

Senators Ron Wyden and Mike Crapo
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Senators Ron Wyden and Mike Crapo,

Thank you for your leadership in seeking to address unmet mental health needs in the United states. We appreciate the attention and urgency that you are giving these issues. In the following comments we respond to your request for policy ideas by addressing the following issues that you identified in your solicitation: the application of digital and communication technology to expand access to treatment, parity implementation, work force, and accountability and its application to integration of behavioral health and other medical care.

Technology Issues:

We offer observations on two sets of issues related to the use of technology to expand access to behavioral health care and supports. We first focus on tele-behavioral health, and then comment on issues related to the regulation of digital technologies in treatment for behavioral health conditions.

During the COVID-19 pandemic, a substantial share of behavioral health services was delivered through telemedicine¹. 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 geographically isolated areas. Policymakers could encourage the continued use of cross-state compacts and federal policy changes that would enable providers in areas with more supply to serve shortage areas through telehealth².

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.

The proliferation of apps and “affective computing” raise issues of the scientific basis for these apps, quality monitoring, and privacy concerns. Such apps include

- Telephone applications that assess anxiety through voice patterns

¹ <https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels>

² <https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/telehealth-licensing-requirements-and-interstate-compacts/>

- Wearable technology that detects stress and anxiety and then launch interventions aimed at stress and anxiety management
- Wearables that guide users in mindful meditation.
- Bot therapists

One important concern is that the scientific foundations of these interventions are often very weak and embed cultural norms. Given the long history in mental health of harmful therapeutic optimism (lobotomy, hydrotherapy, insulin shock) and racial and ethnic inequity, a regulatory framework must be established. The FDA has expedited approval of digital therapies and did so without requiring developers to reveal the underlying mechanisms and scientific basis for their apps. This is a much lower standard than is applied to either drugs or other types of devices. The FDA also failed to offer much in the way of guidance regarding privacy protection and data security. Moreover, the standards that did exist were relaxed during COVID-19.

The FDA may not have the regulatory authority to do everything that needs to be done with respect to such apps. For example, consumers should have full and continuous control over the flow of information through these apps, but FDA may not have the authority to conduct appropriate monitoring. Similarly, the products are often defined in ways that skirt HIPAA, but the FDA does not enforce HIPAA rules. Non-profit rating initiatives like Psyberguide do not have the resources or the standing of a public regulatory structure. Congress should build institutional authority and capacity to address both the initial approval and use of such apps.

Parity Implementation:

The evidence suggests that MHPAEA provisions involving benefit design parameters such as cost sharing, quantitative treatment limitation (e.g., limits on covered inpatient days or outpatient visits) have been largely implemented with fidelity to the law. The unfinished business focuses on Non-Quantitative Treatment Limitations (NQTLs).

NQTLs involve the regulation of interventions that touch on clinical matters. That means there are many nuanced features that guide care management decisions that cannot be fully accounted for in regulatory guidance. Therefore, the regulations will necessarily be incomplete and hard to fully comply with. This is problematic because the incentives to “over manage” behavioral health cases remain, and health plans will adopt practices that respond to those incentives. Hence the current concern with existing parity regulations. Enforcement through litigation is an avenue that is being pursued. It is however, costly, slow to resolve and uncertain.

There are several approaches that could be taken to addressing parity that allow insurers some flexibility to structure their plans efficiently while requiring them to meet outcomes that reflect fair access to treatment. We will address one set of strategies here and then address related policy that is focused on quality of care below in our discussion of accountability.

Our strategies emphasize targeted enforcement -- focusing attention on codifying and enforcing provisions that are based on readily observable and measurable and reflect system outcomes.

1. Monitoring and Establishing Standards for Price Outcomes: The MHPAEA regulation notes 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 an outcome-based approach for enforcing MHPAEA regulations that may serve to ameliorate observed access barriers in insured populations. One example flows directly from those MHPAEA regulations. The regulations clearly state that low provider fees are one form of NQTLs because they restrict the availability of care givers in insurance networks. A simple test of whether provider in-network fees are too low is to compare the ratio of in-network to out of network fees for mental health providers to those for other medical providers such as primary care providers, internists, advance practice nurses etc. This approach would need to require health plans to report the negotiated prices they pay different types of providers for behavioral health and other medical services within their networks. It would also require reporting on the negotiated fees paid to internists, primary care and other relevant providers. Establishing such enforcement approaches takes direct aim at a fundamental concern with the availability of treatment within provider networks.

