Meadows Mental Health Policy Institute

U.S. Senate Committee on Finance Information Request
November 15, 2021

The Honorable Ron Wyden
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

The Meadows Mental Health Policy Institute (Meadows Institute) appreciates the opportunity to provide information on proposals that will improve access to health care services for Americans with mental health and substance use disorder. We also wish to express our gratitude to the U.S. Senate Committee on Finance for initiating a bipartisan process to examine behavioral health care needs and assess the factors contributing to gaps in care.

The Meadows Institute is a Texas-based non-profit policy research institute committed to helping Texas and the nation improve the availability and quality of evidence-driven mental health and substance use care. The Meadows Institute provides independent, nonpartisan, data-driven, and trusted policy and program guidance that creates systemic and equitable changes so all Texans can obtain effective, efficient behavioral health care when and where they need it. We are committed to helping Texas become a national leader in treatment for all people suffering from mental illness and addiction. More information about our work and history can be found on our website.[1]

We thank the Senate Finance Committee for its ongoing focus on these important issues. We have provided a summary of our recommendations below, followed by a detailed explanation that discusses each in detail. For questions regarding these comments, please contact John Snook, Senior Vice President of National Policy Innovation, at jsnook@mmhpi.org or (571) 331-5725 (m).

[1] The Meadows Institute website can be viewed here: https://mmhpi.org; our latest policy work here: https://mmhpi.org/work/policy-updates/; and our history here: https://mmhpi.org/about/story-mission/

Increasing Integration, Coordination, and Access to Care

- Support the establishment and growth of the Collaborative Care Model as a proven tool to detect and treat mental health and substance use concerns in primary care before they become crises.
- Pass and fully fund H.R. 5218, the "Collaborate in an Orderly and Cohesive Manner Act," introduced by Representatives Lizzie Fletcher (D-TX) and Jaime Herrera Beutler (R-WA).
- Ensure national efforts to address crisis care through the 988 system are coupled with broader reforms of the 911 emergency response system.
- Provide resources to ensure that federal reforms anticipate the need for coordination between 988 services, 911 response, crisis response, and the broader mental health and substance use disorder (SUD) treatment systems. Incorporate best practice models like San Antonio's Southwest Texas Crisis Collaborative.
- Ensure federal support for a full range of alternative crisis response models, including best practice multi-disciplinary response teams, like Dallas' Rapid Integrated Group Healthcare Team (RIGHT Care) team and variations in Austin, Amarillo, and San Antonio.

Strengthening Workforce

- Integrate behavioral health into primary care through utilization of the Collaborative Care Model. Leveraging primary care is a force multiplier for the behavioral health workforce, especially at a time of greatly increased demand and limited options for immediately scaling the existing specialty workforce.
- Recruit and support peer specialists and community health workers with a broad emphasis on lived experience, using proven models like the EMPOWER program currently being deployed in North Texas.
- Significantly expand the Coordinated Specialty Care set-aside in the Mental Health Block Grant to reflect the need nationally.
- Require Medicare, Medicaid, and all commercial payers to cover Coordinated Specialty Care.

Expanding Telehealth

- Make regulatory relief for telehealth – including audio-only telehealth – permanent. Eliminate in-person visit requirements for Medicare coverage of mental health telehealth services.
- Support the innovative efforts of states like Texas to expand options and opportunities to meet the needs of its citizens through initiatives like the Texas Child Health Access Through Telemedicine (TCHATT) program.

Improving Access for Children and Young People

- Deploy screening, detection, and early intervention in the two places where America is best able to help children – the family doctor and the local school.
- Establish universal access to child psychiatry consultation in primary care, as Texas has done through the Child Psychiatry Access Network (CPAN).
- Expand telehealth to meet the behavioral health needs of children and young people, leveraging proven best practices such as the TCHATT program.
- Encourage local school districts to implement systemic supports to ensure that local education agencies can provide a multi-tiered system of supports such as those being promoted nationally by the JED Foundation.
- Support early intervention through Coordinated Specialty Care (CSC) for people experiencing a first episode of psychosis. Expand the CSC set-aside in the mental health block grant and require Medicare, Medicaid, and commercial payers to cover CSC.
- Raise awareness about the impact of COVID-related deaths on youth and families, how to cope with grief-related distress, and when to seek treatment.
- Equip and empower community- and school-based clinicians to effectively identify and treat bereaved youth and families who are suffering because of pandemic-related losses.

