KAISER PERMANENTE®

November 1, 2021

The Honorable Ron Wyden, Chairman
The Honorable Mike Crapo, Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Senators Wyden and Crapo:

Kaiser Permanente appreciates the opportunity to respond to the Finance Committee's request for information (RFI) on behavioral health care access and services.

Kaiser Permanente (KP) is the largest private integrated health care delivery system in the U.S., delivering health care to 12.5 million members in eight states and the District of Columbia.[1] We applaud you for calling attention to serious issues affecting access to and delivery of behavioral health services and for considering solutions to improve the nation's shortcomings in meeting the behavioral health needs of the American people.

Below we provide feedback on the issues identified in the Committee's RFI as well as some additional considerations.

Strengthening the Behavioral Health Workforce

The entire health care system is challenged to provide high-quality, timely behavioral health care in the face of steadily rising need, now made even more acute by the COVID-19 pandemic, coupled with a critical shortage of qualified providers. This is true for both children and adults with behavioral health needs, whether or not compounded by substance use disorders or other dual diagnoses. KP supports universal coverage, but coverage does not ensure access to care.

At any given time, one in five Americans aged 13 and above has a diagnosable mental illness,[2] yet fewer than half get treatment, in part due to the current severe mental health provider shortage that exists in most counties in the United States. According to a 2018 estimate, 115 million Americans live in designated mental health professional shortage areas where the population-to-provider ratio is at least 30,000 to 1 (20,000 to 1 for communities with unusually high needs).[3] In 2016, the

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 700 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente's members.

[2] "Results from the 2017 National Survey on Drug Use and Health: Detailed Tables," Substance Abuse and Mental Health Services Administration, accessed June 25, 2019, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab10-1A.

[3] "Mental Health Care Health Professional Shortage Areas," Kaiser Family Foundation, last updated December 31, 2018, https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

One Kaiser Plaza
Oakland, CA 94612

Health Resources and Services Administration (HRSA) estimated that most states had shortages across most behavioral health professions.[4]

There is an uneven geographic distribution of behavioral health providers, which varies by profession. Providers are concentrated in urban areas, and unmet need is highest in the South and lowest in the Northeast.[5] Additionally, the ratios of population to behavioral health providers vary greatly within states.[6]

Finally, the racial/ethnic composition of the workforce of behavioral health providers is out of sync with that of the population requiring services. White professionals constitute almost 84 percent of the psychologist workforce.[7] Populations identifying as African American, Hispanic, Asian, and Native American are underrepresented among physicians, counselors, and social workers.[8]

Several factors have contributed to the provider shortage. These include a growing number of people seeking services as a result of improved mental health coverage following the Mental Health Parity and Addiction Equity Act and the Affordable Care Act; increasing prevalence of mental health conditions among young adults; the opioid epidemic; the return of war veterans with behavioral health needs; and a shift from incarceration to treatment-oriented mental health care in the criminal justice system.[9] Additionally, the literature detailing the impact of COVID-19 suggests that the pandemic is associated with increases in the demand for mental health services.

The aging of the mental health workforce is also a contributing factor. More than 50 percent of psychiatrists currently in practice are expected to retire by 2025,[10] and more than half of U.S. counties have no practicing psychiatrists.[11] Inadequate funding for psychiatry residencies and other clinical training risks are compounding these shortages. The Balanced Budget Act of 1997 (P.L.

---

[4] National Center for Health Workforce Analysis, *State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030*, Health Resources and Services Administration, September 2018, https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf.

[5] For estimates of the number of practitioners needed to remove health professional shortage area designation in each state, please refer to https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false.

[6] Janet Coffman, Timothy Bates, Igor Geyn, and Joanne Spetz, *California's Current and Future Behavioral Health Workforce,* Healthforce Center at UCSF, February 12, 2018, https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf.

[7] National Center for Health Workforce Analysis, *Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2011-2015)*, Health Resources and Services Administration, August 2017, https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations.pdf.

[8] Id.

[9] Jessica Buche, Angela J. Beck, and Phillip M. Singer, *Behavioral Health Workforce Challenges: Recruitment, Retention, and Work Environment,* University of Michigan Behavioral Health Workforce Research Center, September 2016, http://www.behavioralhealthworkforce.org/wp-content/uploads/2016/10/FA2P1_Workforce_Challenges_Policy_Brief.pdf.

[10] "Mental Health in America – Access to Care Data," Mental Health America, accessed June 25, 2019, https://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data.

