10/30/2020

Good Afternoon REDC,

Clock is ticking til elections are over…hopefully! I'm sure you all are as ready as we are! Attached you will find the official Mental Health Liaison Group letter that the REDC led to states without existing telehealth laws about ensuring tele-mental health coverage for all levels of mental health care including IOP & PHP.

Sending over our weekly policy update:

SERVE Act/TRICARE Military Health:

- NDAA is still being conferenced, but with elections hot and heavy, there hasn't been any significant movement this week. The expectation is still to have passage early December.
- **New Co-sponsor to the SERVE Act:** Senator Chris Murphy (D-CT)
- **DoD Inspector General Report on mental health access to care:** We mentioned the report last week in the updated, and wanted to provide you with a summary of the 72-page document. Below highlights the key areas related to ensuring access to care for eating disorders and really demonstrates a systematic issue with DHA and DOD mental health services for both direct care and purchased care:
    - "Evaluation of Access to Mental Health Care in the Department of Defense" was conducted by the Office of the Inspector General (OIG) to determine if the Department of Defense (DoD) is complying with law and DoD policy. The evaluation was conducted from December 2018 to June 2019. OIG selected 13 military treatment facilities and their TRICARE networks to visit and study over the evaluation period.
    - **Findings**
        - The report found that the Department of Defense did not consistently meet outpatient mental health access to care standards in accordance with DoD policies, which state that the wait time for an urgent care visit must not exceed 24 hours, a routine visit must not exceed 1 week (7 days), and a specialty care referral must not exceed 4 weeks (28 days). Specifically, the report found that:
        - "7 of 13 Military Treatment Facilities (MTFs) or their supporting TRICARE network did not meet the specialty mental health access to care standard each month
        - An average of 53 percent all active duty service members and their families, identified as needing mental health care and referred to the purchased care system, did not receive care and the Military Health System (MHS) did not know why
        - 9 of 13 MTFs reported the inability to meet evidence-based treatment or monitor the prescribed behavioral health treatment dosage (including visit frequency) in accordance with DHA-PI 6490.02, which means the patient's follow-up treatment may have been delayed or did not occur"

- The report concluded that the DoD did not consistently meet outpatient mental health access to care standards because the Defense Health Agency (DHA):
    - "Lacked an MHS-wide model to identify appropriate levels of staffing in direct and purchased care
    - Published inconsistent and unclear access to mental health care policies
    - Did not have visibility of patients who attempted, but were unable, to obtain mental health appointments in the purchased care system
    - Measured the 28-day specialty access to care standard differently between the direct and purchased care systems, both of which included only those patients who were able to get an appointment, excluded patients who self-referred, and considered only the patients' first appointment"
- The OIG made 14 recommendations to the DHA to improve access to mental health care. The DHA Director agreed with nine of the recommendations, partially agreed with three, and disagreed with one. The recommendations address the four reasons the DHA failed to meet outpatient mental health access to care standards. Many of the recommendations include the standardization of several procedures including staffing, process and **outcome measurement**, centralized appointing, and referrals. **The recommendations also include the creation of new standardized access to care metrics and assessment, referral, and follow-up procedures.**
    - The DHA Director disagreed with the recommendation that DHA create a new metric tracking the reasons are not used because it would be an invasion of patient privacy. The DHA Director developed plans to address many of the recommendations he agreed to, but the date of implementation for the plans varies extensively from a few months to several years. In my opinion, the recommendations make sense and will likely have a positive impact, but realistically they do more to help DHA understand the problem than to resolve it.
- **Pertinence to the EDC & GAO Report**
    - Generally, this report echoes the EDC's response to the GAO report and concerns about access to care. The report does not address a lack of screening or culture of silence within the armed services, but it highlights an enormous lack of treatment options. There were two findings in the report that would be of particular notice to the EDC.

        I. Patients must use a provider directory known to be inaccurate
            a. "OIG found that TRICARE required patients to make their appointments using an inaccurate online provider directory, which complicated and

delayed care. Specifically, the TRICARE provider online directories in both the TRICARE East and West regions have not been accurate to the required 95 percent for the entire duration of the contract, which began January 1, 2018." The report also noted that the Government Accountability Office (GAO) conducted an evaluation of the TRICARE network in 2000 and found the directory to be inaccurate. Clearly, the issue has still not been resolved.

II. DoD mental health stakeholders were concerned with the adequacy of the TRICARE Network

a. At least five MTFs conducted their own studies of their local TRICARE network using either an internally developed survey, a review of purchased care access, or a collection of patient feedback. "One MTF's survey revealed that of the 125 providers listed, they found duplicate providers, 11 providers who were no longer in practice, and 26 providers who were not taking new TRICARE patients."