Ensuring Parity

- At a minimum, ensure full enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Act).
- To enhance parity compliance, encourage the Administration to provide detailed quantitative data templates for comparative analyses of non-quantitative treatment limitations (NQTLs) through the Department of Labor.
- Pursue requiring parity compliance for traditional Medicare and Medicaid fee-for-service to significantly improve access to behavioral health care for millions of people.
- Continue to strongly support the provisions included in the Build Back Better Act that empower DOL to assess civil monetary penalties for parity violations and support additional funding for the Employee Benefits Security Administration (EBSA) for enhanced enforcement.

Increasing Integration, Coordination, and Access to Care

The Collaborative Care Model: The Meadows Institute supports the bipartisan Collaborate in an Orderly and Cohesive Manner (COCM) Act, H.R. 5128, introduced by Representatives Lizzie Fletcher (D-TX) and Jaime Herrera Beutler (R-WA). Expanding access to the Collaborative Care Model (CoCM) is the best practice for implementing behavioral health with primary care and

one of the most important things we can do to improve care and save countless lives for people struggling with mental health and SUD.

CoCM is a proven tool to detect and treat mental health and substance use concerns in primary care before they become crises. The model is a team-based approach to care[2] that routinely measures both clinical outcomes and patient goals over time to increase the effectiveness of mental health and SUD treatment in primary care settings.[3,4] CoCM is also the only evidence-based medical procedure currently reimbursable in primary care — it has been covered by Medicare since 2017[5] and by nearly all commercial payers since 2019[6] — and is the only model with strong evidence of cost savings.[7,8,9] The potential cost-savings of wide-spread implementation are considerable; a 2013 study found savings in Medicare and Medicaid settings of up to 6 to 1 in total medical costs and estimated $15 billion in Medicaid savings if only 20 percent of beneficiaries with depression receive it.[10] It is also the primary model prioritized by the Mental Health and Suicide Prevention National Response to COVID-19.[11]

Despite its effectiveness and savings, uptake of CoCM by primary care physicians and practices remains low due to up-front costs associated with implementing the model. Additionally, many

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[2] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes*. Health Home Information Resource Center. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

[3] Nafziger, M., & Miller, M. (2013). *Collaborative primary care: Preliminary findings for depression and anxiety* (Doc. No.13-10-3401). Washington State Institute for Public Policy. http://www.wsipp.wa.gov/ReportFile/1546/Wsipp_Collaborative-Primary-Care-Preliminary-Findings-for-Depression-and-Anxiety_Preliminary-Report.pdf

[4] Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. *Archives of Internal Medicine*, *171*(5), 425-431. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/226781

[5] Center for Medicare and Medicaid Services. (2019, May). *Behavioral health integration services.* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[6] Alter, C., Carlo, A., Harbin, H., & Schoenbaum, M. (2019, July 3). Wider implementation of collaborative care is inevitable. *Psychiatric News, 54*(13), 6-7. https://doi.org/10.1176/appi.pn.2019.6b7

[7] Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.

[8] Press, M. J., Howe, R., Schoenbaum, M., Cavanaugh, S., Marshall, A., Baldwin, L., & Conway, P. H. (2017, February 2). Previously cited.

[9] Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018, January). *Potential economic impact of integrated medical-behavioral healthcare. Updated projections for 2017*. https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

[10] Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.

