Depression and Bipolar Support Alliance

November 4, 2021

The Honorable Ron Wyden
Chairman, Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Crapo
Ranking Member, Senate Finance Committee
United States Senate
Washington, DC 20510

Delivered by email to: mentalhealthcare@finance.senate.gov

Dear Chairman Wyden and Ranking Member Crapo:

The Depression and Bipolar Support Alliance (DBSA) applauds the work that the Senate Finance Committee has undertaken to address the need for enhanced mental health services and programs for all Americans. We appreciate the opportunity to respond to the September 21, 2021 open letter to the behavioral health community seeking recommendations on policy options at alleviating barriers to accessing evidence-based mental health treatment for both adults and children. We applaud the committee for the groundwork it has laid in this effort through your two previous hearings this year and your solicitation of stakeholder feedback on these important issues. We will address in particular issues that can be advanced through the work of the Finance Committee and raise other suggestions that can be implemented on a broader public policy basis.

DBSA is the leading national peer-focused organization providing support for individuals living with depression and bipolar disorder. DBSA's peer-based, wellness-oriented, and empowering services and resources are available when people need them, where they need them, and how they need to receive them—online 24/7, in local support groups, in audio and video casts, or in printed materials distributed by DBSA, our chapters, and behavioral care facilities across America. DBSA's federal advocacy priorities are to reduce barriers and/or increase access to mental health care and broaden the integration of peer support services within health care systems. It is with this in mind that we share our recommendations for you to consider.

Through our network of chapter affiliates, DBSA has supported over 500 free in-person weekly support group meetings with virtually all them in an online format since March 2020. In addition, the national organization provides 40 free weekly peer-facilitated online support group meetings. Three of these meetings are for those living with co-occuring substance use and mood disorders, two are designated for the black community, two for young adults, and one for Veterans. More groups for the Black Community are anticipated in the coming months.

Strengthening the Behavioral Healthcare Workforce

Central to the work of DBSA is the development of the peer specialist worker workforce; a key element in providing essential services to individuals living with mood disorders. As defined by SAMHSA, peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions substance use disorders, or both. This mutuality—often called "peerness"—between a peer support worker and person in or seeking recovery promotes connection and inspires hope. Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships. By sharing their own lived experience and practical guidance, peer support workers: help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves.

Currently mental health peer support services are reimbursed through Medicaid in 39 states. We recommend increasing the federal reimbursement rate for mental health care under the Medicaid through the passage of the *S.1727/H.R.3450 Medicaid Bump Act.*

Medicare beneficiaries lack broad access to peer support services except in limited situations with Medicare Advantage programs. We have working with the Committee to advance *S.2144 Promoting Effective and Empowering Recovery Services in Medicare Act of 2021.* This bipartisan bill specifies that peer support specialists may participate in the provision of behavioral health integration services with the supervision of a physician or other entity under Medicare. The bill defines *peer support specialists* as individuals who are recovering from a mental health or substance-use condition and have certain national or state credentials, as specified, to provide peer support services.

While not under jurisdiction of the Committee we also call to your attention *S.2386 Veteran Peer Specialist Act of 2021,* which would provide further expansion of the peer support workforce. This proposed legislation would add to the VA MISSION Act of 2018 by expanding the peer specialist program to all VA medical centers over a five-year period by initiating the program at 25 medical centers per year, hiring two peer specialists at each facility, and ensuing diversity in the hiring or peer specialists. The legislation calls on the VA to provide annual reports to Congress and authorizes $5 million over five years to implement the program to ensure that the VA has adequate funding to hire new peer specialists.

We want to note that the behavioral health workforce severely lacks racial and ethnic diversity. In 2015, the American Psychological Association found that 86% of psychologists in the United States were White, 5% Asian, 5% Hispanic, 4% Black, and 1% multiracial. The APA notes this is less diverse than the country's population, which at the time was 62% White and 38% racial/ethnic minority. A recent study has shown that issues surrounding race and ethnicity are important to ethnic minorities and when these elements are not included in behavioral health treatments, patients generally are less satisfied. Diversifying the behavioral health workforce has been seen as one way to ensure patient satisfaction notably among racial and ethnic minorities.

We recommend passage of the *S. 1578 Mental Health Professionals Workforce Shortage Loan Repayment Act* which would authorize a loan repayment program for mental health professionals who commit to working in communities that lack accessible care. Overall, support for this legislation could help address some of the provider shortage issues and increase access to care for patients.

