



November 1, 2021

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

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

Dear Chairman Wyden and Ranking Member Crapo,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to respond to your open letter to behavioral health stakeholders requesting recommendations to enhance behavioral health care. ABHW appreciates your leadership and looks forward to working closely together on our shared goal to improve access to mental health and substance use disorders care and treatment.

ABHW serves as 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 (MH) and substance use disorders (SUDs), and other behaviors that impact health and wellness.

Overarchingly, our organization's goals aim to **increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes**. Furthermore, through our policy work, we strive to promote equal access to quality treatment and address the stark inequities created by systemic racism. We are deeply concerned about health disparities in this country in the areas of MH and SUD services and are committed to promoting health equity in the health care system.

Behavioral health services have become increasingly important because of social isolation, job loss, illness and death, and domestic violence related to COVID-19; and we anticipate the utilization of such services will continue long after the public health emergency (PHE) is lifted. We believe addressing the following issues can play a critical role in expanding access to MH and SUD services and provide long lasting improvements to our nation's behavioral health system.

Our recommendations are explained below.

Strengthening Workforce

We encourage Congress to advocate for solutions to expand access to care and address ongoing workforce shortages across the country to help ensure people who need MH and/or SUD treatment get the care they need. As one first step, Congress should consider increasing funding to behavioral health providers so that we have an adequate workforce to meet the increasing need for MH and SUD services. We recommend expanding eligible Medicare providers to include marriage and family therapists (MFTs), mental health counselors (MHCs), and certified peer support specialists.

- *Medicare coverage of mental health counselors and marriage and family therapists.* Recognition of MHCs and MFTs as Medicare providers 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.¹ We ask that you include in your package the *Mental Health Access Improvement Act (S. 828, H.R. 432)*, which recognizes MHCs and MFTs as covered Medicare providers, helps address the critical gaps in care, and ensures access to needed services.
- *Medicare coverage of peer support services.* Certified peer support specialists can be vital in providing support to people living with mental health conditions and SUDs. These paraprofessionals are individuals with lived experience of recovery from a MH disorder or SUD. This evidence-based practice helps individuals navigate the often-confusing health care system, get the most out of treatment, identify community resources, and develop resiliency. Due to the COVID-19 pandemic, engagement with treatment and care has been disrupted, but finding and utilizing support, such as peer services, in a timely manner can help mitigate negative health outcomes of the disruption. Recently, the *Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act of 2021 (S. 2144, H.R. 2767)*, was introduced. This legislation is an important step in recognizing the unique role of peer support specialists in helping individuals better engage in services, manage physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities.

Increasing Integration, Coordination, and Access to Care

Increase access to medication assisted treatment (MAT). Research has shown that MAT is the most effective intervention to treat opioid use disorders (OUDs) as it significantly reduces illicit opioid use compared to nondrug approaches and increased access to MAT can reduce overdose fatalities.² As such, ABHW supports the following policy changes to increase MAT access.

- *Eliminate the X-Waiver.* During the COVID-19 pandemic, overdoses and related deaths continue to rise, making access to MAT crucial. HHS recently published a Notice which allows providers to treat up to 30 patients using MAT without first obtaining the X-waiver. While this is a step in the right direction to combat OUDs, more must be done. We ask Congress to pass the *Mainstreaming Addiction Treatment (MAT) Act (S. 445/H.R. 1384)*. This bipartisan legislation would remove the federal rules established by the DATA 2000 Act that require health care practitioners to obtain a waiver (X-Waiver) from the Drug Enforcement Administration (DEA) before prescribing buprenorphine to treat OUDs. The legislation would remove a major hurdle to prescribing MAT, positively impact existing nationwide shortages of treatment providers, and expand access to OUD treatment.
- *Eliminate the in-person evaluation requirement.* Given that not all individuals with SUDs are able to have an initial in-person visit with a provider due to behavioral health provider shortages or physical difficulty traveling, ABHW advocates for actions which would eliminate the in-person evaluation requirement before a provider can utilize MAT via telehealth. The Ryan Haight Act, originally passed to combat the rise of rogue online

¹D. 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.

² Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder, Pew Fact Sheet, November 22, 2016.

pharmacies, requires an in-person evaluation before a provider can prescribe MAT using telehealth to treat SUDs. This safeguard likely suppresses the use of MAT because under current law, the evaluation requirement cannot be fulfilled via a telehealth visit.³ While the Ryan Haight Act allows for providers to use telemedicine when engaged in the “practice of medicine,” it is nearly impossible for providers to do so. The definition of “practice of telemedicine” includes seven categories in which a provider could meet the in-person requirement through a virtual care platform, including under a special registration granted by the DEA. However, the DEA never created that registration process. With the Special Registration for Telemedicine Act of 2018, which was part of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act*, the DEA had until October 24, 2019, to outline rules for providers with a special registration to prescribe controlled substances. That deadline passed without action, severely impeding those with OUDs from receiving the care they need.

The Centers for Disease Control and Prevention (CDC) recently released updated data predicting 99,000 people died from an overdose in the 12 months ending March 2021, a 31% increase from the previous year. Enhancing access to this treatment is even more critical given these numbers. Additionally, nearly 40% of counties in the United States do not have a provider with a DEA X-Waiver to prescribe buprenorphine. We urge Congress to pass legislation that would increase the number of providers to treat opioid use disorder and work with the DEA to promulgate the special registration rule that would allow efficient access to services through telehealth.

Support suicide prevention efforts and increase focus on crisis services. Congress passed the *National Suicide Hotline Designation Act of 2019*, making the National Suicide Prevention Lifeline an easy to remember three-digit number, 9-8-8. The need for Americans to have readily available access to mental health crisis services through a ubiquitous number like 9-8-8 is more urgent than ever.

In addition to swiftly implementing the new crisis line number, it is equally important that the crisis line have adequate resources so that it can operate effectively and ensure that all Americans can access it. Since demand will undoubtedly increase for services of the crisis line, there will need to be significant investment after the initial implementation to expand capacity and provide services consistently for MH and SUD crises. Therefore, we ask that Congress pass the *Suicide Prevention Lifeline Improvement Act of 2021 (S. 2425, H.R. 2981)*. This legislation would require increased coordination, data sharing, and provide more funding to support community-based crisis service delivery.

ABHW supports an evidence-based continuum of crisis care for individuals experiencing a behavioral health crisis. Few communities have a robust crisis system in place, including sufficient local Lifeline call center capacity, mobile crisis teams, peer respite, and crisis stabilization programs for people who need more intensive interventions. Without these services, the use of emergency department and jails are the default. Ensuring crisis response and building and sustaining effective crisis care is vital in communities across the country and critical to advancing equity.

ABHW support the *Crisis Assistance Helping Out on the Streets (CAHOOTS) Act (S. 764/H.R. 1914)* and urges Congress to pass the CAHOOTS Act that would provide enhanced Medicaid and state planning grants for mobile crisis services to increase access to crisis resources and support

³ Kayla R. Bryant, *Health Law Daily Wrap up, Strategic Perspectives: States Fail to Fully Use Telemedicine to Fight the Public Health Crisis*, Wolters Kluwer (September 28, 2018), p.2.

effective responses for individuals in acute distress. It is crucial that individuals experiencing a behavioral health crisis receive equitable and appropriate responses and care, separate from emergency medical and law enforcement interventions. We greatly appreciate the initial investment in mobile behavioral health crisis response that Congress provided as part of the *American Rescue Plan Act* and recommend passage of the additional enhanced federal Medicaid funding to provide community-based mobile behavioral health response to individuals experiencing a mental health or substance use disorder crisis.

