American Hospital Association™
Advancing Health in America

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The Honorable Brett Guthrie
U.S. House of Representatives
Chair
Energy and Commerce
Subcommittee on Health
Washington, DC 20515

The Honorable Anna Eshoo
U.S. House of Representatives
Ranking Member
Energy and Commerce
Subcommittee on Health
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

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) thanks you for your leadership in developing approaches to better meet the nation's behavioral health care needs. As you begin work to reauthorize key programs within the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018, we encourage you to consider policies that will reduce barriers to receiving and administering behavioral health care by improving payment policies, reducing unnecessary regulatory and administrative burden, and strengthening the behavioral health workforce.

REVISING FEDERAL PAYMENT POLICIES FOR BEHAVIORAL HEALTH

Arbitrary and outdated payment policies continue to reflect the undervaluing of behavioral health services; addressing these gaps in payments for behavioral health providers must be a key element of any legislative package seeking to expand access to behavioral health care. To do so, we respectfully request the committee considers the following:

Eliminate the Institutions for Mental Disease (IMD) Exclusion

Since 1965, the IMD exclusion has prohibited federal payments to states for services for adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds and provide inpatient or residential behavioral health (SUD and mental illness) treatment. The discriminatory IMD policy was established at a time when SUDs were not considered medical conditions on the same level as physical

health conditions. Today, we know that SUD is a brain disease that requires evidence-based clinical treatment. 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 solely on the health care setting providing the services.

In 2018, The AHA was pleased to support a provision in the SUPPORT Act which 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. We have heard from our members about how impactful this additional flexibility has been. SUPPORT Act-enabled Medicaid waivers have allowed our members to provide access to behavioral health care through IMDs as well as other parts of the care continuum; we believe that in doing so long-term institutionalization has actually been prevented. **The AHA supports the extension of this program.**

As the committee continues to look for ways improve access to needed substance use disorder treatment services for Americans and reducing stigma, we encourage you to permanently repeal the IMD exclusion for both SUD and mental health treatment. Substance use disorder treatment requires access to the full continuum of care, including inpatient care, partial hospitalization, residential treatment and outpatient services. Different types of patients require different clinical services from across the care continuum, and the IMD exclusion currently excludes critical elements of that care continuum. These populations include adolescents, pregnant women, individuals with unstable housing, persons with high relapse potential, and individuals who have opioid use disorders or other SUDs with cooccurring alcohol or benzodiazepine addictions. Investing only in outpatient or community-based care and failing to provide states with relief from the IMD exclusion would continue to deny many of these patients access to the most clinically appropriate care. To alleviate the dire shortage of inpatient psychiatric beds, **Congress should permanently repeal the IMD exclusion for both SUD and mental health treatment and allow access to beds that are otherwise ready to take patients in need**.

Remove the 190-day Lifetime Limit

As we work to further integrate physical and behavioral health to better address the nation's behavioral health needs, the 190-day lifetime limit on coverage is another obstacle that remains. Currently, Medicare covers only 190 days of inpatient care in a psychiatric hospital in a person's lifetime. No other Medicare specialty inpatient hospital service has this type of arbitrary cap on benefits. For many patients, chronic mental illness will be a lifelong journey and could far exceed 190 days of inpatient treatment.

While not originally addressed in the SUPPORT Act of 2018, we urge the committee to consider other existing policies that serve as barriers for patients seeking to access

care. With the nation's population aging and an increasing number of seniors and people with disabilities seeking inpatient care to address their behavioral health needs, now is the time to repeal this discriminatory policy and ensure that Medicare beneficiaries can receive necessary inpatient psychiatric care. The AHA supports bipartisan legislation such as the Medicare Mental Health Inpatient Equity Act (H.R. 5674 — 117th) to remedy this discriminatory policy.

Bolster Reimbursements for Behavioral Health Providers

Traditional fee-for-service payment systems, including Medicare, have inadequately reimbursed providers across the behavioral health service continuum. Fee-for-service payment structures rarely reimburse for important elements of behavioral health care, such as coordinating care across providers and settings, or for non-face-to-face care management, including referrals and case management. Current reimbursement levels also reflect an undervaluing of behavioral health services, which may require more evaluation and time than certain medical services. For example, schizophrenia, unlike anemia, cannot be identified with a blood test; x-rays can be used to reveal broken bones, but not depression. In addition, separate funding streams and benefit structures for psychiatric and substance use disorders create barriers and limit integration. This is particularly true for the Medicaid program, the largest payer of behavioral health care.

