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Senators Bennet and Cornyn
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Response to: A Bold Vision for America's Mental Well Being

We want to thank Senators Bennet and Cornyn for drawing attention to the need for action to improve the care and support of people with mental illnesses. In what follows we respond to the issues raised and the request for information associated with the White Paper: A Bold Vision for America's Mental Well Being. Our discussion touches on several of the issues raised by the white paper. Specifically, we discuss work force challenges, financial alignment as it pertains to crisis response, a mechanism for improving the capacity of local behavioral health systems in low resourced communities, and the need for greater accountability and the implications for existing financing programs.

Work Force and Technology: The White Paper correctly notes that there is evidence of considerable unmet need for behavioral health services in the U.S. One suggestion in the report is that unmet need is in important ways due to the limited behavioral health work force. The Health Resources and Services Administration has conducted analyses that estimate the number of behavioral health work force shortage areas in the country. They report that there were 5,042 areas in the U.S. in 2018 that experienced a `behavioral health professional shortage.[1] These estimates are based on fixed ratios of professionals to population and frequently fail to recognize the overlapping skills and capabilities of various professions and thus overlook substitution capabilities. It is important, however, to recognize that assessments of the state of the behavioral work force are conflicting. Estimates by SAMHSA, the National Academy of Medicine and other organizations such as the AMA are notable for the variation in their estimates of the numbers of various types of professionals who provide behavioral health services. There is clearly a maldistribution of the workforce with shortages in some locations and under some organizational arrangements. In addition, there appears to be some evidence supporting the existence of aggregate, national level shortages for some professionals who treat specific populations with mental illnesses, such as child psychiatrists. A 2018 review by the Congressional Research Service (CRS) noted, however, that estimates of the supply of specific types of mental health professionals varied by over 100% across estimation efforts.

It is also the case that some professional groups such as psychiatrists and psychologists have very low rates of participation in health insurance programs and Medicaid. That creates access barriers to insured populations without the means to pay fully out of pocket. In these cases, the appearance of a shortage is as much due to payment policies and failure to fully enforce the

[1] Health Resources and Services Administration, Data Warehouse, Health Professional Shortage Areas (HPSA) and Medically Underserved Areas / Populations (MUA/P)," http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx#chart.

Mental Health Parity and Addiction Equity Act (MHPAEA) as it is about the supply of professionals.

These problems are particularly acute now. The pandemic has brought a spike in the demand for behavioral health care and a reacceleration of the opioid epidemic along with a growing stimulant crisis. Together, these developments are stretching behavioral health resources. The ability to access behavioral health services has been especially acute for the participants in public insurance programs like Medicare and Medicaid where there has been less of an expansion in the use of tele-behavioral health care.

Policy responses could usefully be focused on three types of actions: 1) those involving insurance regulation such as MHPAEA enforcement and network adequacy standards, to bring more of those currently practicing into networks where their services are financially accessible to patients; 2) scope of practice regulations to allow better use of trained mental health practitioners who are not physicians; and 3) application of technology. It may also be worth reconsideration of obligations associated with existing work force training subsidies.

MHPAEA Enforcement: To the extent that some shortages are the result of insurer conduct and potential market failures in insurance markets some remedies might stem from enforcement of MHPAEA regulations and establishment and enforcement of consistent network adequacy standards. The MHPAEA regulation note that one form of Non-Quantitative Treatment Limit is the use of low provider prices to limit the supply of services within an insurer's network. Testing whether insurer fee schedules are in line with indicators of broader market-based prices offers a basis for enforcing MHPAEA regulations that may serve to ameliorate observed access barriers in insured populations.

Scope of Practice: While the supply of psychiatrists and PhD psychologists is limited in some areas, there is a substantial, and rapidly increasing, supply of mental health practitioners who are not medically trained and do not have PhDs. Scope of practice regulations are generally the province of the states. Recent reviews of licensing and scope of practice laws indicate that if all states allowed behavioral professions to practice to the "top of their licenses" the number of shortage areas would be notably reduced.[2] Recent efforts by the federal government to increase the supply of buprenorphine prescribers through scope of practice flexibility under the CARA legislation has proved highly successful in expanding supply in rural America. Such efforts can serve as a model for a broader set of behavioral health work force augmentation efforts.