[11] For more information, see: https://nationalmentalhealthresponse.org/our-priorities/priority-2

primary care physicians and practices may be interested in adopting the model but need assistance. H.R. 5128, the bipartisan COCM Act, addresses these roadblocks by providing grants to primary care practices to cover start-up costs and establishing technical assistance centers to provide support to practices implementing the model. Moreover, H.R. 5128 promotes research to identify additional evidence-based models of integrated care. In early 2021, scaling strategies like those advanced through H.R. 5128 were endorsed in comprehensive studies by both RAND and the Bipartisan Policy Center.[12]

The primary lesson that needs to be learned from the COVID-19 pandemic is that the nation can rapidly scale up and deliver early detection, treatment, and prevention if we pair the will to act with the necessary resources. Fortunately, this is much easier to do for mental illness and addiction, because we already know how to successfully detect and treat most of these conditions in an integrated and coordinated way – Collaborative Care.

Crisis Response: During the pandemic, we have witnessed the tragic consequences that result from the overreliance on a public-safety response to mental health emergencies. The current design requires police agencies to carry the burden for the entire community.[13] COVID has also exposed the lack of inpatient treatment resources in virtually every community in the country,[14] and the systemic gaps that fall disproportionately on Black, indigenous, and other people of color.[15]

While national efforts to address crisis care through the 988 system and alternative police response models are making gains, those advances must be coupled with reforms of the 911 emergency response system more broadly.

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[12] McBain, R. K., Eberhart, N. K., Breslau, J., Frank, L., Burnam, M. A., Kareddy, V., & Simmons, M. M. (2021). How to Transform the U.S. Mental Health System: Evidence-Based Recommendations. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA889-1.html

BPC Behavioral Health Integration Task Force. (2021). *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration: Task Force Recommendations*. Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R01.pdf

[13] Treatment Advocacy Center. (2019). *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey.* https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf

[14] Eide, S., & Gorman, C. D. (2021). *Medicaid's IMD Exclusion: The Case for Repeal.* Manhattan Institute. https://media4.manhattan-institute.org/sites/default/files/medicaids-imd-exclusion-case-repeal-SE.pdf

[15] The Front End Project. (2021). *From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response*. Fountain House. https://fountainhouse.org/assets/From-Harm-to-Health-2021.pdf

Texas is implementing best practices to plan and coordinate 911 response, crisis response, and the broader mental health and SUD treatment systems. One best practice is San Antonio's Southwest Texas Crisis Collaborative (STCC). STCC works operationally within the Southwest Texas Regional Advisory Council (STRAC), which coordinates emergency medical response for all health needs (including COVID-19) in the 22-county region surrounding San Antonio. STCC is now facilitating plans with the city of San Antonio, Bexar County, and mental health and substance use stakeholders to maximize the impact of COVID-19 and American Rescue Plan Act relief funds to address mental health and substance use service needs, including housing, trauma response, and other social determinants.[16]

Earlier this year, Austin became one of the first communities nationally to add a mental health response option to its 911 call center. This transformation focuses on the implementation of a health-driven response to mental health emergency calls through the 911 system and is based on a variation of the Multi-Disciplinary Response Team (MDRT) approach.[17]

A MDRT is a team of three: a community paramedic, master's level behavioral health clinician, and police officer with advanced mental health training. All three work as a single unit responding to 911 calls for service, on-site needs, answering officer assist calls, following up on referrals, and conducting outreach and prevention work to end the chronic mental health emergency cycle and alleviate the law enforcement response needs for their local department.

The longest-standing MDRT program being implemented in Texas is the Rapid Integrated Group Healthcare Team (RIGHT Care) in Dallas. MDRT variations like RIGHT Care are also being implemented with Meadows Institute support in large (Austin, San Antonio) and smaller (Abilene, Galveston) Texas communities.

The structure of MDRT programs and the presence of a law enforcement officer allow the team to answer a range of calls, including those that may include public safety risks. Civilian-only response teams provide a valuable service by alleviating the need for law enforcement response to calls for service that expressly do not pose a public safety risk and calls of less acuity, especially those originating from the soon-to-be-established 988 alternative crisis number. However, by design, these teams are inappropriate for or unable to address calls for service that expressly reference a risk of violence or where the risk is unclear (for example, a suicide attempt that may include a risk of firearm).