[11] AAMC, *Addressing the escalating psychiatrist shortage,* February 2018, https://www.aamc.org/news-insights/addressing-escalating-psychiatrist-shortage

105-33) capped the number of residents supported by Medicare, which is the largest source of graduate medical education (GME) funding; the result has been to limit the growth of entry into the field of medicine.

To improve access to behavioral health services and the quality of behavioral health care, our national policies must address shortages, maldistribution, and lack of diversity of our behavioral health workforce. Below we describe a set of policies that we believe will help to address these important issues:

- Reform graduate medical education funding. KP supports an increase in the number of psychiatry residency positions, as part of a comprehensive plan to increase the number of residencies in all fields with too few spots, and we support policies that encourage participation by physicians in addiction medicine fellowships.
    - Establish new programs at hospitals that currently do not train psychiatry and addiction medicine residents and add slots to existing programs.
    - Provide matching funds to hospitals establishing new residency programs until the programs are accredited to incentivize hospitals to invest their own resources. Once accredited, these programs can continue to fund their residency positions using federal Medicare residency dollars.
- Broaden the Medicare-reimbursed workforce. Provide Medicare reimbursement for licensed professional counselors, marriage and family therapists, and masters level addiction counselors.
- Support additional data collection and analysis of the adequacy of the behavioral health workforce by the U.S. Health Resources and Services Administration (HRSA). We believe previous HRSA evaluations have overestimated the supply of behavioral health professionals available to serve Americans who cannot pay out-of-pocket for services. Studies indicate that substantial shares of behavioral health professionals do not accept health insurance, a factor HRSA's methodology has not considered in previous evaluations. HRSA's projections also have not considered the race/ethnicity or languages spoken by behavioral health professionals. Other data sources suggest that insurers have difficulty finding racially/ethnically and linguistically concordant professionals to care for persons who are not white or fluent in English. Finally, a new HRSA evaluation could consider trends in demand/utilization following the COVID-19 pandemic and opioid epidemic.
- Define roles and standardize training based on evidence of improved outcomes and cost-effectiveness for peers, community health workers and non-licensed substance-use disorder counselors; establish certification programs and address reimbursement rates for this workforce.
    - Support research/testing use of non-traditional behavioral health providers, such as peers and counselors, to understand best practices for service delivery.
- Provide scholarships for individuals entering the behavioral health workforce. In addition, KP supports a focus on students from underrepresented backgrounds and linguistic capabilities and/or from medically underserved areas with financial need.

- Increase loan forgiveness and stipend programs for behavioral health providers. Continue and expand existing federal loan forgiveness programs such as Public Service Loan Forgiveness.
- Consider federal action that encourages or facilitates practice in a state by a behavioral health provider licensed and in good standing in another state. One option would be to provide incentives for states to adopt the Psychology Interjurisdictional Compact (PSYPACT) that gives psychologists in member states the authority to practice interjurisdictional telepsychology in other member states.

Increasing Integration, Coordination and Access to Care

As an integrated delivery system, KP supports "whole-person care," which includes providing access to services and resources that address beneficiaries' physical health, behavioral health, and social needs. We know that access to transportation, healthy food, and housing supports including employment and tenancy services improve overall wellness and productivity and reduce the use of emergency care in non-emergency settings.

Policies can support integration and coordination by testing, expanding, and reimbursing for evidence-based models of care that utilize primary care providers. The Collaborative Care Model is a proven, measurement-based approach to providing treatment in a primary care office. In this model, a primary care physician works collaboratively with a psychiatric consultant and a care manager to manage patients' behavioral health needs. This model is supported by numerous randomized control studies that indicate that implementing the model improves access to care. The model works well for depression and anxiety (the two most common mental health conditions) and for older and younger patients. This model has also been shown to reduce disparities in outcomes among ethnic groups. We urge the Committee to explore proposals that would expand the use and adoption of the Collaborative Care Model.

It is well established that a failure to integrate behavioral and physical health care leads to worse outcomes, and a disconnect between care delivery models for commercial and government payers undermines efforts to move care delivery toward a whole person approach. In many places, Medicaid participants must navigate two separate systems for their physical health and behavioral health needs. This separate model of care leads to redundancies and inefficiencies in billing, information sharing, and most importantly, patient care. We recommend that the Committee support full integration in public programs. This can be accomplished though the development of new Medicaid demonstration programs that explicitly require physical and behavioral health services are integrated at the payer and provider level.

