient behavioral health providers. However, to date, behavioral health has not been included in federal health information technology initiatives, making it challenging to provide coordinated care. Many behavioral health providers are using electronic health records, but the field is implementing this technology at a lower rate than other providers. Much of the infrastructure available from major electronic medical records and the

technological improvements have not been realized in mental health, as those providers were excluded from participation in the HITECH Act.

The federal government should provide financial assistance to help psychiatric hospitals and behavioral health providers use electronic health records optimally. In addition, the federal government should help ensure that major medical/surgical hospital EMR vendors build out robust behavioral health platforms.

Additionally, we applaud Congress for amending CFR 42 Part 2 to better align with HIPAA, and we urge you to encourage the Administration to promulgate the final rule implementing this alignment as soon as possible.

Conclusion

The AHA appreciates your recognition of the challenges ahead and the need to examine America's mental health crisis. We look forward to working with the Committee this year on legislation to advance access to quality behavioral health care for all.