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[16] For more information on STCC and STRAC, see: https://www.strac.org/stcc

[17] Meadows Mental Health Policy Institute. (2021, May). *Multi-Disciplinary Response Teams: Transforming Emergency Mental Health Response in Dallas.* Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2021/06/MDRT_PEW_Report_05282021.pdf

This is not to say that there is not value to both strategies. But communities that adopt a civilian-only response team must also incorporate additional strategies to address the significant number of mental health related calls that remain and presumably would necessitate a traditional law enforcement-only response to provide an equitable mental health emergency response; not doing so may contribute to over-policing mental health calls for service.

Ensuring Equitable Access to Care: Pre-dating the pandemic, Black, indigenous, and other people of color across America faced systemic challenges accessing mental health care, with nearly three-quarters (73%) of Asians and Pacific Islanders, 69% of Blacks, and 67% of Latinos with mental illness not receiving needed mental health treatment.[18] Also prior to the pandemic, Black and Latino people were less likely to receive needed behavioral health services compared to the general population, and they are more likely to receive low-quality care.[19] COVID-19 has worsened these pre-pandemic inequities.

Each of the Texas-based reforms highlighted in this response – CPAN and TCHATT for children, the Lone Star Depression Challenge, EMPOWER, CoCM for primary care-based treatment more broadly, and MDRT-based 911 reforms – address health inequities disproportionately impacting Black, Latino, and other people of color. In addition to supporting these programs, Congress should continue to require specific metrics related to eliminating these inequities in all actions going forward, like requirements in the American Rescue Plan Act.

Improve the Primary and Specialty Care Workforce

Major deficiencies in the mental health and SUD workforces are well documented. We thus encourage the Committee to consider two promising strategies currently being implemented in Texas.

The first is primary care integration through utilization of CoCM, as detailed above. Just as primary care is the front line for the heart disease and cancer treatment workforce, it can be the same for behavioral health. Utilizing strategies like those addressed in H.R. 5128 to expand the reach of primary care for mental illness and addiction are force multipliers for the

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[18] Chaves, K., Gray, D., Barton, B., Bonnett, D., Azam, I., Hahn, C., Goldstein, E., Hall, I., Harris, N., Muhuri, P., King, J., Lankford, A., Lau, D., Liang, L., Liu, S., Matosky, M., Matthews, T., Morgan, R., Moser, R., … Valentine, M. (2020). *2019 National Healthcare Quality and Disparities Report*. Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr.pdf

[19] Snyder, C. R., Frogner, B. K., & Skillman, S. M. (2018). Facilitating Racial and Ethnic Diversity in the Health Workforce. *Journal of Allied Health*, *47*(1), 58–65. https://pubmed.ncbi.nlm.nih.gov/29504021/

behavioral health workforce, especially at a time of greatly increased demand and limited options for immediately scaling the existing specialty workforce.

An additional strategy to immediately expand the specialty workforce is to recruit and support peer specialists and community health workers with a broad emphasis on lived experience. As part of our Lone Star Depression Challenge,[20] the Meadows Institute is partnering with the Department of Global Health and Social Medicine at Harvard Medical School to deploy their EMPOWER program[21] in North Texas in 2021 and with a Latino cultural adaptation in 2022.

EMPOWER builds on path-breaking research demonstrating how non-specialist care providers can be trained and supervised to deliver brief psychological treatments for depression with just as much effectiveness as specialist-delivered treatment protocols.[22] This program greatly increases accessibility to mental health care, because the care is delivered by community health workers (CHWs) who live and work with (and often share similar lived experience with their neighbors living in) marginalized communities that are currently underserved.

Building on a decade of implementation research in India, we are on track to deploy EMPOWER to expand the North Texas workforce to better reach communities of color and people living in poverty more broadly in late 2021. EMPOWER addresses the formidable barriers of training, supervision, and quality assurance with a suite of digital tools to train, supervise, and equip the CHWs to consistently deliver evidence-informed care.

