HR POLICY ASSOCIATION®
The Association of Chief Human Resource Officers

AMERICAN HEALTH POLICY INSTITUTE

October 29, 2021

Dear Sen. Wyden and Sen. Crapo:

The HR Policy Association and the American Health Policy Institute submit the following recommendations for your consideration regarding your September 21, 2021 request for information asking for legislative proposals that will improve access to health care services for Americans with mental health and substance use disorders.

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.

HR Policy Association and its American Health Policy Institute are actively engaged in improving behavioral health care access through our partnership with The Path Forward for Mental Health and Substance Use and other HR practice and legislative initiatives. The Path Forward is a disciplined, private sector approach among a variety of stakeholders to systematically and measurably accelerate implementation of five proven best practices for increasing access to behavioral health care.

HR Policy members are laser focused on improving the overall wellbeing of their employees by improving access and lowering health care costs. Mental illnesses are among the most common health conditions in the U.S., with nearly one in five U.S. adults living with a mental illness.[1] Behavioral health conditions are more commonplace than many realize and have a significant impact on an individual's productivity and success in the workplace. Nearly 25 percent of the nation's workers have depression, and these workers miss twice as much work and have five times as much lost productivity as those without depression. Medical costs associated with treating patients with chronic medical conditions and mental health/substance use disorder conditions are two to three times higher than the costs for treating those without a comorbid mental health/substance use disorder. [2] Despite representing only 23 percent of the insured population, those with behavioral health conditions account for 60 percent of total health care costs.[3] Moreover, employers have worked tirelessly to implement successful workplace wellness programs focused on behavioral health however, these programs can only go so far when there are significant access and affordability issues.

[1] National Institute of Mental Illness. Mental Health by the Numbers. https://www.nami.org/mhstats

[2] Potential economic impact of integrated medical-behavioral healthcare. January 2018. https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

[3] Coe E and Enomoto K, "Returning to resilience: The impact of COVID-19 on mental health and substance use," April 2020, McKinsey.com.

Our recommendations below focus on five specific and effective policy areas Congress can address to improve behavioral health care. These focus areas are:

- Improve access to in-network behavioral health specialists.
- Expand mental health/substance-use disorder screening and monitoring through measurement-based care (MBC).
- Expand integration of behavioral health care into primary care settings through implementation of the Collaborative Care model.
- Improve and expand the use of telebehavioral health.
- Achieve mental health parity without imposing civil monetary penalties on employers.

Improve access to in-network behavioral health specialists.

According to a Milliman study, patients use out-of-network care at a higher rate for behavioral health care services than medical/surgical services, with patients 5.1 and 3.6 times more likely to obtain behavioral health care services out-of-network than primary care and specialty care visits, respectively.[4] With cost already cited as a major barrier to access, the limited number of in-network behavioral health providers only further deters patients from seeking care. Inadequate access to mental health providers, particularly, for new patients makes it difficult to see the success of early interventions and measurement-based care. According to HHS, 129.6 million Americans live in areas designated as Mental Health Professional Shortage Areas.[5] There are 6,559 additional BH providers[6] needed to fill these provider gaps.[7] Provider shortages, in conjunction with limited in-network providers, make it difficult for patients to find affordable 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.[8]

HR Policy has a number of recommendations to improve access to behavioral health services including:

1. Increase/provide federal funding to encourage behavioral health providers to practice in Professional Shortage Areas.

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[4] Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman Research Report, November 2019.

[5] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health & Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021, available at: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

[6] 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.

[7] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health & Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021

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

2. Require health care providers and facilities to periodically notify the group health plans or issuers whether they are accepting new patients and how long it takes to get an initial appointment.
3. Expand tele-behavioral health services (see below).

Expand mental health/substance-use disorder screening and monitoring through measurement-based care.

It is estimated that only 18 percent and 11 percent of psychiatrists and psychologists, respectively, use assessment tools regularly.[9] 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 percent when such tools are used over the course of treatment because the provider has additional evidence on the effectiveness of the course of treatment.[10] 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 as described in the next section.