Ensuring Parity

KP supports the goals of the Mental Health Parity and Addiction Equity Act (MHPAEA) to improve coverage of mental health and substance use disorder services. We support finding consensus among states on reporting and the use of tools or attestation in meeting parity requirements and identifying best practices and standards. We also support ongoing guidance and support from federal agencies tasked with enforcing MHPAEA.

While they ensure that coverage of mental health benefits is equivalent to that of other medical conditions, parity laws alone cannot address major shortcomings of our nation's mental health delivery system, including workforce shortages, quality and outcomes, and equity in coverage – major underlying issues that affect access to care.

Expanding Telehealth

For decades, KP has been a leader in providing access to high-quality health care and member health information using technology tools. In our experience, effective telehealth capabilities enhance the patient experience, improve health outcomes, and expand access to routine and life-saving care. We strongly believe expanding the availability of and access to high-quality telehealth can help address behavioral health care workforce shortages and the geographic maldistribution of the behavioral health care workforce. Several key considerations are discussed below, followed by specific policy recommendations.

Care Effectiveness. Our experience and the available evidence indicate that behavioral health care delivered via telehealth is as effective as face-to-face care.[12] However, the literature is limited in its ability to answer the Committee's inquiries about "populations" (e.g., are there populations for which telehealth may be less suitable), as researchers tend to focus on testing whether specific therapies can be effectively delivered via telehealth. Additionally, the use of telehealth for patients with serious mental illness has not been studied as extensively.

Cost-Effectiveness. We are not aware of research conclusively demonstrating cost savings from use of telehealth in behavioral health given the current workforce structure, but we anticipate that clinicians and staff working from lower cost sites can contribute to savings over time. And while digital health can often supplement, rather than replace, in person care or telehealth visits, it may make care more effective, shorten episodes of care and prevent future episodes, which can lead to cost savings, improved outcomes, and greater patient satisfaction.

Integrated Care Modalities. Federal policy should consider telehealth an integrated component of routine patient care rather than a set of stand-alone services. It is important that budget models for expanded telehealth services take into consideration changes in the care delivery model that may be adopted by, for example, removing barriers like the originating site requirement restriction for telehealth reimbursement.

Quality. Quality measurement and reporting programs need to reflect the shifts in care delivery to include telehealth modalities. Specifically, incentive programs should adjust their budgeting and performance scoring methodologies to assure that accountable entities are credited for higher quality where telehealth is permissible and would drive improvement. Reimbursement rates for those telehealth visits should be reassessed as services expand. We also recommend reconsidering

[12] See https://www.milbank.org/publications/telebehavioral-health-an-effective-alternative-to-in-person-care/; https://www.jmir.org/2021/7/e26492; https://mental.jmir.org/2018/4/e62/; https://www.sciencedirect.com/science/article/pii/S0165032719319743

previous assumptions about time, capital and other resources required to complete a telehealth visit as more care is moved to these modalities.

Reimbursement. KP supports appropriate and equitable payment for all telehealth modalities. Given that the costs associated with different types of visits and different modalities can vary substantially, and with health care affordability considerations in mind, we do not believe it is appropriate to mandate reimbursement of telehealth at parity with in-person visits. We believe the negotiation of appropriate payment rates for telehealth modalities should be left to insurers/plans and providers and should factor in the costs of providing care.

Audio-only Telehealth. Audio-only visits are often, but not always, appropriate for treatment of behavioral health conditions. For example, a visual component would be important when there are physical symptoms to assess, such as tremors related to medications. We believe the determination of propriety should be a clinical decision, made jointly by clinician and patient and considering safety, quality, and patient preference.

The availability of audio-only telehealth is also important toward addressing disparities in access to care. As the individual patient level, lack of reliable internet access, limited access to appropriate devices, low digital/technological literacy, and concerns around security and privacy can impede access to care through telehealth. At the systemic level, lack of broadband, technological limitations around platforms and lack of interoperability between payers, providers and patients contribute to access challenges. Audio-only telehealth, where appropriate, is important to bridge gaps in access.

With these considerations in mind, KP supports policies that encourage the adoption and use of telehealth in behavioral health care to modernize and better equip the workforce to meet growing demand while ensuring quality:

- Permitting a broad set of licensed or certified clinicians to provide clinically appropriate care via telehealth.
- Permitting a broad set of health educators to provide education via telehealth.
- Factoring high-quality telehealth options into measurement of provider network adequacy, such as by relaxing or replacing time and distance standards for health plans that demonstrate strong access to behavioral health care via telehealth.
- Eliminating in-person visit requirements where appropriate, including for behavioral health, substance use disorder treatment, and prescribing of controlled substances. KP supports the inclusion of an individual's home as an "originating site" (the location of the patient receiving care via telehealth).
- Including telehealth visits—including audio-only visits—for risk adjustment purposes where appropriate.
- Reducing and ultimately eliminating disparities caused by the 'digital divide' and promoting digital inclusion—ensuring all individuals and communities have access to and can utilize the information and communication technologies/modalities needed for telehealth.