It is important to consider the impact low reimbursement rates have on behavioral health providers' ability to recruit and retain the next generation of behavioral health professionals to serve the growing need for behavioral health care.

REDUCING REGULATORY BURDENS

While federal regulations are largely intended to ensure patients receive safe, high-quality care, there are many which do not improve care but rather, serve as barriers for patients seeking behavioral health care. We respectfully request the Committee considers the following while drafting legislation to the reauthorize the SUPPORT Act.

Repeal In-Person Telehealth Requirement for Behavioral Health

Since the passage of the SUPPORT Act of 2018, behavioral health is one specialty that has seen sustained growth in telehealth utilization. In fact, prior to the pandemic, telehealth visits accounted for less than 1% of behavioral health visits. During the pandemic, they peaked at about 40% of all behavioral health visits and have been sustained at around 36%.[1] There continues to be an increasing demand for behavioral

[1] Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic | KFF

health services, but additional flexibilities are needed to ensure people who need it most are able to access these services.

The Consolidated Appropriations Act of 2021 requires that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment and an in-person visit annually thereafter. From an access perspective, requiring an in-person visit six months before and annually after may serve as an additional barrier from receiving care, particularly for patients in rural or underserved areas. During the pandemic, 55% of patients utilizing behavioral telehealth services were in rural areas.[2] Additionally, the Health Resources & Services Administration (HRSA) has stated that over 158 million people live in mental health provider shortages areas.[3] These patients are not able to readily see an in-person provider given the shortages in their geographic area.

From a quality perspective, ASPE has highlighted that part of what makes behavioral health a great use case for telehealth is the fact that in person and physical exams may not be required as frequently.[4] Data from the pandemic suggest that behavioral telehealth visits were generally substitutes for in-person care, as opposed to overutilization of services. **Therefore, in the interest of supporting increased access, improved quality and reduced costs, we recommend repealing the in-person visit requirements for behavioral telehealth services.**

Establishing DEA Special Registration Process for Telemedicine for Administration of Controlled Substances

The Ryan-Haight Act of 2008 amended the Controlled Substances Act to prohibit prescribing of controlled substances via online forms and outlined requirements for in-person evaluations prior to the prescribing of controlled substances. This in-person requirement could be waived during PHEs (as was done during the COVID-19 state of emergency) or through a special registration process to be administered by the Drug Enforcement Agency (DEA). During the COVID-19 state of emergency, the DEA enacted flexibilities to certain requirements to ensure patients could continue to receive life-saving medications via telehealth while minimizing exposure and preserving provider capacity. Flexibilities, including waiving the required initial in-person visit prior to prescribing controlled substances via telehealth and allowing the use of telephone evaluations to initiate buprenorphine prescribing, have proved critical in best supporting patients. These waivers have improved access to care for patients with substance use disorder where there were already shortages in prescribers even prior to the pandemic.

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[2] Ibid.
[3] Shortage Areas (hrsa.gov)
[4] Medicare-Telehealth-Report.pdf (hhs.gov)

The requirement that the agencies issue a regulation outlining such a special registration process for telemedicine was first established nearly 14 years ago and re-enforced in the SUPPORT Act of 2018 by establishing a deadline of Oct. 24, 2019, for the regulations to be developed. To date, the DEA has continued to ignore congressional intent on this process, and it is clear more congressional action is needed in the reauthorization of the SUPPORT ACT. In DEA's recently proposed rules, the agency has imposed burdensome restrictions and additional administrative requirements on providers and patients. We urge Congress to consider the following:

- **Continue** to urge DEA to require proposed and final rulemaking from agencies for the Special Registration for Telemedicine Regulation.
- **Grant** a permanent exception for separate registrations for practitioners in states that have medical licensing reciprocity requirements.
- **Require** agencies provides a proposed interim plan if there is ever a gap in PHE waivers and rulemaking.

Medication Assisted Treatment

To help prevent SUD relapse, Congress can also provide additional support for programs that fund hospital efforts to initiate medication assisted treatment (MAT) in emergency departments (EDs). The SUPPORT Act requires Medicaid programs to cover MAT from October 2020 through September 2025, and it expands certain providers' ability to treat up to 100 patients in the first year of receiving a waiver. However, access to these programs remains limited. **Congress should make permanent the SUPPORT Act's MAT provisions and expand grant funding included in the 2018 law for hospitals** and other entities to enable the development of protocols on discharging patients from the ED who have overdosed on opioids, including providing MAT; connecting patients with peer-support specialists; and supporting referrals to community-based treatment.