Expanding Telehealth

Congress should also make regulatory relief for telehealth – including audio-only telehealth – permanent and support the innovative efforts of states like Texas to expand options and opportunities to meet the needs of its citizens through telemedicine. Telehealth expansion has enjoyed broad bipartisan support in Texas, as evidenced by the passage of 87(R) HB 4, which

[20] For more information on the Lone Star Depression Challenge, see: https://mmhpi.org/the-lone-star-depression-challenge/

[21] For more information on EMPOWER, see: https://empower.care

[22] Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., Dimidjian, S., Araya, R., Hollon, S. D., King, M., Vijayakumar, L., Park, A.-L., McDaid, D., Wilson, T., Velleman, R., Kirkwood, B. R., & Fairburn, C. G. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: A randomized controlled trial. *The Lancet*, *389*(10065), 176–185. https://doi.org/10.1016/S0140-6736(16)31589-6

made permanent the state's emergency telehealth waivers that had been temporarily granted during the COVID-19 pandemic.[23]

The ongoing COVID-19 pandemic spurred an unprecedented shift to the delivery of care through telemedicine, telehealth, and telephone (audio only), with flexibilities offered at both the state and federal level. The resulting shift to technology has alleviated mental health professional shortages by making services more accessible for people in need, including those in rural and underserved areas.

Accessing tele-behavioral services has been a vital strategy to mitigate the spread of COVID-19. Audio-only services ensure that behavioral health providers can provide treatment to people who have no access to broadband or other technology. The Committee should support policies to ensure Medicaid recipients can access such much-needed mental health and SUD treatment through tele-health, including audio-only, on a permanent basis. Returning to the pre-COVID-19 status quo will lead to higher costs through delays in treatment and worsening conditions.

Expanded telehealth options have been integral to implementing innovative initiatives to serve the behavioral health needs of children and adolescents such as the Texas Child Health Access Through Telemedicine (TCHATT) program (discussed in more detail below). Under the TCHATT program, multidisciplinary providers at participating medical schools provide telemedicine and telehealth services to public school students experiencing a mental health crisis at no cost to school districts. Providers work collaboratively with each other, family members, and school counselors to assess, triage, and stabilize a student prior to connecting them with providers in their communities for ongoing support. Nearly 1.7 million Texas students now have access to TCHATT services.[24]

Expanded telehealth access has also allowed Texas to implement innovative crisis response solutions. Because of the unpredictable nature of police calls for service, crisis workers may not be able to deploy to every call in which they could be of benefit. In Texas and in cities across the country, mobile telehealth is proving to be a workforce multiplier, significantly enhancing systems and making it possible to immediately connect people to crisis and health services.

[23] For more information on the passage of Texas House Bill 4 (Price – Amarillo), please see: https://www.kcbd.com/2021/07/13/gov-abbott-signs-bills-aimed-expanding-telehealth-broadband-across-texas/

[24] For more information, see: https://tcmhcc.utsystem.edu/tchatt/.

Improving Access for Children and Young People

Mental illnesses are primarily pediatric illnesses, with half of all cases manifesting by age 14 and three-quarters by the time the brain stops developing in our mid-twenties.[25, 26] The key therefore is to deploy screening, detection, and early intervention in the two places where America is best able to help children – the family doctor and the local school.

We are scaling these solutions today in Texas. In mid-2019, the Texas Legislature overwhelmingly approved, and Governor Abbott signed into law, 86(R) SB 10, which brought together the state's 12 publicly funded medical schools to form the Texas Child Mental Health Care Consortium (TCMHCC). The Legislature funded the Consortium with an initial $99 million to provide universal access to child psychiatry consultation in primary care through the Child Psychiatry Access Network (CPAN), urgent access to psychiatric telehealth care and referrals in Texas schools through the TCHATT program, and broad expansion of workforce training and the public psychiatry workforce more broadly.[27]

The Executive Committee of TCMHCC developed its implementation plan pre-pandemic and launched on time in May 2020, despite the pandemic. Since then, the TCMHCC has:

- Engaged nearly 5,000 pediatric primary care providers in the CPAN program; and
- Expanded TCHATT access to nearly 1.7 million Texas students with thousands served, including 12.5% Black and 34% Latino students – numbers proportionate to the broader child population of Texas.

