ABHW
Association for Behavioral Health and Wellness
*Advancing benefits and services in mental health, substance use and behavior change.*

January 26, 2016

The Honorable Orrin Hatch, Chairman
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden, Ranking Member
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

We are writing to provide comments on your policy options paper, *Bipartisan Chronic Care Working Group Policy Options Document*. We are grateful for your efforts to make changes that improve the lives of millions of Americans living with chronic illness, and we appreciate the opportunity to provide you with comments on your draft document on behalf of the Association for Behavioral Health and Wellness (ABHW).

ABHW is the national voice for companies that manage behavioral health and wellness services. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health to approximately 150 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum.

Our policy priorities fall into the five areas below:

- Advancing Team-Based Care – Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries
- Expanding Innovation and Technology – Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees
- Expanding Innovation and Technology – Expanding Supplemental Benefits to Meet the Needs of the Chronically Ill Medicare Advantage Enrollees
- Expanding Innovation and Technology – Increasing Convenience for Medicare Advantage Enrollees through Telehealth
- Expanding Innovation and Technology – Providing ACOs the Ability to Expand Use of Telehealth

**Advancing Team-Based Care – Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries**

Managed behavioral health care organizations (MBHOs) bring substantial expertise and valuable capabilities to the current focus on integration, including strong informatics and data analytics; experience with health risk assessment and stratification; and familiarity with preventive and chronic models of care. Through extensive experience serving people with behavioral health disorders, MBHOs have witnessed the challenges that the medical system exhibits with regard to treating chronic illness among individuals with mental health and substance use disorders. Having managed mental health benefits, substance use disorder benefits, and now integrated behavioral health benefits, ABHW members, whether carve-out

entities or health plans with their own internal specialty organization for behavioral healthcare, are well positioned to play a pivotal role in integrating behavioral and medical healthcare for Medicare beneficiaries.

A barrier to integrated behavioral health care is that Medicare providers are prevented from sharing 42 CFR Part 2 (Part 2) data without written authorization from a patient. Part 2 protections of substance use disorder records are such that a Medicare provider could be treating a beneficiary for pain and not have access to substance use disorder information showing that the beneficiary is addicted to opiates. Part 2 was created after Congress recognized that the stigma associated with substance use disorders and the fear of prosecution deterred people from entering treatment. While a laudable goal, these special protections create barriers to integration of behavioral and physical health, such as: inhibiting electronic exchange of health information, reducing the effectiveness of clinical reports to physicians, and delaying data transmission to providers. Changing current regulations so that Part 2 is aligned with the HIPAA privacy rule to allow transmission of Part 2 data without written authorization for treatment, payment, and operations purposes will help promote integrated care.

A further barrier is the lack of Electronic Health Records (EHRs) in behavioral health. EHRs facilitate integrated care, enhance e-prescribing, and track clinical outcomes. These benefits are hard to achieve if behavioral health providers are behind on EHR implementation. Fewer than half of behavioral health providers possess fully implemented EHR systems. When Congress passed the HITECH Act in 2009, it left out behavioral health providers. On average, information technology spending in behavioral health organizations represents 1.8% of total operating budgets – compared with 3.5% of total operating budgets for general health care services. ABHW member companies coordinate behavioral health care with an individual's medical care and use clinical outcomes to help measure the effectiveness of the consumer's treatment; without EHRs this level of care coordination is more difficult to accomplish. To help enable integrated care, ABHW supports extending health information technology assistance eligibility to more mental health and substance use disorder professionals and facilities.

**Expanding Innovation and Technology – Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

ABHW supports giving Medicare Advantage (MA) plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees. In particular, we support the notion of a reduction in cost sharing and suggest offering incentives to MA plans to encourage them to provide lower co-payments, or tiered co-payments based on income levels, such that patients with small fixed incomes would have very low co-payments. We believe that lower co-payments may improve outcomes for patients living with chronic diseases. ABHW members have found that patients frequently do not seek outpatient behavioral health services because of high co-payments. If a patient needs to pick between medications and outpatient services, he or she is choosing medications. These higher co-payments become a barrier that contributes to high readmission rates because people are electing to receive only a piece of the recommended treatment (medication but not outpatient therapy) even though studies show that a combination of medication and outpatient therapy leads to better patient outcomes.

In addition, we support adjustments to provider networks that allow for a greater inclusion of providers and nonclinical professionals to treat chronic conditions. In particular, we support Medicare payment for peers. ABHW member companies are increasingly employing Peer Support Services (PSS) and view them as a valuable component of a comprehensive approach to wellness. PSS are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services that are trained to offer support and assistance to others in their recovery and community-re-integration process. Peer Support is designed on the principles of consumer choice and the active involvement of persons in their recovery processes. We have seen that PSS are an effective component of behavioral

health treatment and have a positive impact on consumers, purchasers, and payers. Peer Support Services are also successful in helping patients engage with their health care providers. Peers can accompany patients to appointments and help them advocate on their own behalf. PSS are not currently eligible for reimbursement under Medicare, and we recommend a change in that policy to help prevent the progression of mental illness and addiction.

ABHW also supports covering all possible provider types that are currently excluded from reimbursement, in particular mental health counselors and marriage and family therapists. Despite the high rates of mental health disorders, many Medicare beneficiaries do not have access to a mental health professional because of their remote locations and the shortage of mental health providers. Medicare currently recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses to provide covered mental health services. In order to increase the array of providers available to Medicare beneficiaries and decrease the workforce shortage, ABHW supports Medicare's recognition of mental health counselors and marriage and family therapists. This would increase the pool of eligible mental health professionals by over 165,000 licensed practitioners and help increase access to care.