Peer Support Role in Care Integration, Coordination, and Access

Peer support groups can range from serving as one therapeutic component of a comprehensive behavioral health treatment plan to serving as an individual's sole support system. Support groups attract a broad variety of participants who may previously have avoided peers and their traditional support system such as family and friends. However, after interacting with a support group, participants report feeling validation.[1]

In this time of physical distancing, online support groups provide increased access to support and reduce the sense of isolation for individuals who cannot access in-person support. Online support groups can function as an effective addition to counseling services for those who may benefit from more support than counseling offers and/or more frequent support than counseling provides.

Participants in online support groups benefit from a combination of seven therapeutic factors, providing experiences that promote the potential for growth, change, and social experimentation. These experiences contribute to the group's cohesion and perceived helpfulness. For example, the factor of "universality" unites people as they share similar thoughts, feelings, fears, and/or reactions with their cyber community. Others struggle too, and this is not always evident to people in distress.[2]

Specialized groups for seniors and Veterans can connect people who have similar life experiences and need someone with whom they can communicate honestly and openly
without regard to geographic boundaries. Support groups also can be dedicated to specific languages, age groups or gender groups.

Peer support is an evidence-based service.
In a recent Pepperdine University initiative that surveyed participants of online support groups, seventy-nine percent (79%) of respondents reported that they are more hopeful at the conclusion of their online support group. Seventy-seven percent (77%) of respondents felt they learned new strategies and information about living with a behavioral health condition.

The efficacy of peer support services delivered by a peer specialist has been long known. Peer support services:

- Reduce recurrent psychiatric hospitalizations for patients at risk of readmission[3,4,5]
- Improve individuals' relationships with their health care providers[3,4,5]
- Reduce expensive outpatient services[3,4,5]
- Better engage individuals in care[6]

Benefits of peer support services
Over the past 15 years DBSA has worked closely with the Department of Veterans Affairs through its Veterans Health Administration (VHA) to expand their peer support services through the provision of training for peer specialists. Within the VHA peer support is not a program, but a profession or discipline. As such, peer specialists work within programs as do other professionals such as physicians, psychologists, social workers, and nurses. Peer specialists provide veterans living with behavioral health conditions a place to build a community, share experiences, discuss coping skills, and offer hope to one another. Participation in peer support services are generally part of an individual's recovery and wellness plan and works in partnership with the care provided by the interdisciplinary treatment team.

Research has shown that evidence-based peer support services improve outcomes by:

- reducing recurrent psychiatric hospitalization for patients at risk of readmission[6],
- improving individuals' relationship with their health care provider[7],
- reducing outpatient visits[6], and
- better engaging individuals in their course of treatment.[7]

Another way of understanding the benefits of a peer specialist is to review the empirical data around DBSA peer-to-peer support groups. Participants reported that they were:[8]

- better informed about their mental health condition,
- had better acceptance of their mental health condition,
- were more confident about their mental health care treatment, and
- expressed optimism about and control of their future.

We recommend passage of several pieces of legislation which address these approaches and address the expansion of crisis response program on the local level.

S. 157 *Virtual Peer Support Act of 2021.* To provide funding for the Assistant Secretary for Mental Health and Substance Use to award grants for the purpose of supporting virtual peer behavioral health support services, and for other purposes.

S.2069 *Excellence in Mental Health and Addiction Treatment Act of 2021.* This legislation would allow every state the option of joining the innovative Certified Community Behavioral Health Clinic (CCBHC) demonstration and authorize investments in the model for current and prospective CCBHCs. Inclusion of peer support services is a key feature of the work of CCBHC.

S.2425 *Suicide Prevention Lifeline Improvement Act of 2021*. This bill expands the requirements for the National Suicide Prevention Lifeline Program. Specifically, the Substance Abuse and Mental Health Services Administration must (1) develop a plan to ensure the provision of high-quality service, (2) strengthen data-sharing agreements to facilitate the transmission of epidemiological data from the program to the Centers for Disease Control and Prevention, and (3) implement a pilot program focused on using other communications platforms (e.g., social media and texting) for suicide prevention. The bill also directs the Government Accountability Office to study the program.

S.1902 *Behavioral Health Crisis Services Expansion Act.* This bill would overhaul our nation's current approach to responding to mental health crises by expanding the availability of behavioral health crisis services, including robust mobile crisis and 24/7 crisis stabilization services, and by providing coverage of these services for patients no matter where they get their health insurance.