Prior Authorization for Behavioral Health Services

Millions of Americans rely on commercial insurers for their health care coverage, including in the Medicare program through Medicare Advantage (MA) plans. Unfortunately, practices such as prior authorization can result in inappropriate denials, additional burdens on providers, and ultimately delays a patient's access to needed care.

The AHA remains particularly concerned with current prior authorization practices for Medication Assisted Treatment (MAT) which are not evidence based and lack uniformity with insurers. Because many mental health services are more time-based than physical health services, with fewer quantitative ways to measure outcomes, these processes take a disproportionate toll on behavioral health services. Studies have shown that, compared with patients whose insurance did not impose prior authorization restrictions

on their medication, odds of treatment effectiveness were 20-20% lower due to lack of medication adherence.[5] Payer practices that restrict access to care include overly broad use of prior authorization, automatic denials (most of which are overturned upon appeal), inappropriate delays of approvals, and insufficient provider networks.

To address these practices within MAT, Congress should:

- **Require** a clear list of drugs subject prior authorization that is uniform across insurers to provide patients and providers with clear and consistent information.
- **Make clear** that coverage across the entire treatment spectrum is necessary (rather than requiring prior authorization each time the prescription is filled).
- **Pass** comprehensive legislation to streamline prior-authorization requirements such as the Supporting Seniors' Timely Access to Care Act.

Psychiatric Facilities — Emergency Medical Treatment and Labor Act (EMTALA) Regulations

Psychiatric facilities confront the daunting task of complying with a growing number of federal regulations. This means clinical staff must devote more and more time to regulatory compliance, distracting from patient care. In addition, these facilities are required to take extra steps to mitigate risks of patient self-harm. Unfortunately, federal guidelines have been unclear and contradictory to clinical care, resulting in millions of dollars in expenses to retrofit facilities to comply with varying interpretations of CMS guidelines on ligature risk abatement.

Another regulatory concern relates to a psychiatric facility's responsibilities under EMTALA. The intent of the law is to ensure that any patient who presents to an ED would be stabilized regardless of the patient's ability to pay. However, regulators have begun interpreting the law in a way that imposes additional requirements on psychiatric facilities. These requirements are not consistent with the intent of EMTALA, run counter to accepted clinical practice, and impose enormous costs on these facilities, which already suffer from inadequate payment.

We urge the committee to consider two ways to reduce the administrative burden on providers:

- **Direct** CMS to review and revise conditions of participation for psychiatric facilities to reduce unnecessary regulatory burdens, such as B-tag requirements and environmental risk mitigation.

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[5] Boytsov, N., Zhang, X., Evans, K.A. *et al.* Impact of Plan-Level Access Restrictions on Effectiveness of Biologics Among Patients with Rheumatoid or Psoriatic Arthritis. *PharmacoEconomics Open* **4**, 105–117 (2020). https://doi.org/10.1007/s41669-019-0152-1

- **Clarify** requirements under EMTALA for inpatient psychiatric facilities with EDs.

STRENGTHENING THE HEALTH CARE WORKFORCE

The chronic underfunding for behavioral health services intensified hospitals' and health systems' ability to retain critical staff, especially as the financial pressures of the past several years further eroded hospitals' ability to subsidize these services. As the need for behavioral health services continues to rise, the nation is ill-prepared to respond to these needs due to severe shortages in the behavioral health workforce.

Another key tool when it comes to supporting and expanding the behavioral health workforce are policies that make it harder for existing providers to treat patients. Reducing barriers to licensure can help maximize limited provider capacity, particularly in areas where there are shortages. **The AHA supports efforts to ensure that licensure processes are streamlined for providers employed by hospitals and health systems operating across state lines and encourages additional research be done on the feasibility, infrastructure, cost and secondary effects of licensure.**

We are committed to working with the health care field and with Congress and the Administration to address the long-term workforce needs. The AHA recommends the following suggestions to support the behavioral health workforce:

- **Reauthorize** the Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program.
- **Invest** in graduate medical education (GME) and increase slots for behavioral health in underserved areas.
- **Streamline and simplify** licensure application and processing by reducing variability of scope-of-practice laws and support changes that drive integration of care teams.

CONCLUSION

The AHA believes that physical and mental health care are inextricably linked, and we share your view that everyone deserves access to high-quality behavioral health care. We look forward to working with you to advance legislation to that end.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Advocacy and Political Affairs