Ensure health coverage for individuals released from jails and prisons. ABHW strongly supports the *Medicaid Reentry Act of 2021 (S. 285, H.R. 955)*, to grant Medicaid eligibility to incarcerated individuals 30 days prior to their release to promote the health care needs of individuals transitioning back into communities. According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness. Of those with serious mental illness, approximately 75 percent also have a co-occurring SUD. Allowing incarcerated individuals to receive services covered by Medicaid 30 days prior to their release from jail or prison will expand access to vital mental health and addiction services. Equipping individuals with timely access to addiction, mental health, and other health-related services before release will facilitate the transition to community-based care upon release that is necessary to help break the cycle of recidivism. This is even more critical during the COVID-19 pandemic.

While this legislation is currently being considered in the 2022 budget reconciliation package, ABHW strongly urges Congress to act swiftly on the *Medicaid Reentry Act* to help improve health outcomes, advance equity, save money, and increase reentry success.

Promote the integration of care. As we work to recruit and train practitioners to be part of the mental health and substance use disorder workforce, patients need immediate, as well as long-term solutions. One of the most promising solutions to get patients the care that they need in an unimpeded, timely manner is broad implementation of coordinated primary and behavioral health care models. The most promising strategy for providing prevention, early intervention and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. The Collaborative Care Model (CoCM) is a proven, measurement-based approach to providing treatment in a primary care office that is evidenced-based and already reimbursed by Medicare, with established CPT codes.

CoCM involves a primary care physician working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads. This model allows patients to receive behavioral health care through their primary care doctor alleviating the need to seek care elsewhere unless behavioral health needs are more serious. CoCM demonstrably improves patient outcome because it facilitates adjustment to treatment by using measurement-based care. Unlike other models of integrated behavioral health care so far, CoCM is supported by over 90 randomized control studies which indicate that implementing the model improves access to care and has been shown to reduce depression symptoms by fifty percent. It is currently being implemented in many large health care systems and group practices throughout the country and is also reimbursed by several private insurers and Medicaid programs. Accordingly, we urge Congress to pass the *Collaborate in an Orderly and Cohesive Manner (COCM) Act (H.R. 5218)*, and to explore proposals that would help expand the use and adoption of CoCM and other evidence-based integrated care models.

To better promote expanded access to comprehensive and evidence-based MH and SUD care, we support nationwide expansion of the Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program through the bipartisan *Excellence in Mental Health and Addiction Treatment Act of 2021 (S. 2069/H.R. 4323)*. CCBHCs offer a comprehensive array of services needed to improve access, stabilize people in crisis, and provide essential treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHCs integrate additional services to ensure a community-based, holistic, and innovative approach to

behavioral health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration, as well as coordination with hospitals, emergency departments, and law enforcement.

Eliminate the Medicaid Institution for Mental Diseases (IMD) exclusion. We urge Congress to remove policy barriers that limit beneficiary access to needed and appropriate MH and SUD care. This includes ending the IMD exclusion, which prohibits Medicaid reimbursement for adults under the age of 65 in residential behavioral health facilities with more than 16 beds. The IMD payment prohibition is a long-standing provision of the Medicaid statute that forbids the federal government from providing Medicaid matching funds to states for services rendered to certain Medicaid – eligible individuals, age 21-64, who are patients in IMDs.

While federal legislative activity and regulatory guidance in the past few years have paved the way for additional opportunities to provide services in IMDs, Congress should act now and pass the *Increasing Behavioral Health Treatment Act (H.R. 2611)*, to permanently remove the IMD exclusion to increase access to inpatient care when it is medically necessary.

All people with mental illness and SUDs, including Medicaid beneficiaries, should have access to a full range of treatment options and inpatient psychiatric care may be an essential component of treatment for some individuals. The IMD exclusion creates barriers for people to access a full array of evidence-based treatment and prohibits a service that may be needed for some people's treatment. It is critical that individuals receive medically necessary care in the most appropriate setting, and the IMD exclusion limits the ability to develop needed inpatient and residential care for those with MH and SUD based on this arbitrary limitation. Far too often, individuals who need IMD care instead experience repeat hospitalizations, homelessness, and episodes of incarceration.