- Holding telehealth and in-person visits to the same high standards for clinical quality and patient safety.
- Aligning and integrating quality and outcomes measurement for in-person and telehealth services. We support the use of existing, applicable clinical measures (e.g., HEDIS measures) to evaluate quality of care delivered via telehealth, and the assessment of variation in quality by telehealth modality and compared to other care delivery modalities.
- Measuring patient and clinician experience and satisfaction with telehealth services and using resulting data to drive improvement.

Improving Access for Children and Young People

Prevention and early intervention are important policies for improving behavioral health. KP has long supported building the capacity of communities to prevent Adverse Childhood Experiences and other factors that contribute to poor mental and physical health and addiction. Such capacity requires the development of expanded capabilities to address needs "upstream" through early intervention in community settings, including schools. This is the foundation of our support for a coordinated approach to the provision of mental health services through schools.

We believe there should be an emphasis on quality and the provision of evidence-based treatment at schools and other community settings. Requirements should focus on the quality of the following: overall program, participating providers, and the efficacy of services provided. Seeing children in the context of their families and measuring and monitoring the quality of care is essential. We also believe it is important that mental health professionals in schools have the flexibility to broadly support teachers and other staff in creating a healthy environment for students and working with entire school populations, and not be limited by payment requirements that constrain the services provided in schools to only traditional therapeutic models.

Additional Considerations

Information Sharing

Information sharing of patient history has been a longstanding issue. Stigmatization of mental illness requires that patient privacy be appropriately safeguarded. At the same time, enabling providers to have the best and most complete information while treating their patient is imperative. We have consistently advocated for policies that simultaneously protect privacy and allow behavioral health patients to benefit from interoperable patient records and health information exchange among treating providers, in particular through updates to 42 CFR Part 2 confidentiality regulations. KP appreciates recent congressional attention to this issue and the inclusion of 42 CFR Part 2 reforms in the CARES Act. KP joins many others in the healthcare industry in supporting alignment of Part 2 with the Health Insurance Portability and Accountability Act of 1996 (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.

Evidence-Based Treatment and Outcomes Measurement

Not only do we need more and better-distributed providers, but we also need providers who are trained to deliver care – like the collaborative care model, cognitive behavioral therapy, and

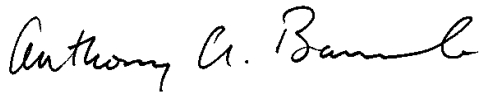
medication management – that research demonstrates is effective. In this respect, many behavioral health conditions are addressable with evidence-based treatment on par with other common and often chronic medical conditions.

U.S. health care policy must incentivize the use of evidence-based treatment. Promoting and evaluating quality will help ensure patients are receiving effective care. We support high-quality implementation and outcomes research to build the evidence base for mental health and substance use disorder treatment and promote research that improves public understanding. Currently, most measures of mental health care quality are process measures, focused on medication adherence, intensive service usage, and clinical scales. Mental health outcomes measures are in early development. Therefore, we also support accelerating development of robust, reliable quality measurement of mental health outcomes, as a crucial step forward, both from a patient-centered, quality care standpoint, as well as a public policy perspective.

KP uses both the Patient-Reported Outcomes Measurement Information System (PROMIS®) measures and open-ended goal setting in treatment planning and evaluation; we also use PROMIS measures in quality improvement strategies.[13] We have found the incorporation of patient feedback into the therapeutic process to be effective in improving patient outcomes. Promoting pilot studies would improve the evidence base for patient reported measures, help to unify the two strategies, and build on the patient-centeredness of care. These types of studies are essential to developing measure concepts that support effective clinical practice and continuous quality improvement.

Kaiser Permanente appreciates the Committee's consideration of our feedback and looks forward to working together on this important issue. Please contact Laird Burnett at (202) 236-7883 or Laird.Burnett@kp.org or me at (510) 271-6835 or Anthony.Barrueta@kp.org with any questions.

Sincerely,



Anthony Barrueta
Senior Vice President, Government Relations

[13] See https://www.promishealth.org/