The 87th Texas Legislature recognized the early success of the Consortium and higher needs due to COVID-19 and appropriated an additional $19.5 million for the Consortium, bringing their funding to $118.5 million for the 2022-23 biennium. In its third called special session, the Texas Legislature approved an additional $113 million in surge funding for two years, thanks to the American Rescue Plan Act.

The Meadows Institute is also working closely with the Texas Education Agency (TEA) to create guidance and supports for local school districts to implement systemic supports to ensure that local education agencies can provide a Multi-Tiered System of Supports, leveraging within an

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[25] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602. https://doi.org/10.1001/archpsyc.62.6.593

[26] Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, *60*(7), 709–717. https://doi.org/10.1001/archpsyc.60.7.709

[27] You can read more about these programs at https://tcmhcc.utsystem.edu.

Interconnected School Framework.[28] The JED Foundation has also released updated guidance for these system-level supports.[29]

Previous COVID-19 relief bills and the American Rescue Plan Act expanded funding for psychiatry access programs like CPAN and school-based mental health supports, but **the scope of the psychiatry access expansion nationally is less than what has funded in Texas alone**, and the school-based efforts lack guidance on infrastructure development initiatives such as TCHATT.

Congress should encourage use of telehealth in school-based mental health and SUD services expansion. Systemic supports such as those we are helping implement in Texas and those promoted nationally by the JED Foundation should also be incorporated into school-based efforts.

Supporting Early Invention Through Coordinated Specialty Care: Today, in Texas and across the United States more broadly, we do not detect and treat mental illness – to the extent we detect and treat it at all – until eight to ten years after symptoms emerge.[30] Psychotic illnesses typically emerge in the teen years or during early adulthood, with the potential for significant long-term impairment. Both research and practice show, however, that early intervention with appropriate treatment and support can both help prevent the full onset of illness in a high-risk state and improve long-term outcomes for those who have had a first episode of psychosis (FEP).[31]

Coordinated Specialty Care (CSC) has been shown to produce greater improvement in clinical and functional outcomes as compared with standard care for those experiencing FEP. These effects were more pronounced for those with shorter duration of untreated psychosis,

[28] For more information, see: https://mmhpi.org/wp-content/uploads/2019/10/RoadmapAndToolkitForSchools.pdf

[29] For more information, see: https://www.jedfoundation.org/wp-content/uploads/2021/02/The-Comprehensive-Approach-to-Mental-Health-Promotion-and-Suicide-Prevention-for-High-Schools_JED.pdf

[30] American Academy of Child & Adolescent Psychiatry. (2012). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

[31] National Association of State Mental Health Program Directors. (2020). *Early Intervention in Psychosis.* https://www.nasmhpd.org/content/early-intervention-psychosis-eip

suggesting that the receipt of appropriate CSC at the proper time in the illness course can have a substantial impact on outcomes.[32]

Texas has been able to use federal Mental Health Block Grant (MHBG) funding thanks to the required CSC set-aside to implement 29 teams to date,[33] but we estimate that eight times as many teams are needed to meet the need statewide.[34] America's response to the pandemic has shown us that we can fully scale treatment if we have the will and resources to do so, and Congress could readily provide care to the 100,000 Americans in need each year by:

- Dramatically expanding the CSC set aside in the MHBG to fund program start-ups; and
- Requiring Medicare, Medicaid, and commercial payers to cover CSC care.[35]

Supporting Access to Behavioral Health Care for Vulnerable Youth Populations: Since March 2020, the COVID-19 pandemic has contributed to an unprecedented level of loss. According to a recent study in *Pediatrics*, at least 140,000 American children (or approximately one in every 500 children) lost a parent or caregiver because of the pandemic; by October 2021, that number had climbed to 170,000. It is estimated that nine family members are affected by one person who dies of coronavirus.[36] This means that in the U.S. alone, nearly five million people have been directly impacted by the loss of a loved one to the coronavirus.