Technology: During the COVID-19 pandemic, a substantial share of behavioral health services was delivered through telemedicine[3]. Expanded use of telemedicine offers opportunities to improve access to behavioral health services in several ways. First, the supply of behavioral health providers is highly geographically localized. During the pandemic, states and the federal government made it easier for providers to offer services across state lines. Over a long period of time, it has proven very difficult to increase the supply of mental health providers in

[2] Heisler EJ, Mental Health Work Force: A Primer, Congressional Research Service Report R43255, April 20, 2018.
[3] https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels

geographically isolated areas. Policymakers could encourage the use of cross-state compacts and federal policy changes that would enable providers in areas with more supply to serve shortage areas through telehealth[4]. Telehealth can also reduce access barriers by reducing the time-cost of using counseling and psychotherapy services, which often require frequent visits, especially at the initiation of treatment and during crisis periods. Reimbursement for telehealth should be designed to facilitate such access. Finally, telehealth may enable new forms of coordinated physical and mental health care. It will be important to ensure that payment policy enables such new forms of care.

Provider Obligations: Medicare currently subsidizes the training of psychiatrists at levels that vary between $105,000 and $182,000 per resident. It seems inconsistent with the public interest to not require that the beneficiaries of those subsidies provide some social benefits other than those fully paid for by relatively well-to-do clients.

Mental Health Crisis/988: The current crisis response system is overly reliant on law enforcement in responding to people experiencing mental health and substance use disorder issues. The results are often terrible. The Congress has taken the important step of directing the executive branch to establish a national 988 crisis line as a key entry point into the behavioral health crisis response services. This represents an important effort for improving mental health delivery and to improve upon equity in the delivery and support of people with mental illnesses and substance use disorders.

For the 988 system to realize its potential it is critically important for there to be the capacity to respond rapidly and appropriately to 988 calls. The White Paper addresses this explicitly. Many jurisdictions currently lack such response capabilities. The Congress recognized the need for new financing streams for such services. They did so primarily through two mechanisms: the American Rescue Plan Act of 2021 (ARPA), which included an 85% matching rate for states that opt to cover mobile crisis intervention services under Medicaid; and a 5% crisis set aside in the Mental Health Services Block Grant (MHSBG) administered by SAMHSA. In addition, there are a variety of existing public programs that can support this important initiative. This includes Medicaid and the overall MHSBG (in addition to the set aside).

A few states, such as Arizona, have developed strategies to "stand up" a behavioral health crisis system. While the specifics would be hard to replicate, the Arizona example offers lessons for developing more general strategies for both Congress and the Administration. First, infrastructure investments are important for establishing the capacity to respond to behavioral health crises. Such investments diminish the risk of having a "call line" available but limited ability to respond. In Arizona, these infrastructure investments were funded through county level bond issues. Variable costs were largely covered by Medicaid. This suggests that coordination is needed at both the state and federal level of government to align Medicaid, block grants and state and local funds and private insurance both to establish initial capacity and to cover recurring variable costs. The ARPA opportunity and MHSBG set aside create two new funding elements.

[4] https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/telehealth-licensing-requirements-and-interstate-compacts/

The *Behavioral Crisis Services Expansion Act* would mandate private insurance to cover behavioral health crisis services among further augmentation of block grants. States like California and private insurers such as United Health Care already require or offer coverage for services that encompass most parts of the crisis continuum. These can serve as models for insurance regulations. Thus, block grant dollars can be used by states to establish the requisite capacity such as mobile treatment teams, crisis beds for adults and youth, and training of necessary personnel. Medicaid and other insurance can be responsible for paying for the services supplied from this newly established infrastructure. The federal government ideally would also provide technical assistance to states and localities to design crisis systems that are appropriate to local conditions.

Expanding Specialty Behavioral Health Resources via CCBHCs: The Congress and the last two administrations have invested in and increasingly relied on Certified Community Behavioral Health Centers (CCBHCs). The impact of CCBHCs are potentially limited because the standards to qualify for certification as a CCBHC are relatively high with respect to resources and infrastructure. The consequence is that many of the poorest communities that include populations of color do not have a CCBHC available. Amending the CCBHC grant program to include provisions for development grants would promote creation of CCBHCs in these low resource locales. These institutions are very important to the maintaining a behavioral health safety net. Yet a simple analysis of the past few rounds of funding allocations shows that resources were deployed in a way that was very weakly correlated with prevalence of mental illness, prevalence of COVD-19, death rates from suicide or COVID-19 or extreme poverty (authors' tabulations).

Accountability: The White Paper highlights the need to adjust relationships between the way federal government funds flow to local communities and how they are deployed. The White Paper emphasizes issues of fragmentation of federal funding streams and inconsistent rules that make coordination and cooperation among treatment and support programs difficult. The example provided in the White Paper on page 5 suggests that the MHSBG offers an attractive model for reforming the federal financing system. More funding is critically needed, but it is also the case that the existing delivery of mental health and substance use disorder care is far too often of low quality and in some cases outright harmful. The systems in place – both private market forces and regulatory and funding standards -- fail to link poor performance to consequences such as reductions in customers, declines in revenues or regulatory sanctions. Reform of the MHSBG must address accountability for the quality of services delivered.

