National Association for Behavioral Healthcare

Access. Care. Recovery.

5 November 2021

The Honorable William Cassidy, M.D.
United States Senate
Washington, DC 20510

The Honorable Christopher Murphy
United States Senate
Washington, DC 20510

Re: Proposals to improve federal mental health and substance use disorder programs and additional recommendations

Dear Senators Cassidy and Murphy:

Thank you for your ongoing leadership to improve mental healthcare and addiction treatment, including with the *Mental Health Reform Act of 2016*. We appreciate your request for feedback on the programs authorized as part of that legislation as well as additional recommendations for how to improve care for individuals with mental illness or substance use disorders (SUDs).

The National Association for Behavioral Healthcare (NABH) represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility- and office-based outpatient programs including medication assisted treatment (MAT) providers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

The pandemic has highlighted and amplified the need for improved access to mental health and addiction treatment. Studies have consistently found significantly higher levels of anxiety and depression and suicidal ideation.[i, ii] In addition, alcohol consumption has increased significantly.[iii] Drug overdose deaths increased almost 30% in 2020 to more than 90,000 deaths, the highest number ever recorded during a 12-month period,[iv] and stimulant-related deaths more than tripled between 2010 and 2017. [v] Although suicide rates seemed to have leveled off and decreased last year,[vi] there have been troubling increases in suicides and suicidal ideation among certain subgroups including Black Americans[vii] and adolescent girls.[viii]

Moreover, experts expect mental health and substance use disorders to remain elevated long after the pandemic ends. Experiences with epidemics in the past indicate that the impact on behavioral health may continue for years to come.[ix]

Support Increased Access and Improvements to Behavioral Healthcare Regardless of Provider Tax Status

A number of programs authorized through the *Mental Health Reform Act of 2016*, including several of those listed in your letter, limit participation to not-for profit providers. This limitation unnecessarily prohibits participation by a large and increasing segment of leading behavioral healthcare providers. One in five mental health facilities (including outpatient facilities, community mental health centers, hospitals, and residential treatment centers)[x] is run by a for-profit organization and thus ineligible to participate in many of the programs that the Substance Abuse and Mental Health Services Administration (SAMHSA) administers.

In addition, more than 40% of addiction treatment providers in the United States (including intensive outpatient, partial hospitalization, opioid treatment programs, other medication assisted treatment providers, and residential treatment providers) are run by for-profit providers, and they treat 45% of all clients.[xi] Sixty-two percent of opioid treatment programs are for-profit organizations.[xii]

Not-for profit status primarily serves to exempt organizations from paying taxes and does not necessarily indicate the quality of care or the relative amount of uncompensated or reduced price care an organization provides.

Moreover, not-for profit status does not necessarily equate with lower prices for consumers. Enrollment in provider networks of insurers is more relevant to out-of-pocket costs for consumers.

This change is particularly important regarding the Community Mental Health Services Block Grant. As you know, in the past year Congress has exponentially increased funding to states through this block grant— as well as the Substance Abuse Prevention and Treatment (SAPT) Block Grant— to help address the behavioral health impacts of the Covid-19 pandemic. However, states will have difficulty spending these funds expeditiously if they may only use them to expand access to and improve quality of treatment at facilities with a not-for-profit status. Recently, SAMHSA has clarified that states may use the SAPT Block Grant to contract with for-profit providers.[xiii] We urge you to enact a similar expansion in the pool of eligible providers for Mental Health Block Grant funds.

Improve Parity Implementation:

We also greatly appreciate your steadfast commitment to improve implementation of the *Mental Health Parity and Addiction Equity Act* (MHPAEA), including enactment of the *Mental Health Parity Compliance Act* that requires insurers to document and federal agencies to review compliance with non-quantitative treatment limitation (NQTL) requirements. We encourage you to promote additional provisions to improve MHPAEA implementation, including the legislation you recently sponsored, the *Parity Implementation Assistance Act* (S 1962), to support state agency implementation of the new NQTL documentation requirements.