Issue regulation for 42 CFR Part 2. We look forward to the promulgation of the next 42 CFR Part 2 (Part 2) rule pursuant to the *Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020*. Part 2, which governs the confidentiality of SUD records, sets requirements limiting the use and disclosure of patients' SUD records from certain substance use programs, including the cumbersome requirement of a signed consent by the patient each time the SUD record is to be shared. The CARES Act brings Part 2 into significant alignment with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Changes in the CARES Act permit a patient to provide one written consent to disclose their Part 2 information for all future treatment, payment, and health care operations (TPO), unless the patient revokes consent. Additionally, under the CARES Act, breaches in a Part 2 program trigger patient notification, Part 2 programs are now subject to HIPAA civil and criminal penalties, and discrimination against Part 2 program patients is prohibited. This legislation culminates years of work from a broad range of organizations, and it represents several critical compromises.

[Here you will find recommendations from the Partnership to Amend 42 CFR Part 2 \(Partnership\)](#), which we have previously shared with the U.S. Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as the Office of National Drug Control Policy (ONDCP). The Partnership, founded by ABHW, brings together a broad spectrum of the healthcare industry to advocate for aligning Part 2 with HIPAA. We urge Congress to work with HHS to ensure that the requirements for Part 2 stated in the CARES Act are reflected in the next Part 2 Rule.

Ensuring Parity

Develop a clear, universal compliance standard related to mental health and addiction parity. ABHW member companies continue to invest significant time and resources to understand and implement the *Mental Health Parity and Addiction Equity Act (MHPAEA)*. Our member companies

have teams of dozens of people working diligently to implement and provide MH/SUD parity benefits to their consumers. We have also had numerous meetings with the regulators to help us better comprehend the regulatory guidance and to discuss how plans can operationalize the regulations.

While parity has progressed in meaningful ways since its adoption and access to MH and SUD treatment providers has greatly expanded, systemic issues continue to be a challenge due to other non-parity factors such as the looming shortage of physicians (both psychiatrists as well as other MH and SUD providers). Examples of key changes since the parity law and regulations were enacted include: the fact that routine MH outpatient treatment no longer habitually requires prior authorization or has explicit quantitative treatment limits; evidence-based levels of care for MH conditions are no longer subject to blanket exclusions (e.g., residential treatment for eating disorders); and transparency, documentation, attention to medical necessity criteria all have improved.

However, despite these gains and the parity language in the *21st Century Cures Act*, aspects of the law and regulations remain overly complex and technical. As a result, compliance is a moving target through a patchwork of conflicting and changing guidance. New parity language was included in Section 203 of the *Consolidated Appropriations Act of 2021 (CAA)*, and the Department of Labor issued a Frequently Asked Questions (FAQs) document to help clarify the CAA provisions. While the FAQs are a step in the right direction, we believe further regulations are necessary to provide the clarity payers need to appropriately implement MHPAEA. We strongly support the flexibility built into the law, yet there has been a proliferation of different compliance approaches, tools, and interpretations, which continues to lead to confusion in implementation, is costly for stakeholders, and ultimately hinders patient care. We would like to work with you and the Administration to re-invigorate efforts to clarify and improve the application of the law for the benefit of all.

We strongly support ensuring access to behavioral health services and believe that addressing the following would lead to improved compliance.