2. Monitoring and Establishing Standards for Access to Treatment: The department of labor recently- codified MHPAEA compliance self-assessment using "early warning signs". We propose that specific indicators of departures from reasonable access norms be established. For example, it is well understood that rates of depression average about 7% in employed populations. If a large employer health plan were to report rates of treatment for depression at 3% that departure from observed treatment norms would trigger an investigation. This is a parity enforcement standard based on a utilization outcome. A broader array of such indicators might well be established to cover other dimensions of mental health and substance use disorder care, including, for example, the duration and intensity of treatment. Departures from empirically based treatment norms could effectively limit care management policies that "over manage" care. MHPAEA and its regulations likely give DOL, HHS and Treasury authority to pursue such actions. Reinforcing those authorities would strengthen implementation.

3. Focus on incentives: A third line of action that can help is to address the enduring incentives to over manage care and discourage enrollment into plans by people with mental health problems. These incentives can be addressed using two sets of existing policy tools: performance measurement and rewards, and risk adjustment. Here we note the potential benefits from improved risk adjusters for mental illnesses and substance use disorders. We discuss performance measures later in the context of accountability. The Medicare Advantage (MA) program, Medicare Shared Savings Program (MSSP), some state Medicaid managed care policies and the Health Insurance Marketplaces all make use of risk adjustment in order to neutralize incentives to plans to take actions to discourage enrollment by people likely to have costly medical needs. Risk adjustment in MA, MSSP, Medicaid and the marketplaces could be improved as research by Montz et al and others has shown.³ Together, these measures could make a marked difference in the management of behavioral health benefits in insurance. We

³ Montz E, T Layton, AB Busch et al, Risk Adjustment Simulation: Plans May Have Incentives to Distort Mental Health and Substance Use Coverage, *Health Affairs* 35(6), 1022-1028, 2016; Cao Z, TG McGuire, Service Level Selection by HMOs in Medicare, *J Health Economics* 22(6):915-931, 2003.

recognize, however, that the design of any improvements in risk adjusters must be sensitive to the ability to “game” risk adjusters for mental illness that result in overpayments to plans.

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.⁴ 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 also important 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 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

⁴ 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>.

patients; 2) scope of practice regulations to allow better use of trained mental health practitioners who are not physicians; and 3) application of technology (discussed earlier).

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 outcome measures discussed earlier.

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.⁵ 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.

Accountability: Overarching Comments

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.⁶ The departures in practice from what is known spans underuse of well-tested somatic treatments like pharmacotherapies for opioid use and alcohol 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

⁵ Heisler EJ, Mental Health Work Force: A Primer, Congressional Research Service Report R43255, April 20, 2018.

⁶ 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

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.⁷ 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 discussed above.

One approach to promoting improved performance and greater integration (discussed below) 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 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.

Accountability and Integration

The U.S. has long struggled to integrate treatment for mental illnesses and substance use disorders into primary care. Researchers and clinicians for many years advocated for specialized payment codes to recognize the extra time and unique challenges encountered in treating depression and other mental illnesses in primary care settings. Likewise, payment restrictions in the Medicare program were posited to stand in the way of implementing models of care that were

⁷ 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.

shown to be both effective and cost-effective. Specifically, restrictions that only permitted a single visit per day from a practice to be reimbursed under Medicare Part B. The Obama Administration addressed both of these barriers to integration and those changes failed to produce the desired results of substantially greater integration of behavioral health into primary care practices. Evidence from that experience alongside demonstration conducted with support from the Robert Wood Johnson Foundation suggests that to improve the likelihood of more integration policy must motivate changes in the work flow of primary care practices, which is more complicated than modest adjustments to payment codes and billing rules. A recent report from the Bipartisan Policy Center outlines many measures that would promote more integration. Here we would emphasize one class of strategy highlighted in that report.⁸ Specifically, we would suggest pursuing a strategy that establishes a shared set of performance measures that would measure outcomes associated with evidence based treatment and successful integration of behavioral health and other medical care across key public payment systems like Medicare Advantage, the Medicare Shared Savings Program, Medicaid Managed Care Organizations and the Health Insurance Marketplaces. In addition, these indicators would carry sufficient weight in the performance measurement systems as to generate meaningful financial consequences.

A key lesson from observing the mental health and substance use disorder delivery systems is that fragmentation in financing leads to fragmentation in care delivery. For this reason, aligning the performance measure sets for behavioral health across federal programs that use risk-based payment systems like capitation or two-sided gain sharing to pay for health care would attach sufficient funds to generate appropriate incentives. These incentives would encourage practices to properly address integration and quality of behavioral health care and change their work flows to accommodate evidence-based care for depression and anxiety among other behavioral health conditions. In addition, such actions could be further bolstered through complementary efforts that would involve restructuring the deeming relationships with accrediting organizations such as JCAHO, CARF and NCQA so that accreditation standards are consistent with performance metrics.

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⁸ Bipartisan Policy Center, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*, Washington DC March 2021.