The context in which these deaths have occurred (e.g., social distancing that prevents in-person support and collective mourning; inability to say goodbye to dying loved ones; survivor's guilt among those who may have inadvertently transmitted the virus) makes the grief-related impact even more pronounced. The pandemic has also revealed significant health, social and economic disparities, leading to disproportionate suffering among populations of color. For example, 50 percent more Black children have lost a parent or caregiver to COVID-19 than other children.

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[32] Kane, J. M. et al. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program. *The American Journal of Psychiatry, 173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

[33] Intellectual and Developmental Disability and Behavioral Health Services Department. (2020). *Intellectual and Developmental Disability and Behavioral Health Services: Fiscal Year 2020 In Review*. Texas Health and Human Services.

[34] Meadows Mental Health Policy Institute. (2020). *Coordinated Specialty Care for Texans*. https://mmhpi.org/wp-content/uploads/2020/09/CoordinatedSpecialtyCare.pdf

[35] Jackson, B., Sternbach, K., Dixon, L., Harbin, H., Schoenbaum, M., & Rowan, M. (2020). *Payment Strategies for Coordinated Specialty Care (CSC)*. Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2020/10/CoordinatedSpecialtyCare-PaymentStrategies.pdf

[36] Verdery, A.M., Smith-Greenaway, E., Margolis, R., & Daw, J. (2020). Tracking the reach of COVID-19 loss with a bereavement multiplier applied to the United States. *Proceedings of the National Academy of Sciences, 117* (30), 17695-17701.

Pandemic-related risk factors as well as preexisting adversities can contribute to significant long-term mental and behavioral health problems among those who are grieving, including substance use, juvenile delinquency, posttraumatic stress, prolonged grief disorder, depression, and suicide. In addition, some of our most pressing societal problems, including domestic violence, community violence, and mass shootings, stem from unresolved traumas and losses in childhood, speaking to the need to identify and address trauma and grief as early as possible.

The Meadows Institute's Trauma and Grief (TAG) Center[37] is designed to raise the standard of care and increase access to best practice care among youth and families exposed to trauma and bereavement. Our research has shown that bereavement is unlike other forms of trauma in that it is both the most distressing form of trauma among youth in the general population[38] and it is the strongest predictor of school problems (e.g., lower academic achievement, decreased school connectedness, increased drop-out) among youth, above and beyond any other form of trauma.[39]

Over the last decade, the TAG Center has been validating risk screening tools to identify traumatized and grieving youth in need of mental health treatment, as well as developing, implementing, and evaluating evidence-based interventions for this population. These interventions have been found to significantly reduce posttraumatic stress, maladaptive grief, depression, suicide risk, and violent behavior. Unfortunately, few organizations across the country exist to provide evidence-based, trauma- and grief-informed care to our most vulnerable youth. Similarly, few community- and school-based clinicians are trained in these best practices.

This Congress has made significant investments to support children exposed to trauma and bereavement through the National Child Traumatic Stress Network. But much more needs to be done to meet the overwhelming need facing America's youth. We need to raise awareness and inform the public about the impact of COVID-related deaths on youth and families, how to cope with grief-related distress, and when to seek treatment. More research is needed to determine

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[37] For more information on the Trauma and Grief (TAG) Center at The Hackett Center for Mental Health, see: https://mmhpi.org/work/trauma-grief-center/

[38] Kaplow, J.B., Saunders, J., Angold, A., & Costello, E.J. (2010). Psychiatric symptoms in bereaved versus non-bereaved youth and young adults: A longitudinal, epidemiological study. *Journal of the American Academy of Child and Adolescent Psychiatry, 49,* 1145-1154.