One of the promising areas of therapeutic advance has been the development of pharmacogenomic testing to assist in the appropriate use of medications for those who choose this health care route. However, coverage through state Medicaid programs has been slow in coming We believe a letter to Medicaid Directors in line with Senator Brown's proposal will help to further educate state leaders and raise awareness on the benefits of including coverage of pharmacogenomic tests for mental health conditions. Senator Brown submitted language to Finance Committee staff which we have provided below and encourage your consideration.

- *Proposal: Require CMS to put out Guidance to States on Best Practices for Mental Health Pharmacogenomics - Not later than 1 year after the date of the enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall issue a State Medicaid Director letter outlining best practices to improve outcomes for beneficiaries with major depressive disorder or other mental health conditions who are receiving medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The letter shall include coverage policy examples from Medicare and/or private payers utilizing pharmacogenetic testing to support clinicians seeking medication options to treat patients and reduce trial and error.*

Ensuring Parity Throughout the Safety Net & Other Federal Health Programs

We share with our colleague organizations a fundamental belief that it will be impossible to ensure parity unless the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Act) is fully extended to Medicare and all of Medicaid. The Federal Parity Act, the landmark law that prohibits discrimination in the coverage of mental health and substance use disorder care, should also be extended through statute to TRICARE to ensure equal coverage for members of the military and their families.

Congress must no longer accept the status quo in which the more than 60 million older adults and individuals with disabilities enrolled in Medicare have among the worst coverage of mental health and substance use disorder services in the country. Additionally, more than 20 million Americans in traditional Medicaid have no protections under the Federal Parity Act and are frequently subjected to discriminatory state plans that offer inferior mental health and substance use disorder coverage. Furthermore, TRICARE's nearly 10 million enrollees do not have full rights under the Federal Parity Act.

Therefore, we urge you to make parity core to your efforts to address the ongoing mental health and addiction crisis facing our country. Indeed, without coverage parity in our nation's foundational public programs, it is difficult to imagine how it will be possible to reimagine the systems of care to meet Americans' needs. While the Federal Parity Act extends to nearly all commercial and Medicaid plans administered commercially, Congress has yet to extend Federal Parity Act protections to tens of millions of Americans in health coverage administered directly by states and the federal government. Unless all medically necessary mental health and substance use disorder services are covered by public and private payers in the same manner as physical health services, grant programs, pilot projects, and demonstrations will continue to fall short.

Medicare's discriminatory coverage provisions are neither isolated nor minor. Its lack of adequate coverage for mental health and substance use disorder treatment is even more problematic because the program serves as a benchmark for other forms of health coverage. For instance, gaps in Medicare are copied in TRICARE, and most commercial insurance plans rely on Medicare procedure codes, which do not exist for some mental health and substance use disorder services. Medicare fails to cover mental health crisis services, which commercial coverage mirrors, inhibiting the expansion of the nationwide 988 mental health crisis system that Congress has taken pains to set up through the National Suicide Hotline Designation Act of 2020. Additionally, Medicare sets provider reimbursement trends across the U.S. health care system, so disparities in its rate-setting

process, which tend to undervalue mental health and substance use disorder services, are replicated elsewhere.

Examples of coverage deficiencies embedded within Medicare include:

- *190-Day Lifetime Limit on Inpatient Psychiatric Hospital Services.* No other medical condition has this limitation, which arbitrarily cuts off necessary treatment for individuals with serious mental illness.

- *Lacks Coverage of Intensive, Evidence-Based Interventions*. Medicare does not cover evidence-based, multi-disciplinary team interventions for people with the most severe mental health and substance use disorders. This includes Coordinated Specialty Care for early psychosis, Assertive Community Treatment (ACT) teams, and medical nutrition therapy for eating disorders.

- *Limited Coverage of Levels of Behavioral Health Care.* Medicare does not cover residential or intensive outpatient levels of care for mental health and substance use disorders. It also inadequately covers services within the American Society of Addiction Medicine (ASAM) Criteria's levels of substance use disorder care, including withdrawal management.

- *Narrow Range of Covered Providers***.** Medicare does not cover the services from the full range of providers that make up a significant part of the mental health and substance use disorder workforces.

- *Restrictions on Telehealth.* Medicare's coverage of mental health and substance use disorder telehealth services remain limited, including for audio-only, though some *temporary* flexibilities have been granted during the COVID-19 pandemic.

Your leadership in addressing these inequalities would be very helpful to the entire health care system.