Recognizing other non-traditional services and providers may help as well. One example of an effective approach for those who speak English as a second language is the Promotoras model. In this case, lay members in the Hispanic/Latino community who receive specialized training to provide basic health education in the community serve as liaisons between their community, health professionals, and human and social service organizations. Promotoras act as advocates, educators, mentors, and translators for patients.

**Expanding Innovation and Technology – Expanding Supplemental Benefits to Meet the Needs of the Chronically Ill Medicare Advantage Enrollees**

ABHW supports allowing MA plans to offer a wider array of supplemental benefits than they do today. Specifically, we support the inclusion of community-based wraparound services for individuals with complex needs that allow people to live in their communities. These social supports such as supported employment, supported housing, wellness plans, and transportation have been proven to help people recover and keep patients from unnecessary inpatient hospital stays. They also keep the goal of recovery at the forefront by helping to maximize function and quality of life. Medicaid waivers have helped to allow for the provision of wraparound services, but the Medicare benefit is not as flexible. We encourage the Medicare program to recognize the benefit of community-based wraparound services and allow Medicare (or MA plans) to reimburse for these services, as appropriate, for individuals with chronic conditions.

**Expanding Innovation and Technology – Increasing Convenience for Medicare Advantage Enrollees through Telehealth**

Expanding access to telehealth services is a top priority for ABHW member companies. We favor permitting MA plans to include certain telehealth services in its annual bid amount and suggest that the services provided be expanded beyond those allowed under the traditional Medicare program. Telehealth services have been proven to drive important advancements for our beneficiaries, expand access to care, improve health outcomes, reduce the inappropriate use of psychotropic medications, overcome the stigma barrier, and cut costs.

Telehealth has the ability to reach a broad range of behavioral health consumers, including patients who reside in areas where there is a shortage of behavioral health providers; elderly patients who may have difficulty leaving their homes to travel to an appointment; and the deaf.

Eliminating the originating site and geographic restrictions to Medicare reimbursement, increasing the list of eligible providers, addressing state regulations and licensure issues, and lessening the barriers created by the Ryan Haight Act would improve access and quality of care for people with behavioral health needs.

The original intent of the telehealth regulation regarding urban versus rural communities was based on the assumption at the time that rural areas were underserved, and therefore supporting telehealth in rural areas would help the underserved. While that assumption is still valid, present reality shows that many urban areas also suffer a shortage of qualified doctors and could similarly benefit from telehealth.

A shortage of behavioral health providers, particularly geriatric psychiatrists, limits access to mental health services. The shortage of psychiatrists and sub-specialists with expertise in geriatric populations is predicted to worsen in the near future. Making telemental services available in all settings is one way to optimize the psychiatric workforce. Expanding the list of eligible Medicare providers to include any licensed behavioral health provider practicing within the scope of his or her license would also help increase access to services. One opportunity to accomplish this goal is to add additional eligible telehealth providers in the next update of the physician fee schedule.

Regarding licensure, states need a way to mutually recognize medical licenses granted by other states, such as what is included in the interstate nursing compact. Reciprocal recognition of other state licenses will circumvent state-by-state licensing and renewal fees and lengthy delays in granting a license. We encourage Congress to direct states to collaborate to create common licensure requirements.

The Ryan Haight Act regulates anyone who delivers, distributes, or dispenses medication through the internet. It requires at least one in-person visit. The initial intent of the law has become a real barrier to administering telehealth services, as oftentimes patients are unable to visit with a provider in person because of a behavioral health provider shortage or physical difficulty traveling. Psychiatrists providing tele-services should be able to prescribe the same range of medications as face-to-face visits. Studies show that tele-prescribing is less abused than prescribing in a face-to-face setting or by phone. ABHW recommends amending the Ryan Haight Act to remove the restrictions preventing psychiatrists from prescribing medicine via telehealth services.

While more research is necessary to understand the full effect on service utilization and healthcare costs, there is a general acceptance of telehealth today. The Centers for Medicare and Medicaid Services (CMS) notes that telehealth is viewed as a cost-effective alternative to traditional service delivery (Centers for Medicare and Medicaid Services, Telemedicine). A key change in regulation could immediately make an enormous difference in access to health care and the health of Medicare beneficiaries; early findings demonstrate that telehealth and teleconsultation programs for behavioral health services may reduce state spending or produce overall cost savings (Improving Behavioral Health Access & Integration Using Telehealth & Teleconsultation: A Health Care System for the 21st Century; National Academy for State Health Policy; November 2015).

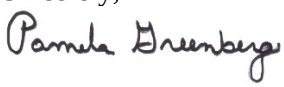
**Expanding Innovation and Technology – Providing ACOs the Ability to Expand Use of Telehealth**

ABHW supports lifting the originating site requirement entirely for ACOs as well as MA plans. Telehealth is an equally important tool for MA plans as it is for ACOs; and as stated above, the current originating site requirement impedes medically necessary, cost-effective care. This is especially true for individuals with a mental or substance use disorder who may not be able to physically get themselves to an originating site due to the symptoms of their disease. Many of these individuals have co-occurring physical illnesses that often go untreated when their behavioral illness is not treated. This can lead to

increased costs on the medical side. Making behavioral health treatment as accessible as possible has a positive impact on an individual's behavioral and physical health and decreases overall health care costs.

Thank you again for directing your attention toward the impact of chronic disease on the Medicare program and the people it serves. We appreciate the opportunity to provide you with comments on your policy options document, and we look forward to working with you to enact some of these policies. If you have any questions, please contact Rebecca Klein at (202) 449-7660 or klein@abhw.org.

Sincerely,



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