- *Develop a core list of non-quantitative treatment limitations (NQTLs) for which documentation may be expected to be available upon request.* The final rule defines NQTLs circularly and there is no guidance to date that explains what can constitute a “limit on the scope or duration of benefits for treatment under a plan or coverage. As such, it has not been possible to develop a 5-step analysis for all NQTLs proactively. Congress should encourage regulators to develop a focused list of NQTLs to better understand what defines this analysis.
- *Provide a clear, comprehensive example NQTL analysis that would meet the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Treasury (collectively “the tri-Departments”) standards under the requirements of the CAA for each NQTL on the focused list.* Given the new requirements mandated by the CAA to utilize the 5-step framework and that it is materially different from the guidance contained in the DOL Self Compliance Guide, comprehensive NQTL examples would greatly improve the NQTL analyses themselves and ensure an efficient use of the tri-Departments’ resources. We appreciate the guidance published over the years, but significant ambiguity remains about the actual breadth and depth of details and supporting documentation required for each component of the CAA’s five-step analyses. Model NQTL analyses would help clarify expectations, promote uniformity, and ultimately improve parity compliance. Accordingly, for each NQTL on the focused list, we believe the tri-Departments should also provide at least one complete example of a compliant analysis.

Additionally, we are aware that during this latest round of audits, the tri-Departments

have sent letters of insufficiency with a great level of detail on what is missing in the documentation for a given NQTL. Congress should urge regulators to use this as a basis for future guidance and in developing best practice examples for NQTL analyses.

- *Define a standard by which NQTL analyses are evaluated and a process by which examinations are pursued.* In FAQ 45, Q2 and Q4, the tri-Departments address the information that must be made available to regulators and the types of documents that should be prepared to submit in support of a given NQTL analysis. In practice, however, the back and forth with the regulators during examinations can be confusing due to the lack of a defined process for NQTL documentation requests. ABHW is willing to work with the regulators to determine the most efficient process to avoid confusion and better implement MHPAEA and asks Congress to support these efforts.
- *Proactively promote uniformity between state and federal requirements.* It is also critical to note that some state parity policies and compliance approaches differ significantly from federal policies and enforcement even when based upon federal parity standards, creating confusion in understanding how to achieve and demonstrate compliance at the state level even if federal requirements are clarified. In fact, there are discrepancies on how NQTLs are interpreted not only between a federal and state level and across states, but within states as well.⁴ As such, we urge Congress to stress to the tri-Departments to proactively coordinate with state regulators to help ease the issues surrounding parity compliance.

We know the Committee is interested in the *Wit v. United Behavioral Health* decision; you can view ABHW's amicus curiae brief [here](#).

Expanding Telehealth

Expand the use of telehealth for MH and SUD services. We appreciate the current guidance and flexibilities in response to the Public Health Emergency (PHE) and request that the flexibilities continue for at least one year after the PHE is lifted. These long overdue changes to telehealth policies have allowed payers and providers to ensure people can access necessary MH and SUD services during physical distancing. ABHW members support extending flexibilities past the PHE and simultaneously collecting and analyzing data before making permanent changes. As the need for behavioral health services continues to grow, we urge you to consider the following policy changes:

- *Eliminate the new in-person visit requirement for mental health services:* We applaud the recent changes made to remove geographic and originating site restrictions for mental health services, allowing beneficiaries across the country to receive virtual care from a location of their choosing. However, these changes were accompanied by a new requirement, mandating that an individual must have an in-person visit with a provider (1) within the six-month period before receiving a mental health service via telehealth and (2) during subsequent periods as determined by CMS. Given that many individuals with mental health issues may not physically be able to leave the home at all or without significant assistance, we urge you to support the *Telemental Health Care Access Act*, (S. 2061, H.R. 4058), which removes the in-person requirement visit prior to receiving

⁴ Medicaid and CHIP Payment and Access Commission, *Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP*, p. 13, January 29, 2021, slide 14: "Some interviewees noted that non-quantitative treatment limitations were assessed and interpreted differently both within and across states." <https://www.macpac.gov/wp-content/uploads/2021/01/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>, last visited May 21, 2021.

Medicare telehealth services for mental health.