For over 20 years since the Surgeon General issued his report on mental health it has been recognized that there are broad arrays of evidence-based practices that can effectively treat many of the major mental illnesses that affect Americans. It remains the case today that people who could benefit from these specific treatments are unlikely to receive them – even if they have access to services. The percentage of treatments making use of evidence-based interventions has been stagnant for nearly two decades.[5] The departures in practice from what is known spans underuse of well-tested somatic treatments like pharmaco-therapies for opioid use and alcohol

[5] Horvitz-Lennon, M, Evidence-Based Practice or Practice Based Evidence: What is the Future?, in Goldman, Frank and Morrissey (eds) *The Palgrave Handbook of American Health Policy*, New York: Palgrave-MacMillan, 2020

use disorders, clozapine for people with schizophrenia at risk of suicide, and ECT for severe forms of depression. Effective psycho-social treatments such as cognitive behavioral therapies are also under-used. At the same time, patients also commonly receive treatments that are contraindicated such as use of antidepressants alone for bipolar disorder or inpatient detox without follow up using medications for opioid use disorder. Such treatment approaches are dangerous and make illnesses worse.

There are a variety of barriers to high quality care. These include the stigma associated with mental illnesses and substance use disorders, uneven care management in many insurance programs, and failures to provide appropriate training of professionals. A key factor that is amenable to policy action is that existing accountability systems are weak. Our major public insurance programs, including Medicare Advantage, the Medicare Shared Savings Program (MSSP), State Medicaid Managed Care programs, and the Health Insurance Marketplaces have been slow to develop and implement metrics to hold insurers and providers accountable for the care provided. The consequences of failing to meet what standards do exist are minimal. Accreditation agencies that federal and state governments rely upon regularly come up short in holding providers to standards of care. For example, a significant share of residential substance use disorder treatment programs that refuse to provide medications for opioid use disorder to their patients with that illness have received accreditation from CARF and JCAHO.[6] State licensing regulations are seldom revised and do not reflect much of what is known about modern clinical science. Together, these circumstances reflect a failure to establish accountability norms.

This situation has important implications for how to best promote a realignment of relationships between government financing programs and service delivery on the ground. In this respect, the MHSBG has some important downsides. The block grant has very weak accountability mechanisms and, at least in its current form, has little ability to influence the quality of behavioral health care. The block grant reporting systems focus on administrative processes; they provide little information on the impacts that funds have on the health of each state's population, making it virtually impossible to judge whether taxpayer dollars are being used to *effectively* address mental illnesses and substance use disorders. This absence of strong accountability contributes to the failures in performance outlined in the White Paper and discussed above.

The Block Grant funding mechanism also means that behavioral health providers are paid in a completely different way than are providers of general health services. This furthers the disconnect between general medical care and behavioral health care and undermines efforts to integrate these types of care.

An alternative approach to promoting improved performance and greater integration would build on the alternative payment mechanisms that exist in major public health insurance programs. This approach would introduce greater accountability through establishing performance metrics that reflect the use of modern clinical science, reward integration of behavioral health and other medical care and bolster accreditation systems used by government to ensure the adequacy of

[6] Beetham T, B Saloner, M Gaye et al, Therapies Offered at Residential Addiction Treatment Programs in the United States, JAMA 324(8):804-806, 2020.

providers to meet the needs of their populations. Medicare Advantage, MSSP and Medicaid Managed Care all use risk-based payment systems that are flexible in how funds are deployed to meet the needs of the covered populations. Each system also has quality measurement systems and financial consequences linked to them. Making the behavioral health metrics a more important part of each of these accountability systems would represent a practical set of actions that would drive important segments of health plan and provider markets towards greater attention to the delivery of behavioral health care and to the quality of care delivered on the ground. In providing guidance on the direction that metric development might take it would be important to include measures of both behavioral-physical health integration and equity.[7] Complementary actions would involve restructuring the deeming relationships with organizations such as JCAHO, CARF and NCQA so that accreditation standards are consistent with performance metrics. Building on existing programs that pay for the bulk of health care for large segments of the U.S. population is the most likely path to reduce the impact of payer fragmentation, offer consistent signals to the market about the importance of high quality behavioral health care, and begin to realign all segments of the accountability system for behavioral health.

Concluding Remarks

We very much appreciate the attention Senators Bennet and Cornyn have given to the US behavioral health system and its needs. We believe that well-designed policy can transform the US behavioral health system and the lives of the tens of millions of Americans who could benefit from quality care. Improving the behavioral health system will require more money – but simply funding the existing structure better will have modest effects. To do more, policymakers need to think creatively about the use of resources – workforce and technology, combine operating funds with infrastructure investments, and demand much more accountability from all providers and funders in the system.

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[7] Bipartisan Policy Center, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*, Washington DC March 2021.