For your consideration, we also recommend the following proposals:

- **Eliminate the authorization for non-federal government plans to opt out of compliance with MHPAEA.**

  As you may know, self-funded, non-federal governmental group health plans may choose not to comply with several beneficiary protections in the *Public Health Service Act* ,including MHPAEA.[xiv] Well over 150 state, county, and municipal health plans have opted out of parity requirements for 2021.[xv] As a result, public servants across the United States—including firefighters, teachers, police officers, first responders, bus drivers, nurses, and others— are subject to discriminatory limits on mental health and addiction treatment. This is even more appalling given the undeniable evidence and widespread consensus that the pandemic has had an especially harmful impact on these essential workers. We urge you to prioritize elimination of this opt-out provision.

- **Require federally regulated health plans to base utilization management on generally accepted standards of care.**

  Ensuring compliance with parity requirements for NQTLs has proven to be very challenging in commercial plans as well as in Medicaid and CHIP benefits.[xvi] A more straightforward solution would be to adopt the approach taken by the federal court in the ground-breaking *Wit v. United Behavioral Health* decision to require that insurers base mental health and addiction treatment medical necessity determinations and other utilization management practices on generally accepted standards of care. While the court ruling in this case relied on requirements under the *Employee Retirement Income Security Act* that applies to large employer-sponsored health plans, we urge you to develop legislation to require all federally regulated health plans to base utilization management on generally accepted standards of care to improve compliance with parity and help address many of the challenges with implementation of NQTL requirements.

- **Establish additional benefit classification in parity rules for an intermediate level of care.**

  Partial hospitalization, intensive outpatient, and residential treatment programs are widely recognized as critical for helping people with serious behavioral health conditions transition out of acute inpatient settings when they no longer need to be there. These treatment settings in the intermediate level of care can also serve as alternatives to inpatient care for those who require intensive services but do not need acute care. However, capacity of these treatment settings is quite limited, and managed care plans and issuers often place strict limits on receiving care in these settings.

  The MHPAEA regulations designated six classifications of benefits to be used in determining compliance with parity rules: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescriptions drugs, and emergency care. The MHPAEA final rule clarified that managed care plans and issuers should categorize these intermediate level programs in either the outpatient or inpatient benefit classifications for purposes of a parity analysis. However, partial hospitalization, intensive outpatient, and residential treatment programs clearly belong in a separate intermediate level of care comparable to skilled nursing facilities and rehabilitation programs for medical conditions.

  Designating a separate intermediate level of care classification would help to clarify how parity applies to these services and could improve health plan coverage of partial hospitalization, intensive outpatient, and residential programs. We urge you to develop and promote legislation requiring a change in the parity rules to add an intermediate level of care benefit classification for purposes of compliance with parity.

Allow Telehealth for Methadone Treatment Induction

We encourage you to address an important access issue for individuals with opioid use disorder (OUD) who require methadone treatment. As you may know, individuals with the most severe cases of opioid use disorder can benefit from methadone treatment provided through an opioid treatment program (OTP). During the pandemic, OTPs have been able to provide counseling and other services via telehealth for individuals already receiving methadone treatment. Unfortunately, SAMHSA has not permitted telehealth services for methadone induction even when the patient is physically located in the OTP and accompanied by another qualified provider who has ‘eyes on’ the patient, and when it is the prescriber is working remotely.

This hybrid model of telehealth in which the individual is physically present in the OTP but prescribers or other practitioners are working remotely is critically important for maximizing physician/prescriber capacity, and also for helping individuals with the most severe cases of OUD who are often difficult to engage in treatment and vulnerable to overdose and death. At minimum, we request that funding be provided to implement pilot programs to test and evaluate the use of telehealth for methadone for new patients through this hybrid telehealth model.

Thank you for considering our recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin, President and CEO

National Association for Behavioral Healthcare

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About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C. The association was founded in 1933.

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