HR POLICY ASSOCIATION®
The Association of Chief Human Resource Officers

AMERICAN HEALTH POLICY INSTITUTE

April 14, 2021

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES, EDUCATION & LABOR COMMITTEE
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, & PENSIONS
HEARING ON
"IMPROVING ACCESS TO BEHAVIORAL AND MENTAL HEALTH CARE"
APRIL 15, 2021

The HR Policy Association and the American Health Policy Institute appreciate the Committee holding this important hearing on behavioral and mental health care issues.

The HR Policy Association is the leading organization representing chief human resource officers of over 390 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 20 million employees and dependents in the United States. The American Health Policy Institute, a part of HR Policy Association, examines the challenges employers face in providing health care to their employees and recommends policy solutions to promote affordable, high-quality, employer-based health care. The Institute serves to provide thought leadership grounded in the practical experience of America's largest employers.

The HR Policy Association and the American Health Policy Institute are also part of The Path Forward initiative to execute a disciplined, private sector approach to systematically and measurably improve five established best practices of mental health and substance use care.

Congress should enact the below policy recommendations to improve access to behavioral and mental health care services.

Network Access

Background – 119.3 million Americans live in areas designated as Mental Health Professional Shortage Areas and 6,464 additional behavioral health (BH) providers[1] are needed to fill these provider gaps.[2] Provider shortages, in conjunction with limited in-network providers, make it difficult for patients to find in-network providers. A survey of privately insured patients also found that 53 percent of those that used provider directories found inaccuracies in their insurer's provider directory often leading them to use out-of-network providers.[3]

[1] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.

[2] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2020 available at: https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[3] Busch, S. & Kyanko, K. June 2020. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* Retrieved February 1, 2020 at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

Policy Recommendations

1. Increase/provide federal funding to encourage BH providers to practice in Professional Shortage Areas.
2. Require health care providers and facilities to notify the group health plan or issuer whether or not they are accepting new patients.
3. Employer health plans should not be required to meet network access standards unless behavioral health care providers are required to participate in those networks.
4. Expand telebehavioral health services (see below).

Collaborative Care Model (CoCM)

Background – Behavioral health is not integrated with primary care leaving patients with undiagnosed or poorly managed behavioral health conditions. Behavioral health conditions often initially appear in a primary care setting. Primary care clinicians provide mental health and substance use care to the majority of people with behavioral disorders and prescribe the majority of psychotropic medications. However, most primary care physicians do not provide evidence-based care to these patients. A collaborative care model that integrates behavioral health and primary care would significantly reduce the burden of other illness, reduce the demand for BH services, lower medical costs and reduce disparities in identification and the effectiveness of treatment for BH issues. Over 70 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[4] Collaborative care interventions have a CMS/AMA billing code that pays for the service.

Policy Recommendations

1. Allocate funds to support a change effort to provide technical assistance, training and startup funds to allow for large scale adoption for collaborative care across the country. Collaborative care can be delivered virtually or by in person care managers so this model can deliver to large medical groups or small and rural primary care practices.
2. CMS to establish a national Technical Assistance (TA) center and regional extension centers to assist primary care practices in implementing the CoCM.
3. Incentivize behavioral health care providers to adopt electronic health record technology that is interoperable with general health care providers into their practices.
4. Expand research on promising integrated care models: There have been a number of integration models promulgated over the past two decades. These integration models represent important efforts to improve the care of behavioral conditions in primary care and have added value by supporting primary care practitioners. Additional evidence is needed for these other models to document improved clinical outcomes, costs savings and feasibility of implementation in multiple practice settings (*e.g.,* rural and urban, population health-based care).

[4] https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.