Furthering the Use of Telehealth Beyond the Pandemic

We regularly hear through our chapters and directly from participants of local support groups of the need to expand access to mental health services, both therapeutic resources and medical management needs. The ability for Americans to access this vital and essential set of services has been interrupted due to the need for physical distancing in response to the impact of the Covid-19 virus. A survey of our community—conducted between April 14 and May 20 of last year—revealed 78% of the respondents are utilizing mental health telehealth services. The vast majority, 96%, are new to these services. Forty-one percent indicated they had been receiving telehealth services for the last several months and 55% in just the last few days or weeks.

The expanded use of telehealth services for those living with mood disorders has been critical to allowing mental health therapeutic and medical management services be available to individuals seeking help. This has been particularly true for essential workers in a range of settings and those who live in underserved areas. We believe it is important to offer a range of telehealth modalities including the use

of audio calls for those who are unable to access or uncomfortable with using video conference calls. We recognize the importance of creating safe and private environments for both peers and clinicians to share confidential information and appreciate the complementary work being done to address the applicable privacy rules.

We are pleased with the announcement November 2, 2021 by the Centers for Medicare and Medicaid Services (CMS) to provide announced permanent authorization of tele-mental health from patients' homes and for the continued used of audio-only tele-health. However, further issues need to be addressed which are the subject of two pieces of legislation

Two pieces of legislation have been introduced to address many of these issues which are call for passage of. Your committee has jurisdiction over the first bill, *S.2061 Tele-mental Health Care Access Act of 2021*. This bill removes the statutory requirement that Medicare beneficiaries be seen in person within six months of being treated for mental health services through telehealth. Last year's end-of-year package permanently expanded access for Medicare patients to be treated in their home and other sites for mental health services, but unfortunately put in place an arbitrary requirement that would require the patient to be seen in-person before they could receive telemental services. The *Tele-mental Health Care Access Act of 2021* eliminates this in-person requirement so that patients can directly access mental health services via telehealth.

The second bill is being addressed by the Health, Education, Labor, and Pensions Committee is *S.660 Tele-Mental Health Improvement Act*. This bill requires private health insurance plans that cover in-person mental health or substance use disorder services to cover such services on equal terms via telehealth (i.e., information technology used to aid treatment and diagnosis at a physical distance) during and shortly after the COVID-19 (i.e., coronavirus disease 2019) public health emergency. Specifically, this bill requires plans to, among other things, cover these services at the same rate as in-person services, exclude charges for facility fees, and provide information about how to access these services. Additionally, providers of these services may not charge facility fees to plan enrollees.

Improving Access to Coverage and Care for Young People, Children and New Mothers

According to a survey from Mental Health America, 9.7% of youth in the U.S. have severe major depression, compared to 9.2% in 2020. This rate was highest among youth who identify as more than one race-- 12.4%. The majority of youth do not receive treatment for their mental health conditions. Alarmingly, the Center for Disease Control reported suicide as the second leading cause of death for individuals aged 10-34 in 2017. Further, the COVID-19 pandemic has had a profound impact on the daily lives of children, exacerbating the already growing youth mental health crisis. From March to October of 2020, the proportion of emergency room visits for mental health-related concerns increased 24 percent for children aged 5-11 and 31 percent among adolescents aged 12-17, compared to the same timeframe in 2019.

Ideally, mental health concerns in children are identified by parents and caregivers but that's not always possible given children spend the majority of their day in school. Further, caregivers aren't always aware of mental health symptoms. DBSA endorses the recommendation of the American Academy of Pediatrics: "a developmental approach to children's mental health that encompasses primary prevention through promoting social-emotional health and safe, nurturing relationships; secondary

prevention through screening, identification, and assessment; and tertiary prevention through treatment and co-management with mental health professionals."

In light of the these concerns we recommend the passage of two important pieces of legislation.

- *S. 1390 Youth Mental Health Services Act of 2021*, which would authorize state and local educational agencies to use Student Support and Academic Enrichment grants to improve mental health services available to students. It would also allow the funds to be used for identifying best practices for mental health first aid, emergency planning, coordination of services, and telehealth services, and enhancing access to behavioral healthcare for the young adult population. This legislation would specifically address behavioral health for youth populations, through increased access to care and improved coordination of services.

- *S.484 Moms Matter Act* has two key provisions, first investing in community-based programs that provide mental and behavioral health treatments and support to mothers with maternal mental health conditions or substance use disorder and second providing funding to grow and diversify the maternal mental health and behavioral health workforce to expand access to culturally congruent care and support.

DBSA thanks you for your leadership these important issues facing our society these days. Addressing the behavioral health needs of Americans in crisis is critical and with thoughtful implementation provide much needed relief.

Sincerely,

Michael Pollock
Chief Executive Officer

Citations

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