HR Policy has a number of recommendations to increase the use of measurement-based care including:

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.

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[9] 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.

[10] 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.

Expand integrations of behavioral health care into primary care settings through implementation of the Collaborative Care Model.

HR Policy Association supports the Collaborative Care Model (CoCM) for the integration of behavioral health with primary care. The CoCM creates a care team comprised of a primary care provider, psychiatric consultant and a behavioral health care manager. Over 90 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[11]

Behavioral health conditions often initially appear in a primary care setting. Primary care clinicians provide mental health and substance use care to most 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 behavioral health services, lower medical costs and reduce disparities in identification and the effectiveness of treatment for behavioral health issues. Furthermore, collaborative care interventions have had a CMS/AMA billing code that pays for the service since 2017, and most private payers recognize and pay for the model. However, the uptake of the model in primary care practices has been minimal due to the startup costs it requires.

HR Policy supports The Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) which promotes the uptake of the CoCM by providing grant funding to remove the barriers that primary care practices face when trying to implement the model.

HR Policy also has a number of recommendations to increase the use of integrated care models including:

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. Authorize CMS to establish a national Technical Assistance 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 into their practices that is interoperable with general health care providers.
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 that can document improved clinical outcomes, costs savings and feasibility of implementation in multiple practice settings (*e.g.,* rural and urban, population health-based care).

[11] Jürgen Unützer, et.al., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center, May 2013, available at: https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.

Improve and expand the use of telebehavioral health.

HR Policy supports making the COVID-19 telehealth flexibilities permanent. During the COVID pandemic, liberalized telehealth rules resulted in an exponential growth in the use of telehealth, particularly telebehavioral health. A survey of HR Policy members showed that 79 percent of respondents offered mental health virtual care and telebehavioral health services to their employees to address access challenges.[12] Telebehavioral health has the potential to overcome patient stigma and improve access and efficiency of care for behavioral health services. Since the public health emergency, there has been a significant increase in patients keeping their behavioral health 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 telebehavioral health results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions.[13]

While telebehavioral health has demonstrated comparable efficacy to in-person behavioral health care, there remains concern that quality of care is not uniform across telebehavioral health settings and additional research is needed. 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 U.S.

HR Policy has a number of recommendations to improve telebehavioral health including:

1. Eliminate cross-state border restrictions on telebehavioral health 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 telebehavioral health 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. Specifically, Congress should pass the Telehealth Expansion Act of 2021 (S. 1704 and H.R. 5541).
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.

[12] HR Policy Association, CHRO Survey 2021.

[13] Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J. & Yellowlees, P.M. (2013). The effectiveness of telemental health: A 2013 review. https://www.liebertpub.com/doi/10.1089/tmj.2013.0075.

Achieve mental health parity without placing undue burden on employers.

HR Policy opposes the enactment of civil monetary penalties for mental health parity violations in the House Build Back Better legislation. Employers work hard to provide high quality mental health and substance use disorder coverage to employees and their families, however, the mental health crisis is the result of a complicated combination of stigma, limited access and inconsistent use of evidence-based behavioral health practices. To achieve significant improvements, Congress should focus on fostering partnerships between employers, providers, and carriers rather than punitive legislative provisions which further push stakeholders into their respective corners.

Employers acknowledge the impact that provider shortages and long wait times have on access, however, employers frequently face challenges in getting providers to join our networks at reasonable rates. Imposing penalties on plan sponsors does nothing to address the provider shortages both inside and outside networks. Furthermore, increased requirements for plan sponsors to address inadequate networks should be paired with requirements for providers. Providers should be required to let employers and carriers know if they are enrolled in at least one preferred provider organization (PPO) network, accepting new patients, and whether they have implemented measurement-based care models and are participating in telebehavioral health.

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We welcome any opportunity to provide further input on ways to expand access to behavioral health care and look forward to scheduling a meeting with you to discuss our recommendations.

Sincerely,

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