[39] Oosterhoff, B., Kaplow, J. B., & Layne, C. (2018). Links between bereavement due to sudden death and academic functioning: Results from a nationally representative sample of adolescents. *School Psychology Quarterly*, *33*(3), 372–380.

the most effective grief-related interventions for youth exposed to deaths in the context of the pandemic, particularly "at-risk" youth who have preexisting traumas and losses. Finally, we need to further equip and empower our community- and school-based clinicians to effectively identify and treat bereaved youth and families who are suffering because of pandemic-related losses.

Ensuring Parity

There is a public health imperative to ensure that behavioral health conditions are given the same level of care and insurance coverage as other health conditions, such as heart disease and diabetes. Unfortunately, the complexities and gaps of current parity laws, combined with ineffective enforcement, have allowed most large group health plans and insurers to continue with business as usual.

Federal law does not require large employer groups to cover behavioral health services, and state regulations primarily reach only fully insured plans. In addition, it is possible for group health plans to "appear" to comply with parity laws by adjusting their plan designs, when the real-world application of non-quantitative treatment limits such as utilization review and medical necessity determinations result in more frequent denials for behavioral health inpatient levels of care than those for inpatient medical care.

Numerous nationwide claims data studies have shown that many commercial insurers are reimbursing behavioral health providers significantly less than medical/surgical providers for similar services. These studies also show that access to in-network behavioral providers is significantly less than access to medical/surgical providers. A 2019 Milliman disparities study showed that primary care reimbursements were 28.3 percent higher than behavioral health reimbursements. This study also showed that 17.2 percent of behavioral health office visits were to an out-of-network provider compared to 3.2 percent for primary care visits and 4.3 percent for medical/surgical specialists.[40] The lack of enforcement has contributed to these disparities.

The lack of parity in access to the full range of behavioral health services contributes to high total medical costs. A 2020 Milliman cost study showed that the most expensive ten percent of patients (2.1 million people) accounted for 70 percent of total annual health care costs. 57 percent of those patients (1.2 million individuals) had both physical and behavioral health

[40] Davenport, S., Gray T.J., & Melek, S. (2019). *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement.* Milliman. https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p/

conditions. This subgroup—5.7 percent of the study population—accounted for 44 percent of the annual total healthcare costs (for 21 million individuals), with the vast majority spent on physical health conditions.[41]

The expanded role of U.S. Department of Labor (DOL) and the U.S Department of Health & Human Services (HHS) in parity enforcement, based on the Consolidated Appropriations Act, 2021, should be continued and further expanded. DOL should also be required to provide detailed quantitative data templates for comparative analyses of non-quantitative treatment limitations (NQTLs) to enhance parity compliance. Data templates will provide greater and much-needed guidance to self-insured employers, third-party administrators, and health insurance issuers. Consistent guidance on best practice quantitative data templates will reduce the administrative costs for insurers when providing NQTL parity compliance analyses to regulatory agencies.

Furthermore, requiring parity compliance for traditional Medicare and Medicaid fee-for-service would significantly improve access to behavioral health care for millions of people. It is important to note that Medicare and Medicaid fee-for-service programs have no out-of-network benefits. Thus, inadequate network access results in 100 percent out-of-pocket costs for consumers enrolled in these programs.

Structural challenges, such as provider shortages and size of provider networks, have been effectively addressed by insurers and plans for medical/surgical benefits by increasing reimbursement rates and other proactive network strategies. However, these actions have typically not been undertaken by insurers or plans to address the same challenges for behavioral health benefits.

At a minimum, the Committee should ensure full enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. In the Build Back Better Act, the U.S. House Committee on Education and Labor included provisions that provide DOL with the power to assess civil monetary penalties for parity violations and added $195 million over five years in funding to the Employee Benefits Security Administration (EBSA) for enforcement. If enacted, both provisions would save lives and increase access to care for millions of Americans.

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[41] Davenport, S., Gray T.J., & Melek, S. (2020). *How Do Individuals with Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending?* Milliman. https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx

Thank you again for the opportunity to provide information on proposals that will improve access to health care services for Americans with mental health and substance use disorders. We look forward to working with the Committee to address the needs of Americans with mental health and substance use disorder.

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