- *Expand cross state licensure:* During the pandemic, all 50 states have used emergency authority to waive certain aspects of state licensure laws, thus providing widespread access to care. We encourage efforts for states to foster cross state licensure reciprocity to support increased access to services. We also propose convening a task force of federal and state leaders to examine this issue and outline recommendations on changes that would increase access to behavioral health services.
- *Examine audio-only telehealth services.* ABHW supports patient access to audio-only behavioral health services for the duration of the PHE and recommends that the appropriate regulatory agencies conduct research to determine how best to leverage audio-only technology as a modality to provide quality, evidence-based and clinically appropriate behavioral health services as a long-term strategy. The recent Centers for Medicare and Medicaid Services (CMS) CY 2022 Physician Fee Schedule (PFS) proposed an audio-only modifier. Given the increase in utilization and reliance on audio-only services, a modifier is necessary so providers can appropriately code and bill for their services. ABHW supports the finalization of the proposed audio-only modifier and encourages the evaluation of new modalities of treatment, so individuals continue to receive quality care.

Evaluation of audio-only services would be beneficial to demonstrate quality and efficacy for behavioral health. ABHW advocates that audio-only services be evaluated, particularly for partial hospitalization programs, applied behavioral analysis, psychological testing, and group therapy to ensure that reimbursement is equitable and appropriate. We encourage Congress to weigh in with regulatory agencies to encourage evaluation of quality standards, and protections against potential fraud, waste, and abuse.

Invest in technological infrastructure. ABHW supports initiatives to propel broader electronic health record (EHR) adoption among mental health and substance use treatment providers. This includes urging the Centers for Medicare and Medicaid Innovation (CMMI), as recommended by Section 6001 of the SUPPORT Act, to finance a demonstration furnishing health information technology (IT) incentive payments to behavioral health providers, including but not limited to, psychiatric hospitals, community mental health centers, and substance use disorder treatment providers. Second, we advocate and recommend to Congress that they adopt statutory amendments to Section 6001 requiring CMMI to finance these much-needed incentives.

Improving Access for Children and Young People

ABHW members are committed to addressing urgent challenges children and adolescents are experiencing as we strive to recover from the COVID-19 pandemic. We have witnessed soaring rates of behavioral health challenges among children, adolescents, and their families over the course of the COVID-19 pandemic. Emergency room visits for mental health conditions increased 31% for those 12-17 years old and 24% for children ages 5 to 11 from March to October 2020, compared to the same period in 2019.⁵ In 2019, roughly half or 50.3% of white youth with a past-year major depressive episode received mental health services, but only 35.6% of Black and 36.8% of Hispanic youth, with a past-year episode received treatment. Death by suicide is a leading cause of death for youth and young adults 10-34 nationwide.⁶ As a result, the American Academy of Pediatrics, the American Academy of

⁵ Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. [Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020](#). *MMWR Morb Mortal Wkly Rep* 2020; 69:1675–1680.

⁶ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. [National Survey on Drug Use and Health, 2004-2019](#). 2004-2019 (retrieved on October 26, 2021).

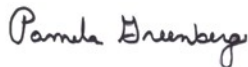
Child & Adolescent Psychiatry, and the Children's Hospital Association recently declared a national emergency for children's mental health.

It is critical that families and children have access to evidence-based mental health and substance use disorder screening, diagnosis, and treatment. ABHW suggests improving access by:

- increasing federal funding to ensure access to behavioral health services,
- improving access to effective, quality-based telemedicine,
- supporting effective models of school-based mental health care,
- accelerating integration of mental health care in primary care pediatrics,
- strengthening efforts to reduce the risk of suicide in children and adolescents, and
- addressing workforce challenges and shortages so that children can access mental health services regardless of where they live.

Thank you for the opportunity to provide suggestions to address important behavioral health policies. If you have any questions or would like to discuss ABHW's policy priorities please contact Maeghan Gilmore, Director of Government Affairs, at gilmore@abhw.org or 202-449-2278.

Sincerely,



Pamela Greenberg, MPP
President and CEO