Measurement Based Care

Background – Primary care and BH providers are generally not utilizing evidence-based BH assessment tools such as the PHQ-9 or GAD-7. It is estimated that only 18% and 11% of psychiatrists and psychologists, respectively, use assessment tools regularly.[5] When such tools are used in initial assessments, earlier diagnosis is more likely and can prevent conditions from becoming more severe. Outcomes improve 20-60% when such tools are used over the course of treatment because the provider has additional evidence on the effectiveness of the course of treatment.[6] Measurement based care provides an objective tool for providers, mitigating inherent biases and resulting disparities in treatment. Measurement based care is also a critical component of the collaborative care model above.

Policy Recommendations

1. Establish incentives with carriers (e.g., star ratings) and providers (e.g., pay for performance) to increase the use of appropriate measurement tools when providing care.
2. Allocate funds to support a change effort to educate and implement measurement-based care across the country. A portion of such funds should be allocated to virtual programs such as telebehavioral interventions and digital behavioral apps to facilitate behavioral health integration models to add measurement-based care for small and rural practices in addition to larger practices.
3. Instruct the CMS Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program to mandate that certified electronic health record (EHR) vendors must include screening and symptom follow up tools using standardized measures (PHQ-9, GAD-7) for major mental health and substance use disorders, including depression, suicide, anxiety, PTSD, mania, addiction, and psychotic disorders at no cost to providers. Supports for documentation, billing, panel management, and tracking measure scores over time should also be included.
4. Increase incentives for using existing CPT Codes such as GO444, 96127, 96160, 96161, 96130, 96139.
5. Include measurement-based care as a standard of care regardless of the modality.

TeleBehavioral Healthcare (TBH)

Background – During the COVID-19 pandemic, Medicare rules related to TBH have been liberalized resulting in an exponential growth in the use of TBH, including enabling cross-state care which has been critical to underserved areas and rural communities. However, the requirements for employer health plans around how TBH is provided and reimbursed remain far too restrictive and result in access and quality disparities. TBH has the potential to overcome patient stigma and improve access and efficiency of care for BH services. We know that since

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[5] Wood, J. & Gupta, S. Using Rating Scales in a Clinical Setting. *Current Psychiatry* 2017; 16[2]: 21-25. Retrieved on January 14 from https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/Document/August-2017/CR02709028.PDF.

[6] Fortney, J., et al. A Tipping Point for Measurement-Based Care. Psychiatry Serv. 2017 Feb 1;68(2):179-188. doi: 10.1176/appi.ps.201500439. Epub 2016 Sep 1. PMID: 27582237.

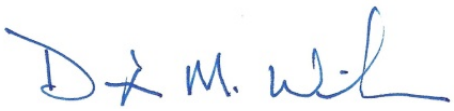
the COVID-19 public health emergency, there has been a significant increase in patients keeping their appointments. In general, when patients keep their first appointment, they are more likely to keep subsequent appointments; and when patients are satisfied with treatment, they are more likely to continue with their course of therapy. Research also suggests that TBH results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions. However, many older adults and people with disabilities, lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have them. Likewise, many in racial/ethnic and low- income communities lack access to broadband or video-enabled devices, which only expands the health inequities in the US. While TBH has demonstrated comparable efficacy to in-person BH care in many instances, there remains concern that quality of care is not uniform in TBH settings and additional research is needed.

Policy Recommendations

1. Eliminate cross-state border restrictions on TBH on a permanent basis for Medicare, employer and commercial plans. Licensing requirements should be based on the location of the provider not the patient.
2. Enable patient access to TBH without having the first provider appointment be in person.
3. Make permanent the allowance of first-dollar coverage of telehealth in high deductible health plans.
4. Allow employers to offer standalone "excepted benefit" telehealth benefits.
5. Adopt technology-neutral requirements, permitting use of different types of technology platforms for telehealth services.
6. Establish a uniform set of rules for multi-state telehealth benefit plans to eliminate state restrictions that block patients from telehealth benefits.

The HR Policy Association and the American Health Policy Institute welcome any opportunity to provide input and speak in further detail about improving access to behavioral and mental health care services. We look forward to working with you on this important topic.

Sincerely,



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