COVID-19 Relief

I. Provider Relief Funding

a. HHS will no longer define the revenue providers have lost during the pandemic by simply comparing how much they earned in 2019 to 2020 when reviewing reporting requirements.

i. This decision was after immense pushback from providers and hospitals who worried the measure would force them to return the relief.

b. Providers that receive more than $10,000 in relief are required to send HHS their COVID-19 related expenses for which they haven't been reimbursed.

i. The department released its first detailed guidance on the reporting requirements on Sept. 19, and the formula for calculating the amount of revenue lost due to the pandemic immediately sparked criticism from providers, lawyers, accountants and hospitals.

ii. HHS responded to those critiques Thursday (Oct. 22) and opted not to take operating costs into account when calculating providers' lost revenue due to the pandemic. The department

said it was initially attempting to make sure providers would not profit from the pandemic relief pay.

II. REDC/EDC-led Letter to States Urging Telemental Health Coverage Through 2021

a. The REDC and EDC led a letter on behalf of the Mental Health Liaison Group (MHLG) urging Governors to extend telemental health coverage through 2021, which aligns with what is currently proposed, but not finalized at CMS.
b. The letters were only sent to states that do not have a telehealth mandate including Alabama, Florida, Idaho, Louisiana, North Carolina, Pennsylvania, South Carolina, Wisconsin and Wyoming. All the letter are attached above for your reference.

ACA Watch

I. Last week, the House Ways & Means Committee held a hearing entitled, "Maximizing Health Coverage Enrollment Amidst Administration Sabotage" (full summary attached)

a. **Key Takeaways:**

i. State-based marketplaces have been generally successful at providing timely, flexible, and informed access to care to its residents during the COVID-19 pandemic.

ii. There remains partisan lines in Congress regarding the effectiveness of the ACA.

iii. The Trump administration has dramatically reduced funding for the ACA. There is no agreement on whether those actions were beneficial.

II. Threats to the ACA Could Add to Health Disparities

a. The ACA's insurance subsidies, Medicaid expansions of eligibility and its protections for preexisting conditions have especially helped Americans of color.

i. Coverage gains are among the most significant since the passage of Medicare and Medicaid and the desegregation of American hospitals more than 50 years ago.

b. Between 2013 and 2018, the rate of Latinx adults without health insurance plummeted from 40% to 25%.

i. The uninsured rate for Black adults fell from 24% to 14%.

ii. For white adults, it dropped from 15% to 9%.

c. According to the non-partisan Urban Institute, if the health law disappeared, the gaps would widen again—almost back to 2013 levels.

i. This estimation was in 2019—before the devastation of the COVID-19 pandemic.

ii. The 38 states that have expanded Medicaid would be hard hit.

1. In expansion states, gains in reducing the risk of amputation in people with diabetic foot ulcerations, as well as improvements in infant mortality and maternal rates. The gains were concentrated among Black mothers and children.

d. A second Trump term would certainly mean limited outreach and marketing, which ACA supporters say has stifled enrollment.

e. In contrast, Biden is promising to expand on the ACA proposing a public option that would auto-enroll low-income people who lose their jobs and giving people a new choice for coverage.

i. Biden has also proposed lowering the Medicare age to 60, which would further reduce the uninsured gap and doubling investments into community health centers.

Parity

I. DOL has issued the final 2020 MHPAEA self-compliance tool that can be accessed here.

a. The news release can be found here: https://www.dol.gov/newsroom/releases/ebsa/ebsa20201023

b. Preface to 2020 MHPAEA Self-Compliance Tool available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool-preface.pdf

BCBS Millennial Health: Trends in Behavioral Health Conditions

I. The full report can be found here: https://www.bcbs.com/the-health-of-america/reports/millennial-health-trends-behavioral-health-conditions#keyfindings

a. Key Findings

i. 1/3 of millennials have a behavioral health condition, and rates are rising by double digits.

ii. Millennials with a behavioral health condition are at 2x the risk of having a chronic physical condition.

iii. Millennials from majority Black and Hispanic communities have lower rates of behavioral health conditions compared to millennials from white communities—likely due to under diagnosis.

iv. Substance use disorder continues to rise among this group. Those diagnosed with an opioid use disorder are 46% less healthy than their peers and treatment varies by race with Blacks and Hispanics having lower overall rates of treatment than whites.

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